Audit, Risk & Assurance Committee

Mon 18 July 2022, 10:00 - 12:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_18July2022.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 13 June 2022 for approval

ARA_Item_1.3_Unconfirmed_Minutes_13Jun22.pdf (6 pages)

1.4. Matters arising from previous meeting

1.5. Committee Action Log

ARA_Item_1.5_Action Log_13Jun22.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application for Single Tender Waiver

Attached *Director of Finance and IT*

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

2.2. Losses and Special Payments Annual Report 2021-22

Attached *Director of Finance and IT*

ARA_Item_2.2_Losses and Special Payments Annual Report 2021-22.pdf (9 pages)

2.3.

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Internal Audit Progress Report 2022-23

Attached *Head of Internal Audit*

ARA_Item_3.1_Powys ARAC A&A Progress Report July 22 Cover.pdf (3 pages)
ARA_Item_3.1a_Powys ARAC A&A Progress Report July 22.pdf (8 pages)

3.2. Internal Audit Review Reports:

Attached *Internal Audits and Executive Leads*

3.2.1. Risk Management and Assurance (Reasonable Assurance)

ARA_Item_3.2a_PTHB2122.01 Risk Management Assurance Final Report.pdf (15 pages)

3.2.2. Breathe Well Programme (Reasonable Assurance)

ARA_Item_3.2b_PTHB22.07 Breathe Well Final Report.pdf (15 pages)

3.3. External Audit Progress Report 2022-23

Attached *External Audit*

ARA_Item_3.3_2001A2020-21 Audit Wales ARAC Update.pdf (10 pages)

3.4. Counter Fraud Update

Attached *Head of Local Counter Fraud*

ARA_Item_3.4_Counter Fraud Update Report.pdf (3 pages)
ARA_Item_3.4a_Counter Fraud Update Report - Copy.pdf (3 pages)
ARA_Item_3.4b_Appendix 1 Counter Fraud Benchmarking Performance Report.pdf (4 pages)
ARA_Item_3.4c_Appendix 2 Counter Fraud Investigations Update Report.pdf (2 pages)

3.5. Register of Interests

Attached *Interim Board Secretary*

ARA_Item_3.5_Delaration of Interests_June_2022.pdf (3 pages)
ARA_Item_3.5a_Appendix_A_Board Declarations of Interest Register 2022-2023.pdf (3 pages)
ARA_Item_3.5b_Appendix_B_Standards of Behaviour Framework Summary.pdf (3 pages)

3.6. Annual Governance Programme Reporting

Attached *Interim Board Secretary*

ARA_Item_3.6_Annual Governance Programme_2022-23_Q1_.pdf (10 pages)

3.7. Audit Recommendation Tracking

Attached *Interim Board Secretary*

ARA_Item_3.7_Audit Recommendations_Report_June 2022.pdf (11 pages)
ARA_Item_3.7a_Appendix_d_Interal Audit Recommendations Outstanding.pdf (3 pages)
ARA_Item_3.7b_Appendix_e_Internal Audit Recommendations Completed since previous report.pdf (2 pages)
ARA_Item_3.7c_Appendix_f_Internal audit Recommendations Not Yet Due for Implementation.pdf (2 pages)
ARA_Item_3.7d__Appendix_g_ External Audit Recommendations that remain outstanding.pdf (1 pages)
ARA_Item_3.7e_Appendix_h_ External Audit Recomendations Completed since previous report.pdf (1 pages)
ARA_Item_3.7f_Appendix_i_External Audit Recommendations Not Yet Due for Implementation.pdf (1 pages)
ARA_Item_3.7g_Appendix_j_Local Counter Fraud Recommendations Outstanding.pdf (1 pages)

3.8. Welsh Health Circular Tracking

Attached *Interim Board Secretary*

ARA_Item_3.8_Welsh Health Circulars May_2022.pdf (4 pages)
ARA_Item_3.8a_Appendix_1_WHC's currently Outstanding_.pdf (1 pages)
ARA_Item_3.8b_Appendix_2_WHC's Implemented since last report_.pdf (1 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

4.1. Committee Work Programme

Attached *Interim Board Secretary*

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:

27th September 2022 at 10am

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
MONDAY 18th July 2022 10.00 – 12.00
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 13th June 2022	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 13th June 2022	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Application for Single Tender Waiver	Attached	Director of Finance and IT
2.2	Losses and Special Payments Annual Report 2021-22	Attached	Director of Finance and IT
3	**ITEMS FOR ASSURANCE**		
3.1	Internal Audit Progress Report 2022-23	Attached	Head of Internal Audit
3.2	Internal Audit Review Reports: a) Risk Management and Assurance *(Reasonable Assurance)* b) Breathe Well Programme *(Reasonable Assurance)*	Attached	Internal Audit and Executive Leads
3.3	External Audit Progress Report 2022-23	Attached	External Audit
3.4	Counter Fraud Update	Attached	Head of Local Counter Fraud
3.5	Register of Interests	Attached	Board Secretary
3.6	Annual Governance Programme Reporting	Attached	Board Secretary

3.7	Audit Recommendation Tracking	Attached	Board Secretary
3.8	Welsh Health Circular Tracking	Attached	Board Secretary
4	**ITEMS FOR DISCUSSION**		
4.1	Committee Work Programme	Attached	Board Secretary
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 27th September 2022 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, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

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

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE EXTRAORDINARY MEETING HELD ON TUESDAY 13 JUNE 2022 VIA MICROSOFT TEAMS MEETING

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Gareth Lucy	External Audit
Ian Virgil	Internal Audit
Jayne Gibbon	Internal Audit
Pete Hopgood	Director of Finance and IT
James Quance	Interim Board Secretary
Andrew Gough	Deputy Director of Finance
Sarah Pritchard	Head of Financial services

Observers:

Vivienne Harpwood	PTHB Chair

Committee Support

Stella Parry	Interim Corporate Governance Manager

Apologies

Tony Thomas	Independent Member – Finance (Committee Chair)
Ronnie Alexander	Independent Member – General
Matthew Dorrance	Independent Member – Local Authority
Claire Powell	Powys CHC

ARA/22/028	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/22/029	**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/22/030	**MINUTES OF THE MEETINGS HELD 26 APRIL AND 17 MAY 2022** The minutes of the meetings held on 26 April and 17 May 2022 were RECEIVED and AGREED as being a true and accurate record.
ARA/22/031	**MATTERS ARISING FROM PREVIOUS MEETINGS** The following matters arising were discussed: 26th April 2022 (ARA/22/009): It was queried whether the Committee felt that that Recommendation 2.1 as discussed by the Committee should be included within the Committee Action Log. The Board Secretary confirmed that due to the nature of the recommendation monitoring would be undertaken through future capital schemes within the Powys programme. The Committee Chair queried whether an In-Committee session on cyber security would be beneficial for Members. The Director of Finance and IT reported that a session was under development for a forthcoming Board Development meeting. The Interim Board Secretary confirmed that consideration would be given to a separate in-Committee session for Committee Members to focus on assurances required.
ARA/22/032	**COMMITTEE ACTION LOG** The Committee received and NOTED the action log.
ARA/22/033	**ANNUAL REPORT AND ACCOUNTS 2021-22, INCLUDING LETTER OF REPRESENTATION** The Director of Finance and IT and Interim Board Secretary presented the Annual Report and Accounts 2021-22. It was noted that the draft sections had been reviewed by the Executive Committee, Delivery and Performance Committee and Audit, Risk and Assurance Committee and that the Annual Accounts had been audited by Audit Wales. The Committee was requested to consider the Annual Report and Accounts for recommendation for submission to the Board for formal approval on 14th June 2022 and submitted to Welsh Government on 15th June 2022, in-line with HM Treasury Requirements.

	Independent Members sought assurance by asking the following questions: *It was noted that timescales were tight for providing feedback at this stage and it was queried whether this was an extraordinary circumstance for 2021-22?* The Interim Board Secretary noted that due to the nature of the deadline and the requirements of the audit of the financial statements' timescales were always compressed, it was however highlighted that this is mitigated by the robust scrutiny of the draft components of the report undertaken by the PTHB Committees to seek to ensure that any amendments of the final version are minor. The Committee confirmed that a RECOMMENDATION would be made for formal approval of the Annual Report and Accounts 2021-22, including the letter of representation at the PTHB Board on 14th June 2022. Committee Members and those in attendance wished to express their thanks to the External Audit team for the ongoing support with the financial audit work undertaken on the accounts.
ARA/22/034	**APPLICATION OF SINGLE TENDER WAIVER** The Director of Finance and IT presented the following 5 applications for single tender waiver received during the period of 1 April 2022 and 31 May 2022:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2122028	Quote	Network of Staff Supporters	Counselling Services for Staff	Extension of previously tendered contract as interim measure while formal procurement is undertaken	13/04/2022	£14,027	2 Months	Prospective	A1
POW2122027	Tender	Kaleidoscope	Substance Misuse Prescribing Services	Extension of existing contract whilst procurement process undertaken	13/04/2022	£133,595	5 months	Prospective	A2

	POW2122025	Quote	My Dentist	Continuation of Emergency Out of Hours Dental Service for Newtown and Llandrindod areas	Extension of existing contract whilst procurement process undertaken	06/04/2022	£19,153	3 months	Prospective	A3
	POW2122022	Tender	Brecon Mind	9 month Continuation out of hours service for Mental Health for South Powys	Sole Supplier continuation of previous pilot funded by PTHB	06/04/2022	£47,570	9 Months	Prospective	A4
	POW2122021	Tender	Ponthafren Association	9 month Continuation out of hours service for Mental Health for North Powys	Sole Supplier continuation of previous pilot not funded by PTHB	06/04/2022	£18,319	9 Months	Prospective	A5

Independent Members sought assurance by asking the following questions:
Was a process in place to monitor whether departments were taking forward slippage from procurement?
The Director of Finance and IT agreed that this requires attention and suggested that there was a timely opportunity to establish this process. It was noted that the annual statistics had previously been considered by the Committee which confirmed that numbers were low in comparison to Wales. However, this matter would be followed up. **Action: Director of Finance and IT.**

ARA/22/035

HEAD OF INTERNAL AUDIT OPINION 2021-22
The Head of Internal Audit presented the item and noted that in accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) was 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 an audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2021-22 plan was formally approved by the Audit, Risk and Assurance Committee at its March 2021 meeting.

	It was noted that the Draft HIA Opinion had been presented to the Committee in May 2022 and drew attention to a number of reports which remained in draft at the time of reporting. The Committee NOTED the 'Reasonable Assurance' rating provided for 2021-22 and the Chief Executive and Committee Chair expressed their thanks to the Head of Internal Audit and internal audit colleagues for their ongoing work and support. The Committee CONSIDERED and NOTED the Head of Internal Audit Opinion and Annual Report 2021-22.
ARA/22/036	**INTERNAL AUDIT REPORTS** *a) Concerns Tracking and Monitoring (Substantial Assurance)* The Committee received the report and noted the two matters arising presented. The Chief Executive requested that the report be reported to the Patient Experience, Quality and Safety Committee for information. Independent Members sought assurance by asking the following questions: *What plans were in place for the improvement of Records Management?* It was confirmed that a Records Management Improvement Plan had been developed and that a position update was due to be reported to both the Executive Committee and Delivery and Performance Committee. *b) Recommendation Tracking and Follow-Up (Substantial Assurance)* The Committee received the report which had undertaken a review of the audit recommendation tracking process and had undertaken a follow up on two limited assurance reports from 2021-22 which had confirmed the implementation of recommendations made. The Committee welcomed the assurance provided by the report. *c) Occupational Health Services (Limited Assurance)* The Committee received the report and noted the Limited Assurance Rating. Independent Members sought assurance by asking the following questions: *The assurance summary provided a rating of 'reasonable' in relation to resources whereas it appeared that most issues were in relation to resources, what was the reason for this?* It was noted that a reasonable rating had been provided to recognise that a business case was in place whilst still recognising the issues facing the service. The Head of Internal Audit confirmed that the rating sought to provide balance with what the health board is already aware of and is making steps to address at the time of the audit. *How would the health board follow up progress against this report?* The Interim Board Secretary confirmed that the Committee would receive regular updates against progress through the Audit Recommendation Tracker reports received by the Committee at each meeting. It was also

	noted that further consideration would be given to the mechanisms by which performance reporting is provided to Committees. The Head of Internal Audit also noted that a follow-up review would be undertaken by Internal Audit in due course due to the Limited Assurance rating given to the review. The Committee received and NOTED the Internal Audit Reports.
ARA/22/037	**EXTERNAL AUDIT REPORTS** *External Audit of Financial Statements 2021-22* The Director of Finance and IT introduced the item and welcomed Gareth Lucy, Audit Manager for the Annual Accounts. It was noted that Audit Wales had provided an audit opinion on the accounts in relation to two separate matters: the truth and fairness of income and expenditure, which had been found to be satisfactory and the regularity of expenditure, for which a 'qualified' opinion has been provided with regard to the regularity of 'Scheme Pays' expenditure for clinicians. The Audit Manager assured the Committee that the qualification was in respect of a Ministerial Direction issued in December 2019, therefore any NHS organisation in Wales with the expenditure within their accounts will receive a qualified opinion. It was also reported that there had been an uncorrected misstatement in relation to indexation of land and building assets (£999,000), this was due to an updated All Wales indexation from the District Valuer in late March 2022 for which the accounts had not been updated. It was again noted that this was an issue across Wales. The Committee welcomed the report and expressed their thanks the Audit Wales colleagues for their support and contribution.
ARA/22/038	**COMMITTEE WORK PROGRAMME** The Committee received and NOTED the Committee Work Programme.
ARA/22/039	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be brought the attention of the Board and other Committees.
ARA/22/040	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/22/041	**DATE OF NEXT MEETING** 18 July 2022, 10:00 am, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(Following the meeting held 13 June 2022)

Minute	Date	Action	Responsible	Progress	Status
ARA/22/034	13 June 2022	Consideration would be given to a process for monitoring the way in which departments were managing slippage from procurement	Director of Finance & IT		

Parry Stella 12/07/2022 13:43:48

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 18th July 2022**
Subject :	**SINGLE TENDER WAIVERS**
Approved and Presented by:	Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:
To seek the Audit, Risk and Assurance Committee's RATIFICATION of Single Tender Waiver requests made between 1 June 2022 and 30 June 2022.
RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 1 item during the period of 1 June 2022 and 30 June 2022 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 June 2022 meeting which covered the period from 1 April 2022 and 31 May 2022.

A summary of the use of Single Tender Action from 1 June 2022 and 30 June 2022 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223029*	Tender	Medilogik	Maintenance of Endoscopy Reporting System	Sole Supplier	16/06/2022	£70,536	4 years	Prospective	A1

*Please note due to an administrative error within Procurement the Single Tender Waiver register log for 2022/23 commenced on STW2223029 therefore this is the first Single Tender Waiver for 2022-23 not the 29th

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 and Assurance Committee	**Date of Meeting:18th July 2022**
Subject :	Annual Report for Losses and Special Payments for the period 1st April 2021 to 31st March 2022
Approved and Presented by:	Director of Finance & ICT
Prepared by:	Head of Financial Services and Assistant Director, Quality and Safety
Other Committees and meetings considered at:	None

PURPOSE:
To NOTE the Annual Report of Losses and Special Payments for the period 1st April 2021 to 31st March 2022.
RECOMMENDATION(S):
The Audit Committee is asked to: It is recommended that the Audit Committee NOTE this Annual Report on Losses and Special payments covering the period 1st April 2021 to 31st March 2022.

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:

Losses and special payments are items that the Welsh Government would not have contemplated when they passed legislation or agreed funds for the NHS; such payments would also include any ex gratia payments made by the THB.

By their nature they are items which should be avoidable and should not arise. They are subject therefore to special control procedures and are included within a separate note in the THB's annual accounts.

DETAILED BACKGROUND AND ASSESSMENT:

The following relate to payments made on behalf of cases for which Powys THB have responsibility. Claims relating to the Residual Clinical Negligence (relating to former Health Authorities) cases are scrutinised by the Welsh Risk Pool advisory panel and therefore are not required to be included below.

The Audit Risk and Assurance Committee received an Interim report at its November 2021 meeting documenting Losses and Special payments made between the period 1st April 2021 to 31st October 2021.

This paper provides an annual report for the period 1st April 2021 to 31st March 2022.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Senior Manager, Putting things Right, who has responsibility for this area of work, manages the claims on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support is provided by the Welsh Risk Pool Services and Legal & Risk Services on the processes and on the management of individual cases.

Systems and processes have been established and databases documenting all claims activity alongside the individual claims files exist. Decision making on payments are approved in a number of ways:

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery. All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety Committee (and the former Experience, Quality and Safety Committee).
- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2021 to 31 March 2022, the THB made payments in respect of 9 cases totalling £122,307.05 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year the THB received one reimbursement in respect of cases that exceeded the £25,000 THB liability.

Details of the payments are included in **Appendix Ai**.

	No. of payments/Receipts	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	31	9	122,307.05
Total	**31**	**9**	**122,307.05**
Receipts from Welsh Risk Pool	**1**	**1**	**209,363.40**
Total	**1**	**1**	**209,363.40**

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 13 open which are inclusive of clinical negligence (8) and personal injury (5) claims, with NWSSP Legal and Risk Services instructed to act on behalf of the health board.

Redress (Putting Things Right)

These relate to smaller claims that are managed by the THB in line with the Putting things Right Legislation. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2021 to 31st March 2022 are included in **Appendix Aii.**

	No. of payments/receipts	No. of cases	£
Redress Payments	36	14	18,514.13
Total	**36**	**14**	**18,514.13**

Redress Receipts	5	5	40,355.80
Total	**5**	**5**	**40,355.80**

Details of the receipts in 2021/22 from Welsh Risk Pool in respect of reimbursements for Redress are included in **Appendix Aii.**

GP Indemnity

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GP's and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. All payments made in respect of such cases are reimbursable from Welsh Risk Pool

Details of the payments made during 1st April 2021 to 31st March 2022 are included in **Appendix Aiii.**

	No. of payments/receipts	No. of cases	£
GP Indemnity	5	2	17,324.00
Total	**5**	**2**	**17,324.00**

Other Special Payments

Details of the payments are included in **Appendix Aiv**

	No. of payments/receipts	No. of cases	£
Other Special Payments	6	6	38,388.43
Total	**6**	**6**	**38,388.43**

Conclusion

The Audit Committee is asked to note the above annual report for 2021/22 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

The Audit Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

Losses And Special Payments for 2021-22 Financial Year
1st April 2021 to 31st March 2022

Appendix Ai

Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Defence	MN/030/1166/AV	Apr-21	£2,446.20		
Clinical Negligence	Claimant Costs	MN/030/1166/AV	Apr-21	£16,000.00	£18,446.20	Case Finalised
Clinical Negligence	Defence	MN/030/1564/AS	Jun-21	£10.00		
Clinical Negligence	Defence	MN/030/1564/AS	Jan-22	£1,200.00		
Clinical Negligence	Defence	MN/030/1564/AS	Nov-21	£3,000.00		
Clinical Negligence	Defence	MN/030/1564/AS	Nov-21	£5,753.65		
Clinical Negligence	Defence	MN/030/1564/AS	Dec-21	£1,250.00		
Clinical Negligence	Defence	MN/030/1564/AS	Dec-21	£750.00		
Clinical Negligence	Damages	MN/030/1564/AS	Dec-21	£8,000.00	£19,963.65	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1454/OF	Jun-21	£4,032.00	£4,032.00	Interim payment case ongoing
Personal Injury	Defence	PI/030/1432/AH	Jun-21	£720.00		
Personal Injury	Defence	PI/030/1432/AH	Jun-21	£100.00	£820.00	Interim payment case ongoing
Clinical Negligence	Damages	MN/030/1441/RR	Sep-21	£25,000.00		
Clinical Negligence	Claimant Costs	MN/030/1441/RR	Sep-21	£30,000.00		
Clinical Negligence	Defence	MN/030/1441/RR	Aug-21	£648.00		
Clinical Negligence	Defence	MN/030/1441/RR	Aug-21	£270.00		
Clinical Negligence	Defence	MN/030/1441/RR	Dec-22	£1,320.00		
Clinical Negligence	Damages	MN/030/1441/RR	Dec-22	£10,000.00	£67,238.00	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1509/OF	Oct-21	£1,860.00	£1,860.00	Interim payment case ongoing
Personal Injury	Defence	PI/030/1556/AH	May-21	£427.90		
Personal Injury	Defence	PI/030/1556/AH	Jun-21	£330.00		
Personal Injury	Defence	PI/030/1556/AH	Jul-21	£347.60		
Personal Injury	Defence	PI/030/1556/AH	Oct-21	£264.00		
Personal Injury	Defence	PI/030/1556/AH	Mar-22	£451.00	£1,820.50	Interim payment case ongoing
Personal Injury	Defence	PI/030/1552/AH	May-21	£289.30		
Personal Injury	Defence	PI/030/1552/AH	May-21	£346.50		
Personal Injury	Defence	PI/030/1552/AH	Jul-21	£476.30		
Personal Injury	Damages	PI/030/1552/AH	Aug-21	£1,200.00		
Personal Injury	Damages	PI/030/1552/AH	Aug-21	£1,392.00	£3,704.10	Interim payment case ongoing
Clinical Negligence	Defence	GEN/030/1602/DAG	Dec-21	£1,722.60		
Clinical Negligence	Damages	GEN/030/1602/DAG	Dec-21	£2,700.00	£4,422.60	Case Finalised
		TOTAL		£122,307.05	£122,307.05	

Reimbursements from Welsh Risk Pool

Receipt Date		Laspar Reference	Nature of Reimbur	Amount		
Feb-22		MN/030/1166/AV	Damages and Defence	-£209,363.40		Case Finalised
			Total	-£209,363.40		

Appendix Aii

Redress Losses And Special Payments for 2021-22 Financial Year

1st April 2021 to 31st March 2022

Appendix Aii

Payment Date	Redress Reference	Laspar Reference	Nature of Payment	Amount	Amount per case
Apr-21	4464	216C4MN0004	Damages	£1,500.00	£1,500.00
Apr-21	4596	216C4MN0009	Defence	£9.90	
Apr-21	4596	216C4MN0009	Damages	£1,000.00	
May-21	4596	216C4MN0009	Defence	£29.70	£1,039.60
May-21	3925	206C4MN0007	Damages	£1,600.00	£1,600.00
Jul-21	3492	196C4MN0012	Defence	£360.00	
Dec-21	3492	196C4MN0012	Defence	£180.00	
Nov-21	3492	196C4MN0012	Defence	£217.80	
Nov-21	3492	196C4MN0012	Defence	£79.20	£837.00
Nov-21	3590	196C4MN0013	Defence	£108.90	
Nov-21	3590	196C4MN0013	Defence	£45.90	
Jan-22	3590	196C4MN0013	Defence	£19.80	£174.60
Jul-21	3111	196C4MN0006	Damages	£300.00	£300.00
Apr-21	3222	196C4MN0007	Defence	£207.90	
Aug-21	3222	196C4MN0007	Defence	£1,720.00	£1,927.90
Aug-21	3292	196C4MN0005	Defence	£1,890.00	
Nov-21	3292	196C4MN0005	Defence	£326.70	
Mar-22	3292	196C4MN0005	Damages	£750.00	
Mar-22	3292	196C4MN0005	Claimant Costs	£1,600.00	
Mar-22	3292	196C4MN0005	Claimant Costs	£53.33	£4,620.03
Sep-21	42947	216C4MN0006	Defence	£1,705.00	
Nov-21	42947	216C4MN0006	Defence	£59.40	£1,764.40
Jul-21	4445	216C4MN0007	Defence	£19.80	
Aug-21	4445	216C4MN0007	Defence	£99.00	
Nov-21	4445	216C4MN0007	Defence	£69.30	£188.10
Apr-21	4449	216C4MN0008	Defence	£39.60	
Jul-21	4449	216C4MN0008	Defence	£29.70	
Aug-21	4449	216C4MN0008	Defence	£49.50	
Jan-22	4449	216C4MN0008	Defence	£300.00	£418.80
May-21	4165	226C4MN0001	Defence	£79.20	
Jul-21	4165	226C4MN0001	Defence	£39.60	
Dec-21	4165	226C4MN0001	Defence	£1,920.00	
Mar-22	4165	226C4MN0001	Defence	£1,600.00	£3,638.80
Apr-21	42248	226C4MN0002	Defence	£198.00	
Feb-22	42248	226C4MN0002	Defence	£207.90	£405.90
Nov-21	WEB43252	226C4MN0007	Defence	£99.00	£99.00
			Total	**£18,514.13**	**£18,514.13**

Reimbursements from Welsh Risk Pool

Receipt Date		Laspar Reference		Amount	
Sep-21		216C4MN0001		-£750.00	
Nov-21		196C4MN0008		-£26,205.80	
Nov-21		216C4MN0004		-£1,500.00	
Jan-22		196C4MN0019		-£10,000.00	
Jan-22		196C4MN0010		-£1,900.00	
			Total	**-£40,355.80**	

Appendix Aiii

GP Indemnity Losses And Special Payments for 2021-22 Financial Year

1st April 2021 to 31st March 2022

Appendix Aiii

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount per case
Jul-21	GPM/030/1555/CAP	Defence	£12.00	
Sep-21	GPM/030/1555/CAP	Defence	£600.00	
Mar-22	GPM/030/1555/CAP	Damages and Claimant Costs	£13,000.00	£13,612.00
Nov-21	GPM/030/1417/CAP	Defence	£1,152.00	
Dec-21	GPM/030/1417/CAP	Defence	£2,560.00	£3,712.00
		Total	**£17,324.00**	**£17,324.00**

Reimbursements from Welsh Risk Pool

Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
			£0.00
		Total	**£0.00**

Appendix Aiv

Other Losses And Special Payments for 2021-22 Financial Year

1st April 2021 to 31st March 2022

Appendix Aiv

Payment Date	Laspar Reference	Nature of Reimbursement	Amount
Apr-21	216C4EG0001	Agreement of lesser amount in respect of fraud case	£1,515.60
Jun-21	216C4EG0002	Loss of personal hearing aids whilst on ward	£2,939.30
Aug-21	216C4EG0003	Agreement of lesser amount in respect of dental clawback as based on legal advice - Amount approved by Welsh Government	£32,863.53
Dec-21	216C4EG0004	Damage to Vehicle from PTHB Sign	£320.00
Feb-22	216C4EG0005	Public Service Ombudsman instructed payment in respect of complaint around claim handling	£250.00
Mar-22	216C4EG0006	Public Service Ombudsman instructed payment in respect of findings within a complaint report	£500.00
		Total	**£38,388.43**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.1

Audit, Risk and Assurance Committee	**Date of Meeting: 18 July 2022**
Subject:	**Internal Audit Progress Report**
Approved and Presented by:	Board Secretary / Head of Internal Audit
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

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

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Note** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
- **Approve** the proposed adjustments to the 2022/23 Internal Audit 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 two audit reports from the 2021/22 plan have been finalised since the June 22 meeting of the Committee:

- Risk Management & Assurance (Reasonable Assurance)
- Breathe Well Programme (Reasonable Assurance)

Although these reports were not finalised in time for submission to the June Committee, the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

The progress report also includes details of proposed amendments to 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 July 2022

NWSSP Audit and Assurance Services

Partneriaeth Cydwasanaethau
Cydwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

1. Introduction

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

Two audit reports from the 2021/22 plan were not finalised in time for submission to the Audit Committee in June 22, although the draft outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

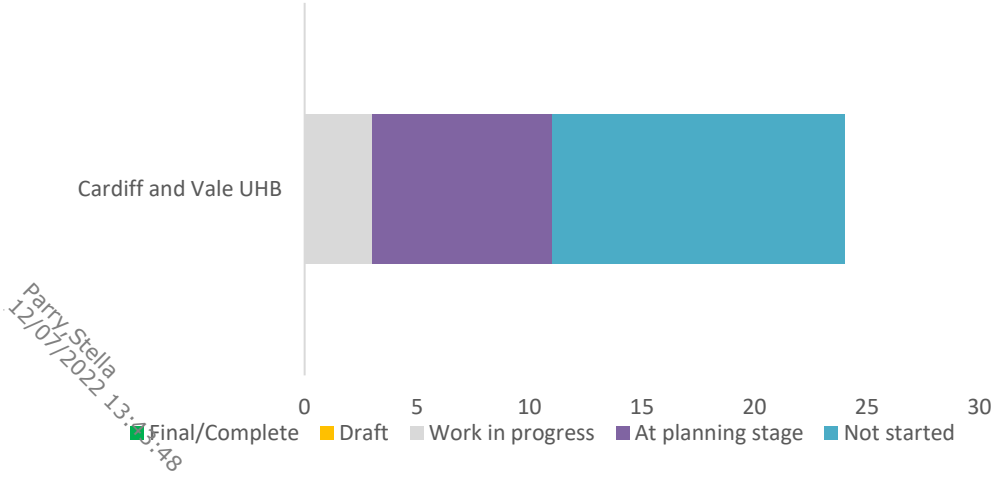
Both of the audits have now been finalised, as detailed in the table below along with the allocated assurance ratings.

The full versions of the reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS (2021/22 Opinion)	ASSURANCE RATING	
Risk Management & Assurance	Reasonable	
Breathe Well Programme		

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 24 reviews included within the 2022/23 Internal Audit Plan (including the additional audit detailed under section 4 below), and overall progress at this early stage of the year is summarised below.



From the illustration above it can be seen that there are three audits that are currently work in progress with a further eight at the planning stage.

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

4. Changes to the 2022/23 Plan

- **Proposed Timings**

  The plan that was agreed by the Committee in April 22 included details of the proposed quarters in which each of the identified audits would be undertaken.

  Following a more detailed review of the availability of Internal Audit resources and discussions with relevant lead contacts, adjustments have since been proposed to the planned timings for the following audits:

  - North Powys Wellbeing Programme – Move from Q1 to Q2
  - Review of a service area within the PC&MH Directorate – Move from Q1 to Q2
  - Staff Rostering – Move from Q3 to Q2
  - Temporary Staffing Department – Move from Q1 to Q3
  - Professional Governance Structure – Move from Q4 to Q3

- **Addition of Site Co-ordination audit**

  This audit was deferred from the 2021/22 plan after the 2022/23 plan had been agreed by the Committee and has therefore been added to the current plan.

5. Engagement

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

<u>Board / Sub Committees</u>

- Board – 25 May

<u>Health Board Meetings</u>

- Stella Parry, Interim Corporate Governance Manager – 14 April
- Mark McIntyre, Deputy Director of Workforce & OD – 19 May
- Claire Roche, Director of Nursing & Midwifery – 31 May
- Carol Shilabeer – Chief Executive – 1 June
- Jamie Marchant, Director of Environment – 6 June
- James Quance, Board Secretary – 15 June
- Pete Hopgood, Director of Finance – 30 June

<u>Audit Wales</u>

- Bethan Hopkins – 28 April, 30 June

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
IT Asset & Infrastructure Management	9	Finance, Information & IT	1		Work in Progress		September
Welsh Language Standards	13	Therapies & Health Science	1		Planning		September
Operational Service Review – Security Services	20	Environment	1		Planning		September
Decarbonisation	22	Environment	2		Work in Progress		September
Site Co-ordination *(Deferred from 21/22)*	24	Environment	2		Work in Progress		September
North Powys Wellbeing Programme (Deferred from 21/22)	16	Planning & Performance	~~1~~	2	Planning		November
Review of a service area within the PC&MH Directorate	18	PC&MH	~~1~~	2	Planning		November
Staff Rostering	2	Workforce & OD	~~3~~	2	Planning		November
Covid 19 Incident Management	19	Public Health	2		Planning		November
Workforce Futures Framework (Deferred from 21/22)	*4*	*Workforce & OD*	*3*		Planning		*November*
Charitable Funds	8	Finance, Information & IT	2		Planning		January
Looked After Children with Mental Ill Health (Deferred from 21/22)	5	Nursing & Midwifery / PC&MH	2				January

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Cancer Services (Deferred from 21/22)	11	Medical / Planning & Performance	2				January
Temporary Staffing Department	3	Workforce & OD	~~1~~	3			January
Professional Governance Structure	14	Therapies & Health Science	~~4~~	3			January
Directorate Quality & Safety Governance Arrangements	6	Nursing & Midwifery / PC&MH	3				March
Cyber Security	10	Finance, Information & IT	3				March
Planned Care / Recovery of backlog Services	17	Planning & Performance	3				March
Machynlleth Project	*21*	*Environment*	*3*				*March*
Savings Plans / Efficiency Framework	*7*	*Finance, Information & IT*	*4*				*March*
Follow-up Action Tracker	23	Board Secretary	4				March
Performance Management & Reporting (Deferred from 21/22)	15	Planning & Performance	3				April
Board Assurance Framework / Risk Management	1	Board Secretary	4				April
SLAs for In-reach Medical Staff	12	Medical	4				April

Assurance Ratings

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

Office details:

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

Risk Management & Assurance
Final Internal Audit Report

July 2022

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-2122-01
Report status:	Final
Fieldwork commencement:	11th May 2022
Fieldwork completion:	7th June 2022
Debrief meeting:	15th June 2022
Draft report issued:	15th June 2022
Management response received:	7th July 2022
Final report issued:	8th July 2022
Auditors:	Jayne Gibbon, Stuart Bodman
Executive sign-off:	James Quance, Interim Board Secretary
Distribution:	James Quance, Interim Board Secretary Stella Parry, Interim Corporate Governance Manager Andrew Cresswell, Assistant Director - Facilities & Support Services Directorate Louise Turner, Assistant Director – Women's & Children's Services
Committee:	Audit Risk & Assurance Committee

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

To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Risk Management and Assurance.

Overview

We have issued Reasonable assurance on this area.

We have identified four key matters requiring management attention:

- Absence of a dissemination and awareness exercise to support the revised November 2021 iteration of the Risk Management Framework.
- Absence of any formal and structured risk management training to Health Board members and staff.
- Revision and updating of Corporate Risk Assurance Group (RAG) Terms of Reference document.
- Absence of Corporate Risk Assurance Group during 2021/22.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Risk Management Framework, Policy and Procedures	Reasonable
2	Risk Identification	Reasonable
3	Risk mitigation, monitoring and reporting	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	Awareness and dissemination of 2021 Risk Management Framework	1	Design	Medium
2	Risk Management training	2	Design	Medium
3	Outdated Corporate Risk Assurance Group (RAG) Terms of Reference	2	Operation	Medium
4	Absence of Corporate Risk Assurance Group during 2021/22	3	Operation	Medium

1. Introduction

1.1 Our audit review of Risk Management and Assurance was completed in line with the 2021/22 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

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

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

1.4 Our testing was undertaken within the following three areas:

- Corporate Governance Department;
- Support Services Department, Facilities & Support Services Directorate; and
- Women's & Children's Directorate.

1.5 The relevant Executive lead for our review was the Interim Board Secretary.

1.6 The key risks considered in our review are as follows:

a. Lack of awareness of the Risk Management Framework and supporting processes;
b. Risks are not being identified, assessed, or included on appropriate risk registers;
c. Risks are not being actively addressed; and
d. Risks are not being escalated through the Health Board as appropriate.

2. Detailed Audit Findings

Objective 1: Risk Management Strategy, Policy and Procedures

2.1 The Health Board has a current Risk Management Framework and Toolkit in place dated November 2021 which provides 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.

2.2 Whilst the Risk Management Framework and Toolkit are easily accessible via the Health Board's intranet and internet sites there has been no formal promotion or dissemination exercise to ensure the widest possible awareness of this document to all staff. *(Matter Arising 1 – Medium Priority)*

Conclusion:

2.3 Whilst there is a current and comprehensive Risk Management Framework in place, the absence of wider promotion of its existence could lead to a lack of awareness which may impede effective risk management practice across the organisation. We have provided reasonable assurance against this objective.

Objective 2: Risk identification

2.4 The Risk Management Framework and Toolkit clearly outlines key principles and processes that enable risk identification and assessment to determine and prioritise how the risks should be managed.

2.5 The Risk Management Framework and Risk Management Toolkit provides clear and comprehensive guidance on the appropriate scoring of risks according to the scenario/context of the risk identified.

2.6 The document also sets out selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level, cognisant of risk appetite. A clear link is also stated between the Corporate Risk Register and the Directorate/Departmental Risk Registers.

2.7 Our review of the three risk registers within the Corporate Department, Support Services Department and Women & Children Directorate confirmed that all risks stated were 'real risks', and not issues that were included that do not actually impact on service provision, in accordance with the prescribed definitions of risk stated in the Risk Management Framework.

2.8 However, there is currently no formal and structured risk management training plan in place for the organisation to support and supplement the content of the Risk Management Framework. We were also unable to identify that any specific Health Board risk management training had been provided to all Health Board members and relevant staff. *(Matter Arising 2 – Medium Priority)*

2.9 All three sampled areas have risk champions to support the delivery of risk management within their respective Directorates/Departments. It is however noted that although risk management roles and responsibilities are stated within the Corporate Risk Assurance Group (RAG) Terms of Reference (ToR) document, the ToR is three years out of date and requires review and updating to reflect the implementation of the risk champions. *(Matter Arising 3 – Medium Priority)*

Conclusion:

2.10 Risks are being appropriately assessed and recorded within Directorate risk registers and risk champions have been identified. However, risk management training should be provided to all Health Board members and staff to maximise awareness of processes and knowledge documented within the Risk Management Framework. The RAG ToR should be updated to reflect current risk management practices and processes. We have provided reasonable assurance against this objective.

Objective 3: Risk mitigation, monitoring and reporting

2.11 The Risk Management Framework and Risk Management Toolkit outlines the risk mitigation processes to be undertaken by Directorates/Departments, and our review of sampled risks within each of the three aforementioned risk registers evidenced that these processes are being formally documented and put into practice.

2.12 Each risk register is current in content and is subject to regular review and action planning is undertaken to ensure mitigation of the risks stated.

2.13 The treatment of significant risks (high scoring risks or those of a strategic nature) at Directorate/Departmental level is stated within the Risk Management Framework in respect of their prioritisation of escalation to, or de-escalation from the Corporate risk register.

2.14 Those risks that relate to clinical, operational and financial strategy are assigned to the appropriate Sub-Committees of the Health Board e.g., Delivery Performance Committee, Patient Experience Quality & Safety Committee and Workforce & Culture Committee. The Sub-Committees' role in relation to the assigned risks are referenced within their respective Terms of Reference documents.

2.15 Our review of Agendas and Minutes of the each of the Board Sub-Committees meetings for the period November 2021 to March 2022 confirmed that risk management (including risk register review & action plans) was a standing agenda item at each. It was also evident that regular monitoring and scrutinising of risks, including those risks that may be irrelevant and redundant in nature is being undertaken in accordance with their Terms of Reference requirements.

2.16 It is however noted that Risk Assurance Group (RAG) meetings have been minimal during 2021/22 due to operational and staffing pressures arising from the Omicron COVID variant and changes to Group membership. As such its key role and function regarding risk management scrutiny, monitoring and risk register progress are not being undertaken. However, this shortfall has been in part covered via the fact that the Executive Committee and Board meetings are provided with updates of the Corporate risk register accordingly. *(Matter Arising 5 – Medium Priority)*

2.17 Additionally, a review of the ToR for the Audit Risk & Assurance Committee identified that regular updates on the Corporate Risk Register and a copy of the Risk Register should be received at each Committee meeting. Our fieldwork identified this did not occur at any of the Committee meetings in 2020/21, and therefore the role of the Committee needs to be confirmed and the ToR updated if required. The Committee should then receive appropriate reports in accordance with the confirmed role and ToR *(Matter Arising 4 – Low Priority)*

Conclusion:

2.18 Risks are being appropriately escalated through the Health Board and are effectively monitored by relevant Board Sub-Committees. However, the Corporate RAG meetings should be reactivated as soon as practicable so as to provide the required oversight and scrutiny of risk management as prescribed within its Terms of Reference. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Awareness and Dissemination of the 2021 Risk Management Framework (Operation)	**Impact**
The current iteration of the Risk Management Framework which was approved by the Board in November 2021 outlines risk management governance criteria, roles, responsibilities and reporting processes at all levels of the organisation and the Board's statement on risk appetite. The Risk Management Toolkit, which sits as part of the Framework, is the key risk management procedure which clearly and comprehensively states the processes to be undertaken, documented and reported. Discussions with the two sampled areas (Support Services & Women's and Children's Directorate respectively) identified that this document is used exclusively with no other local risk management guidance being required or in use. It is also noted that the requirements stated within the Risk Management Framework aligns to the content of the individual Terms of Reference documents of the Corporate function, and the senior management team groups of the two sampled areas who oversee risk management as part of their overarching governance processes. However, whilst the current Risk Management Framework and supporting information is accessible on the Health Board intranet site, there is no evidence of any communications or dissemination exercise undertaken to Directorates so as to maximise awareness of this documentation.	Lack of awareness of the Risk Management Framework and supporting processes.

Recommendations		**Priority**
1	Future iterations of the Risk Management Framework should be supported by an awareness exercise and ensure dissemination of the documentation to Directorate senior management so they can cascade the information to their staff accordingly and reduce the potential of inconsistent or inadequate risk management practices across the Health Board.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1	Recommendation Accepted It should be noted, however, that members of the current RAG are aware of the risk management framework, as are all Board members. Wider awareness throughout the organisation can always be improved and accept that future iterations should have a proactive awareness exercise in place to support them.	31 December 2022	Interim Board Secretary

Matter Arising 2: Risk Management Training (Design)	**Impact**
Section 10, Pages 17-18 of the Risk Management Framework states the required training need and frequency of training across different staff groups in accordance with their role in risk awareness and management of risks. At the time of the audit, the Interim Corporate Governance Manager was not aware of any planned and structured risk management training having been in place prior to her commencement in January 2022, other than a session provided to the Therapies Department in October 2021. Currently there are no formal or timetabled plans to provide any further training to other Directorates. Additionally, it is noted that the last risk management training provided to Board Members was proposed to have been undertaken in September 2020 but there is no evidence that this took place. The two sampled areas (Support Services Department & Women's and Children's Directorate) also confirmed that they have not received any risk management training in recent years.	Lack of awareness of the Risk Management Framework and supporting processes.

Recommendations		**Priority**
2	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	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	31 October 2022	Interim Board Secretary

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	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.		

Matter Arising 3: Outdated Corporate Risk Assurance Group (RAG) Terms of Reference document (Operation)	**Impact**
Good practice is noted that the three sampled areas have nominated risk champions to support the delivery of risk management roles and responsibilities stated within their respective Directorate/Departmental senior management team Terms of Reference (ToR) documents, and these were formally approved in April 2022 by the Executive Team. However, whilst risk management roles and responsibilities are stated within the Corporate RAG ToR document, it is noted that the ToR is three years out of date. These should be updated to reflect the roles and work to be undertaken by the risk champions, and subsequent changes in the organisation's structure and governance processes since the previous iteration of the document which was produced in 2019.	Lack of awareness of the Risk Management Framework and supporting processes.

Recommendations		**Priority**
3	The Corporate RAG ToR document should be updated accordingly to reflect organisational changes and approach to risk governance since 2019.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	Recommendation Accepted The TOR of the RAG were considered at its meeting of 5 July 2022 and it was agreed that generally they remain fit for purpose. However, a wider review of risk management arrangements is due to conclude in November 2022 when the review of the Risk Management Framework is due to be reported to the Board of which the role of RAG will be updated as required.	30 November 2022	Interim Board Secretary

Matter Arising 4: Audit & Risk Assurance Committee ToR – Workplan Report and Corporate Risk Register (Operation)	**Impact**
Section 3.2 of the Audit, Risk & Assurance Committee Terms of Reference document (ToR) refers to a workplan report that should be submitted to the Committee summarising any significant changes to the organisation's strategic risks, along with a copy of the Corporate Risk Register. From Internal Audit's attendance at Audit Committee during 2021/22 and our review of Q4 2021/22 sets of Committee Minutes we were not able to see any evidence of either a workplan or the Corporate Risk Register being reviewed. The Committee's workplan for 2022/23 does not include any matter relating to receipt or review of the Corporate Risk Register. However, it is noted that the Corporate risk register is received, reviewed and scrutinised by the Executive Committee and Board itself.	Lack of awareness of the Risk Management Framework and supporting processes.

Recommendations		**Priority**
4	The role of the Audit, Risk & Assurance Committee in receiving and monitoring the Corporate Risk Register should be confirmed and the ToR should then be updated if required. The Committee should then receive appropriate reports in accordance with the confirmed role and ToR.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Recommendation Accepted This will be clarified during the next quarterly reporting cycle.	31 October 2022	Interim Board Secretary

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Matter Arising 5: Absence of Corporate Risk Assurance Group during 2021/22 (Operation)	**Impact**
Corporate Risk Assurance Group (RAG) meetings have been negligible during 2021/22 due to operational and staffing pressures arising from the Omicron COVID variant and changes to Group membership. As such, currently the stated requirements of RAG Terms of Reference and specifically that of its roles and responsibilities regarding risk management scrutiny, monitoring and risk register progress are not being undertaken. However, it is noted there is a bi-monthly cycle whereby the Executive Committee and Board are provided with updates of the Corporate risk register which in part mitigates one of the roles of the RAG.	The Executive Committee does not receive effective support in ensuring implementation and management of the risk management process.

Recommendations		**Priority**
5	Corporate Risk Assurance Group meetings should be reactivated in 2022/23 so as to meet its roles and responsibilities prescribed within its Terms of Reference document.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	Recommendation Accepted RAG meetings have been reactivated with an initial discussion with Group members on 8 March and the first formal meeting on 5 July. Meetings for the year ahead have been scheduled.	Complete	Interim Board Secretary

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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Breathe Well Programme
Final Internal Audit Report

July 2022

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-2122-07
Report status:	Final
Fieldwork commencement:	April 19th 2022
Fieldwork completion:	June 7th 2022
Debrief meeting:	June 15th 2022
Draft report issued:	June 14th 2022
Management response received:	July 4th 2022
Final report issued:	July 4th 2022
Auditors:	Ian Virgill, Head of Internal Audit Jayne Gibbon, Internal Audit Manager Sharon Edwards, Principal Auditor
Executive sign-off:	Claire Madsen, Executive Director of Therapies and Health Science
Distribution:	John Morgan, Transformation Programme Manager Clare Lines, Assistant Director Transformation & Value
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 audit assessed the adequacy of the systems and controls in place for the 'Breathe Well Programme'.

Overview

We have issued reasonable assurance on this area.

The processes in place for the governance of the programme are well established with regular reviews of the Programme Plan and updates being provided to key Health Board meetings.

We identified three key matters requiring management attention:

- There is a lack of a clear audit trail between the closure of Phase 1 and the move to Phase 2 of the programme.
- Enhancements are required in the information recorded in the 'progress tab' of the programme plan.
- Key workstreams were identified in the initial Programme Initiation Document, but these have not been realised. The Programme Initiation Document needs to be updated to reflect current workstream arrangements.

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

Report Opinion

Reasonable assurance

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	Business Case and Programme Initiation Documents in place	Substantial
2	Programme Team / Board with defined roles and responsibilities	Substantial
3	Detailed Programme Plan and Workstreams in place	Reasonable
4	Systems in place for monitoring the ongoing delivery of the Breathe Well Programme	Substantial
5	Governance arrangements in place which provide clear reporting lines.	Substantial

[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	Phase 1 Programme Plan archived	3	Design	Medium
2	Detailed information in Programme Plan	3	Design	Medium
3	Key workstreams	3	Design	Medium

1. Introduction

1.1 The review of the 'Breathe Well Programme' was completed in line with the Powys Teaching Health Board's (the 'health board') 2021/22 Internal Audit Plan.

1.2 The overall aim of the Breathe Well Programme is to:

- Transform the wellbeing, primary and community services model, within a whole system approach; and
- Improve respiratory clinical outcomes, symptom management and experience for the people of Powys.

1.3 The 'Breathe Well Programme' focuses on key transformational actions, specifically on areas where considerable change is needed as opposed to areas where improvement is "business as usual". The Programme does not involve the introduction of a new service or development but the re-designing of various services that make up the respiratory Services.

1.4 The Programme initially commenced as a multi-agency Programme in March 2019, as a result of the COVID pandemic activities were stalled, however they resumed in July 2021.

1.5 The objectives of the Breathe Well programme are to:

- Ensure there is a consistent and effective service model for all Powys residents by transforming wellbeing, primary and community services, within a whole system approach;
- Improve outcomes for children and young people;
- Ensure there are robust respiratory intelligence and performance reports, for clinicians and other stakeholders, spanning the whole system for Powys residents; and
- Establish and maintain effective Project and Governance arrangements.

1.6 The Executive Director of Therapies and Health Sciences is the lead for this review.

1.7 The key risks considered in the review were:

- Due process is not followed leading to poor and / or inefficient delivery of the Programme;
- The Health Board is exposed to reputational damage and disruption of services provided to patients; and
- Ineffective governance arrangement due to a lack of appropriate structures and reporting lines.

2. Detailed Audit Findings

Objective 1: Approved business case(s) and programme initiation documents are in place, and they reflect a clear and controlled process for defining the overall objective of the 'Breathe Well Programme'

2.1 The current/most recent Breathe Well Programme Initiation Document was presented by the Executive Director of Therapies and Health Science to the Renewal Strategic Portfolio Board in August 2021, where it was approved. It was also presented at the Executive Committee of the Health Board.

2.2 The Renewal Strategic Portfolio Board is chaired by the Health Board Chief Executive and other attendees at the committee include Executive Directors across the Health Board along with the Board Secretary and the Medical Director.

2.3 The Breathe Well Programme aligns with the PTHB Integrated Medium Term Plan.

2.4 The Breathe Well Programme Initiation Document clearly sets out the scope and objectives, the approach that is going to be taken and the governance arrangements that are in place.

2.5 There are various iterations of the Breathe Well Programme Initiation Document which have been version controlled when amendments have been made.

Conclusion:

2.6 The Programme Initiation Document for the Breathe Well Programme is in place and clearly sets out the objective of the Breathe Well Programme. Accordingly, we have allocated Substantial Assurance for this objective.

Objective 2: An appropriately constituted Programme board and / or team is in place with clearly defined roles and responsibilities.

2.7 There is an established Programme Board in place for the Breathe Well Programme which has identified defined roles for Executive Directors and key Senior staff with responsibilities stipulated within the Programme Initiation Document.

2.8 Within the Programme Initiation Document for the Breathe Well Programme it states that the quorum for the Programme Board is two Executive Directors of the Health Board.

2.9 The minutes that were reviewed specified that where the Programme Board meeting wasn't quorate, discussions were held but no decisions were made due to the absence of the required two Executive Directors.

2.10 The Programme Initiation Document contains suggestions for programme team membership, however no quoracy is defined as the team is not a decision making body, with all decisions discussed and agreed at the programme board level.

2.11 The frequency of the Programme Board / Team meetings is not noted within the Programme Initiation Document. However, it was evident from reviewing the minutes that the Programme Team meets the month prior to the Programme

Board, but this is not stipulated within the document. *(Matter Arising 1 – Low Priority).*

Conclusion:

2.12 Defined roles for the Programme Board and Programme Team are in place, but the Programme Initiation Document should include the information relating the frequency of the meetings. Accordingly, we have provided Substantial Assurance for this Objective.

Objective 3: Detailed Programme plan(s) and work stream(s) are in place that allow for proactive and timely coordination of the 'Breathe Well Programme'.

2.13 A programme plan has been produced which identifies each work activity which has a reference number, a specified lead, and RAG status. There are also columns which indicate when the work will start and finish, along with information on its progress. The Programme Plan has been divided into phases to make it easier to follow.

2.14 Phase 1 of the Programme Plan was archived when Phase 2 was created. However, we noted that some of the work activities that weren't completed were not transferred onto Phase 2 of the work plan. *(Matter Arising 2 – Medium Priority)*

2.15 Several work activities have their RAG status as "GREEN - on time or within one week of date, you know it will be on time". The narrative included does not provide sufficient progress updates. Likewise, work activities which are marked as "complete" did not have sufficient supporting narrative within the progress tab to evidence completion. *(Matter Arising 3 – Medium Priority)*

2.16 Four key work streams were identified in the approved Programme Initiation Document although none of them are currently active. It also states within the PID that the key work streams will be supported by five further workstreams. They have been identified in the Programme Plan but haven't been implemented yet. However, one workstream has been developed but this is not named in the Programme Initiation Document. *(Matter arising 4 – Medium Priority)*

Conclusion:

2.17 The Programme Plan is classed as a live document so that there can be regular updates. However, our review established that the "progress tab" doesn't always reflect the most up to date information. Although key workstreams were identified within the Programme Initiation Document, none of these have been implemented. Two of the workstreams listed may not be developed at all which could affect the agreed governance arrangements that are in place. Accordingly, we have allocated Reasonable Assurance to this objective.

Objective 4: Adequate systems are in place for monitoring the ongoing delivery of the 'Breathe Well Programme'. Including maintenance and review of a Programme risk register and production of appropriate performance reports.

2.18 A risk register is in place for the Breathe Well Programme which recognises risks relating to the Programme, some of these are identified as high risk. Mitigating actions have been noted within the risk register and there is information on progress / notes which are regularly updated.

2.19 The risks register are discussed at both the Programme Team and Programme Board meetings but any decisions relating to the risk register are only actioned at the Programme Board. Any risks scoring 15 or above are reported up to the Renewal Strategic Portfolio Board.

2.20 The Programme Board minutes show that there is regular monitoring of the risk register, and it is clear to see that risks have been added or closed and scores have increased / decreased as necessary.

Conclusion:

2.21 It is evident that the Programme team discuss and update the risk register to reflect the status of the Programme risks. The risks and issues relating to the Breathe Well Programme are also presented to the Executives at the Programme Board. Accordingly, we have allocated Substantial Assurance for this Objective

Objective 5: Appropriate governance arrangements are in place for the Programme which provide oversight with clear reporting lines and escalation processes to relevant groups/ committees.

2.19 The development of the Breathe Well Programme can be evidenced throughout the minutes of the Programme Board & Team meetings, which documents the progress from the start of the programme and highlights the areas that are still outstanding.

2.20 The Programme Plan is discussed in depth at the Programme Team meetings, and decisions are fed through to the Programme Board meetings where further discussions take place and where actions are approved and noted.

2.21 Minutes of the meetings for the Programme Team, Programme Board, and Renewal Strategic Portfolio Board include details relating to the progress /delays in the Breathe Well Programme. Actions are escalated to the Renewal Strategic Portfolio Board and through to the Executive Board on an exception basis for information as well as outcomes being disseminated back through the process and are presented at the Programme Team and Board for information.

2.22 Updates on the Breathe Well Programme are also provided to the Board for information.

Conclusion:

2.23 The Programme Initiation Document outlines the reporting and escalation process which we were able to evidence. Accordingly, we have allocated Substantial Assurance to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Frequency of Meetings (Design)			Impact
The Programme Initiation Document (PID) for the Breathe Well Programme does not state the frequency of the meetings for the Programme Team or Programme Board.			Due process is not followed leading to poor and / or inefficient delivery of the Programme.
Recommendations			**Priority**
1.	The Programme Initiation Document should be updated to reflect the frequency of the Programme Team / Programme Board meetings		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.	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.	October 2022	Transformation Programme Manager (Breathe Well)

Matter Arising 2: Phase 1 Programme Plan (Design)	Impact
The Breathe Well Programme has been split into phases to show the progress that has been made since the programme started. Phase 1 of the Programme Plan was archived when Phase 2 was created. We note that despite three of the work activities being RAG rated as Amber on Phase 1, they were not transferred onto Phase 2 of the programme plan. However, when discussing this with the Transformation Programme Manager he did state that these were combined with other work activities in the programme plan, but this was not noted within the progress tab.	Due process is not followed leading to poor and / or inefficient delivery of the Programme.

Recommendations		Priority
2.	Management should ensure that an appropriate audit trail is maintained of all changes agreed/proposed to activities listed in the programme plan.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	October 2022	Transformation Programme Manager (Breathe Well)

Matter Arising 3: Work Activity Status (Design)	Impact
Testing was carried out on the Programme Plan to establish if there was supporting evidence within the progress tab to validate the following "status" of the work activities within the Programme Plan: Blue – Activity is complete Green - on time or within one week of date, you know it will be on time". When reviewing the Programme Plan it was evident to see that several work activities have their RAG status as "GREEN - on time or within one week of date, you know it will be on time". The narrative within the Progress tab states that "Timescales aligned to proposed IMTP submission" which does not provide the Programme Team, Programme Board, or the Renewal Strategic Portfolio Board with clear updates as to where they are with the development of that work activity. Likewise, 9% of work activities are marked as "Blue - Activity is complete". A review was undertaken of two of the completed activities on the workplan to establish if they had been completed in line with the information within the work activities, but this was unclear. The two sampled activities were : 3.01.1 Seek C&VUHB Paediatrician involved at Breathe Well workshop to support Progress tab states "Meeting with RHIG C&YP lead being arranged" but it doesn't state if the Paediatrician was involved or if the meeting happened. 3.01.2 Scoping meeting in advance of children's workstream being convened Progress tab states "Meeting held with WVT Paediatric Clinical Director and PTHB AD Women & Children's on 07/09/2021 to discuss children and young people's workstream actions in a COVID-19 context".	Due process is not followed leading to poor and / or inefficient delivery of the Programme.

However, due to the OMICRON outbreak, this workstream was paused but the progress tab has not been updated to reflect this and the work activity remains as closed. This could provide an inaccurate picture of the progress of the Breathe Well programme, with progress being overstated.		
Recommendations		**Priority**
3.	Management should ensure that more detailed information is outlined within the progress tab in Phase 2 of the Programme Plan. The live document should be utilised to keep up to date information which provides accurate and descriptive records which is reported to the Programme Board and advises them of the current status of each work activity within the Breathe Well Programme. Where work activities are deemed as complete, there should be more detailed information within the Progress Tab to validate this.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	October 2022	Transformation Programme Manager (Breathe Well)

Matter Arising 4: Workstreams (Design)	Impact
Four key work streams were identified within the Programme Initiation Document which has been formally approved by the Renewal Strategic Portfolio Board along with the Executive Board. However, the status at the time of the review was that none of them are currently active. • Transformed clinical model for wellbeing, primary and community service, within a whole system approach - no workstream at present • Improve outcomes for children and young people - classed as blue on the programme plan which means that action is completed, but due to Covid 19 then Omicron, the workstream hasn't met yet but hoping to organise one shortly. • Develop intelligence and performance reports - analysist being involved and discussions are taking place, but not as a workstream yet. • Establish project and governance arrangements - it was felt that the governance arrangements are in place, and the reporting structure is known so there isn't any need for a workstream. It also states within the Programme Initiation Document that the key work streams will be supported by cross cutting "enabling" professionals for: • Digital and Intelligence • Finance and Efficiency • Workforce • Quality and Safety • Whole system commissioning. These are identified on Phase 2 of the Programme Plan but under progress it states, "timescale aligned to proposed IMTP submission" and doesn't go into detail as to what has been developed. However, one workstream has been developed and has had an initial meeting but this isn't mentioned within the Programme Initiation Document.	Due process is not followed leading to poor and / or inefficient delivery of the Programme.

Recommendations		Priority
4.	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.	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.	October 2022	Transformation Programme Manager (Breathe Well)

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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Archwilio Cymru
Audit Wales

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

Date issued: July 2022

Document reference: 2001A2020-21

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

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

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Contents

Audit, Risk & Assurance Committee Update

About this document

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

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Accountability Report and Financial Statements	Our work is complete and the ISA260 report was presented to ARAC on 13th June 2022.
Audit of the 2021-22 Charitable Funds Account	Audit planning due to start autumn of 2022 – exact timetable to be discussed with management in due course.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment (Phase 2) – Corporate Governance and Financial Management Arrangements	January 2022
Review of Quality Governance Arrangements	November 2021
Structured Assessment (Phase 1) Report – Operational Planning Arrangements	July 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Date of publication realigned with anticipated publication date of national planned care work September 2022
Renewal Programme Executive Lead – Director of Planning & Performance	This local work will examine the arrangements put in place to deliver the Health Board's renewal programme.	Report being drafted September 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Blog and data tool published in April 2022 Project brief to commence detailed work to be issued in July 2022.
Structured Assessment Executive Lead - Interim Board Secretary	This work will continue to form the basis of the work we do to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The 2022 work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).	Fieldwork underway November 2022

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Workforce Planning	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Review currently being scoped TBC
Local Work 2022	The precise focus of this work is still to be determined.	TBC

Good Practice events and products

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

5 Details of future events are available on the GPX website. Events include sharing a range of perspectives on the impact the pandemic has had on public services in Wales two years on from the start of the pandemic.

NHS-related national studies and related products

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

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

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

Title	Publication Date
Tackling the Planned Care Backlog in Wales	May 2022
Unscheduled Care	April 2022

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Audit Risk and Assurance Committee	**Date of Meeting: 18th July 2022**
Subject:	**Counter Fraud Update Report**
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 purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2022/23.
RECOMMENDATION(S):
It is recommended that the Audit Risk & Assurance Committee receive the report for discussion and information.

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	✓				

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

Item 3.5

Counter Fraud Update Report

18 July 2022

1. INTRODUCTION

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

2. BACKGROUND

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

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

3. STRATEGIC GOVERNANCE

The Health Board's annual self-review against NHS Standards has been finalised and submitted to NHS Counter Fraud Authority (NHS CFA). The NHS Counter Fraud Authority Quality Assurance Inspector is to attend Wales in September 2022. The Health Board has been identified as an Organisation to be reviewed in line with self-review submission.
Further details of this will be forwarded by NHS CFA closer to the time but focus is believed to be on NHS Counter Fraud Standard 3 relating to fraud risk assessments.

A statistical analysis of performance against key performance indicators has been produced and at Appendix 1 to this report. The analysis measures Health Board performance against an all Wales benchmark average to provide greater context to the statistical information.

4. INFORM AND INVOLVE

As detailed within the agreed Counter Fraud Work Plan, an on-going programme of work has been put in place to raise awareness of fraud, bribery and corruption amongst all staff and practitioners across all sites. A programme of awareness sessions have been established for 2022/23 and these dates are being offered to staff to self-book onto counter fraud learning. The Counter Fraud Team now also have a slot to deliver training as part of the Health Board's Managers training programme.

A staff survey on counter fraud arrangements within the Health Board has concluded. The surveys covered all staff for response but also targeted Primary Care, Finance Department and Workforce & OD with surveys aligned to specific counter fraud risks they face. This information will be utilised to inform engagement approaches to those departments and wider Health Board.

5 PREVENT AND DETER

The Counter Fraud Team have undertaken a proactive exercise around compliance with the Health Board's Standards of Behaviour Policy specifically focussing on compliance with declaration of gifts, hospitality, sponsorship, and external interests covered by that Policy. The exercise utilised data from the Health Board's National Fraud Initiative datasets which show employees with external interests in secondary employment roles or businesses for which the Health Board has engaged for supply of goods and/or services. A full report containing findings for this exercise is at Appendix 2 to this report.

6 HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 3 to the report. A summary of basic investigation KPI data is presented at outset of the appendix.

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

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

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

8. RECOMMENDATION

The Audit Committee is asked to **note** the Counter Fraud Progress Report.

Item 3.5

Appendix 1

Counter Fraud Benchmarking Performance Report

18 July 2022

Introduction

This report has been produced utilising All Wales Operational Performance Report data. The analysis undertaken takes the mean average for all NHS Wales Health Boards and Trusts. This is then compared against Health Board performance figures across areas considered to be key performance indicators.

The averages have been calculated utilising full year data for 2019/20, 2020/21 and 2021/22.

It is immediately apparent from the data that Covid has had an impact on performance numbers particularly during the height of the Pandemic in 2020/21; this was true for all NHS Organisations. There has been some recovery in 2021/22 and positive performance indicators have shown steady improvement.

The Table below represents Health Board figures relating to performance on investigations. The Health Board performs relatively consistently even accounting for Covid disruption. One area of concern is the referral rate for 2021/22.

Police community resolution was tracked from 2019/20 following more widespread implementation by Police as an option for out of court disposal.

Year	NHS Organisation	No of open cases as at start of year	No of referrals received	No of cases closed	No of open cases at end of period	Recoveries £	Sanctions				
							Criminal			Disciplinary	Civil
							Court Case	Police Caution	Police Community Resolution		
2019/20	Powys THB	9	6	1	14	1787	0	0	0	0	1
2020/21	Powys THB	14	3	11	6	0	0	0	0	2	0
2021/22	Powys THB	6	10	13	3	6241	0	0	0	3	4

Referral Rate	All Wales Avg.	Powys
2019/20	16	6
2020/21	11	3
2021/22	19	10

The referral rate at the Health Board has been consistently below all Wales average, this dipped even further in in 2020/21 during the peak of covid disruption. Numbers of referrals have increased 'post-covid' which is a good sign of recovery following that period of turbulence.

Investigation Progression Rate	Referrals Received	Cases Closed	Difference
2019/20	6	1	5
2020/21	3	11	-8
2021/22	10	13	-3

Case Closure Rate	All Wales Avg.	Powys
2019/20	15	1
2020/21	16	11
2021/22	22	13

It is important to track that investigations are progressing through the investigative cycle. It should be a cause for concern when cases build up as we may not necessarily have resources available to meet requirements to clear a backlog. In 2020/21 and 2021/22 the Counter Fraud Team achieved a negative progression rate demonstrating good progress being made on in investigations to allow closure.

Sanctions	All Wales Avg.			Powys		
Year	Criminal	Disciplinary	Civil	Criminal	Disciplinary	Civil
2019/20	1.6	3.0	4.2	0	0	1
2020/21	1.0	2.6	3.1	0	2	0
2021/22	0.2	5.8	4.4	0	3	4

The Health Board has performed well in securing sanctions as a result of investigative work in 2021/22 and the ratio of referrals received to sanctions applied is comparable to the increasing level of referrals the Team receives.

The tables below present data relating to the presentations delivered as part of the Counter Fraud Awareness Programme. Attendance at presentations dropped across NHS Wales Organisations in 2020/21 as focussed shifted to Covid response but the Health Board performed well despite tis disruption and is now double the all Wales average for number of attendees as a percentage of staff headcount for 2021/22.

Attendance as % of Staff Headcount	All Wales Avg.	Powys
2019/20	12%	6%
2020/21	4%	5%
2021/22	4%	8%

Average Attendance of a Presentation	All Wales Avg.	Powys
2019/20	29	30
2020/21	18	7
2021/22	15	5

Number of Presentations	All Wales Avg.	Powys
2019/20	45	5
2020/21	13	17
2021/22	16	31

Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/22/00624	01/06/2022	Abuse of position - contracts	Staff	Anonymous allegation relating to awarding of contracts to friends and social contacts.	Initial enquiries are being undertaken to ascertain veracity of allegation.

Pending Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/21/00239	22/09/2021	Working whilst sick	Ex-Staff	Information that the subject was working at a local petrol station and café whilst on sick leave and receiving sick pay.	Investigation revealed that the subject had taken on a job whilst on sick leave, and then resigned from the health board after commencing in their new role. Following interview the subject admitted that there was a cross over period where they held two posts. Subject stated they were willing to repay any monies outstanding and arrangements are being made to recover funds.
INV/22/00490	04/04/2022	Overpayment Child Care Voucher Scheme	Ex-Staff	Following leaving employment with the Health Board the subject continued to receive child care voucher payments.	Enquiries established that no funds had been paid directly to the subject. The funds were traced to the child care provider via a third party payment processor. Recovery is being

Pending Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					made of the funds following voluntary agreement.

Closed Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
INV/22/00158	02/02/2022	Timesheet	Contractor	Locum alleged to not have been completing hours claimed for via submitted timesheets	Following investigation a deficit of hours was established in claims versus completed hours. Following interview, the subject agreed to voluntary repayment of £7459.
INV/22/00495	05/04/2022	Timesheet	Staff	Employees alleged to have not been completing contracted hours	Following initial enquiries the allegation could not be corroborated and no fraud was established.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Audit, Risk and Assurance Committee	**Date of Meeting: 18 July 2022**
Subject:	**PTHB BOARD MEMBER DECLARATION OF INTERESTS – 2022/2023**
Approved and presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee, 29th June 2022

PURPOSE:
The purpose of this paper is to provide the Audit, Risk and Assurance Committee with the latest position for Register of Interests for Independent Members and Executive Directors at 24 June 2022 and to update the Committee on improvements being made to our processes.
RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to NOTE the contents of Register of Interests for PTHB Board Members at 24 June 2022.

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 Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour.

The Board is strongly committed to the health board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership. In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions.

DETAILED BACKGROUND AND ASSESSMENT:

In accordance with the requirements of the health board's Standing Orders and Standards of Behaviour Policy, a report is required to be received by the Audit, Risk and Assurance Committee which details the Declarations of Interest received by Board Members.

The Register of Interests is maintained by the Corporate Governance Department with each Declaration reviewed and checked by the Board

Secretary with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests. The register for 2022-2023 as at 24 June 2022 is attached at **Appendix A.**

All employees and Independent Members of the Board must ensure that they are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the health board. Declarations must be made to the health board for recording in the Register of Interests any relevant interests at the commencement of employment, whenever a new interest arises or if asked to do so at periodic intervals by the health board. The onus regarding declaration will reside with the individual employee or Independent Member.

An escalation process has been put in place by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted.

Progress has been made in this area and the Corporate Governance Team is now pursuing best practice and encouraging all staff to declare interests where applicable.

To actively promote the Standards of Behaviour Policy and Declarations of Interests across the organisation, the Corporate Governance Team are reviewing the current process of how Declarations are made and recorded. In addition, work is underway to develop a Communications plan, and to streamline the process of which Declarations are made and recorded. A further update will be shared at a future Audit, Risk and Assurance Committee.

The Standards of Behaviour Framework summary from the Standards of Behaviour Policy is set out in **Appendix B.** The Board Secretary has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on the health board's website to ensure openness and transparency.

NEXT STEPS:

The Register of Declaration of Interests (Board Members) for 2022/2023 will be published on the PTHB website and will be maintained up to date by the Corporate Governance Team.

POWYS TEACHING HEALTH BOARD - REGISTER OF DELCARATION OF INTERESTS 2022/23							Date Updated: May 2022
Name	**Nature of Interest**	**Nature of Declaration**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**
Viviene Harpwood	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Mar-21	Current	Director of Ellucido – a company providing on-line learnin	NIL yet. A course entitled 'Demystifying Medical Ethics' is due to be launched very soon	16/05/2022
		Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	Mar-22	Current	Ellucido - As above. Part ownership.There are no current plans to do business with PTHB or other NHS Wales organisations, (although that might change).	NIL	
		Sponsorship or funding from a known NHS supplier or associated company/subsidiary	2001	Current	I write on Consent to Healthcare Treatment for EIDO, a company which supplies courses to some NHS organisations in England, (but no longer to Wales).	£5,000 per annum	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2012	Current	I am a Trustee of a registered charity - Saint Woolos Sinfonia, Newport Wales	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2019	Sep-22	I am the Chair of the Welsh NHS Confederation	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2019	Sep-22	I am an Independent Member of the central NHS Confederation and Trustee of the same	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2018	Current	I am an Emerita Professor of Medical Law and Ethics at Cardiff University	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2020	Current	Membership of the UNESCO Council Member of the UNESCO Department of Education, participating in international webinars on medical law and ethics in the time of COVID. Not remunerated.	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2021	Current	Membership of the International Program of the South Asia UNESCO Chair in Bioethics, delivering modules on the comparative law of consent to treatment and clinical negligence. Not remunerated.	NIL	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2022	Current	UK member of the UNESCO South Asia Education Department's International Research Committee on Health Law and Bioethics. Not remunerated	NIL	
	Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2000	Current	One of my sons has family interests in Renishaw, a company manufacturing medical equipment which is sold in Wales to the NHS and elsewhere	NIL	
Kirsty Williams	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2021	Current	Honory Visiting Fellow Cardiff University and Volunteer Powys Samaritans.	None	06/05/2022
	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	2023	Commissioner to the Constitutional review on the Future of Welsh Governance	Paid a daily rate for work undertaken	
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1987	Current	Husband is a partner in DC Rees & Son (farming business)		
Matthew Dorrance	Personal						
	Spouse/Partner/Other						
Frances Gerrard	Personal						
	Spouse/Partner/Other						
Rhobert Lewis	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	NED of Green Inc Training Company Swindon	None	19/04/2022
		Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2022	Current	Chair of governors Neath Port talbot Group of Colleges		
	Spouse/Partner/Other						
Cathie Poynton	Personal	NIL			NIL		04/04/2022
	Spouse/Partner/Other	NIL			NIL		

Ian Phillips	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Apr-22	Current	Chair of Welsh Renal Clinical Newtwork (sub-Committee of WHSSC)	Band 3 WG sclae for Public appointments. 2 days per month	04/05/2022
	Spouse/Partner/Other	NIL			NIL		
Mark Taylor	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception	2013	Current	Auster Counsulting Ltd	Non NHS	12/04/2022
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2013	Current	Auster Consulting Ltd	Non NHS	
		A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2021	Current	Son - GPHC Registered Training Position, Primary Care/CTMHB		
Tony Thomas	Personal	NIL			NIL		13/04/2022
	Spouse/Partner/Other	NIL			NIL		
Ronnie Alexander	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	03/05/2022
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Audit and Risk Committee Hafod/Hendre Housing Association	£2500.00 per annum	
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Carol Shillabeer	Personal	NIL			NIL		07/04/2022
	Spouse/Partner/Other	NIL			NIL		
Jamie Marchant	Personal	NIL			NIL		05/05/2022
	Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Current	Wife is Coporate Director of Social Services in Bridgend County Borough Council. I am not aware of any commissioning relationship with this body. There is no interaction between BCBC and my portfolio and areas of direct responsibility		
Stephen Powell	Personal						
	Spouse/Partner/Other						
Pete Hopgood	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not relevant	08/04/2022
	Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	
Claire Madsen	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	20/04/2022
	Spouse/Partner/Other				NIL		
Claire Roche	Personal	NIL			NIL		06/04/2022
	Spouse/Partner/Other	NIL			NIL		
Julie Rowles	Personal	NIL			NIL		07/04/2022
	Spouse/Partner/Other	NIL			NIL		

Hayley Thomas	Personal	NIL			NIL		05/04/2022
	Spouse/Partner/Other	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Husband is General Manager of Bronglais General Hospital	Not Relevant	
Kate Wright	Personal	NIL			NIL		04/04/2022
	Spouse/Partner/Other	NIL			NIL		
Alison Merry	Personal	NIL			NIL		05/04/2022
	Spouse/Partner/Other	NIL			NIL		
Board Secretary							
James Quance	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Current	Wife is employed as a senior audit manager in NWSSP and is involved in providing internal audit services to the Health Board in respect of capital and estates. We do not have any direct professional relationship and I am unable to influence her work in any way. All outputs	Not Relevant	03/05/2022
	Spouse/Partner/Other	NIL			NIL		

Appendix D - Standards of Behaviour Framework Summary

The Board has described its vision that underpin the way that services are provided and to support this, all employees must ensure that they carry out their roles with dedication and commitment to the Special Health Authority and its core values. All staff must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles: ▪ **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends; ▪ **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties; ▪ **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit; ▪ **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position; ▪ **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for	To uphold these principles, you must: - Ensure that the interests of patients and the public remain paramount; - Be impartial and honest in the conduct of your official business; - Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money; - Not abuse your official position for personal gain or to benefit your family or friends; - Not seek advantage or to further private business or other interests in the course of your official duties, and; - Not seek or knowingly accept, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the SHA. The Standards of Behaviour Framework Policy outlines the arrangements within the Special Health Authority to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship (even if these are declined). Further guidance is available via the Standards of Behaviour Policy on the intranet site. It is your responsibility to ensure that you are familiar with the requirements of the Policy and supporting guidance. The relevance

their decisions and restrict information only when the wider public interest clearly demands it; ▪ **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and; ▪ **Leadership** – Individuals should promote and support these principles by leadership and example.	of this information will vary depending on your role within the Special Health Authority and your interests outside of your employment. Remember that the need to declare an interest also includes those of your close family and possibly friends. Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions. Obtain your Directors permission before accepting any commercial sponsorship or hospitality;
In summary:- **DO:**	In summary:- **DO NOT:**
• Make sure that you are not in a position where your private interests and NHS duties may conflict. Declare any relevant interests. These include:- • Directorships, including Non-Executive Directorships held in private companies or PLCs.; • Ownership or part-ownership, of private companies, businesses, or consultancies likely or possibly seeking to do business with the Special Health Authority. • A position of authority in a charity or voluntary body in the field of health and social care; • A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team; • Sponsorship or funding from a known NHS supplier or associated company/subsidiary;	• Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries; • Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined; • Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations; • Abuse your position to obtain preferential rates for private deals; • Unfairly advantage one competitor over another or show favouritism in your dealings with commercial organisations; • Use NHS resources for your own private use. If you need any further guidance, please contact the Corporate Governance Team via email or Microsoft teams. powysdirectorateofCorporatGovernance@wales.nhs.uk

• Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice; • Anything else that could cause a potential for conflict.	

ANNUAL GOVERNANCE PROGRAMME

MILESTONES

2022/23

Quarter 1 Update

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

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

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
	Scheme of Delegation and Reservation of Powers						
c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Identify all existing partnerships and collaborations to inform development of a Framework	Director of Planning & Performance					Overview of partnership governance arrangements presented to board at Strategic Planning Session and Planning, Partnerships & Population Health Committee.
	Mapping of these partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes						
	Development and population of a Partnership Register						Due to capacity constraints, development of the Partnership Governance Framework has been delayed but is in the work programme for PPPH and Board.
	Development of the Partnership Governance Framework for presentation to Board in September 2022						
d) Further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship	Embed Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee	n/a					Discussions are taking place nationally with regard to the development of electronic recording of interests. Work is also underway to develop an all-Wales Policy.
	Fully implement an electronic system to support recording and reporting of declarations made						

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status Q2	RAG Status Q3	RAG Status Q4	RAG Status Q1	Comments
2. ENSURING BOARD EFFECTIVENESS							
a) Review and strengthen the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure	Review committee structure for implementation in 2021/22	Chair/Committee Chairs					Action Complete – Approved by Board 28th July.
	Review committee terms of reference and operating arrangements with any changes presented to Board for approval in May 2021						Action Complete – Approved by Board 28th July.
	Review committee membership with any changes presented to Board for approval in May 2021						Action Complete – Approved by Board 28th July.
	Fully populate committee workplans, aligned to the Corporate Risk Register and Board Assurance Framework, for Board approval in May 2021						Action Complete – Approved by Board 29th September.
b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum (HPF) and the Stakeholder Reference Group (SRG)	Review Terms of Reference and membership of the Stakeholder Reference Group	• Director of Planning & Performance (SRG) • Clinical Directors (HPF)					Terms of reference and plan for implementation in development.
	Meeting of the SRG to be held						
	Appoint Chair of the SRG as an Associate Member of the Board						
	Review current engagement mechanisms with professionals to inform approach to HPF						
	Terms of Reference and Membership of HPF to be developed						
	Inaugural meeting of HPF to be held						

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
	Appoint Chair of the HPF as an Associate Member of the Board						
c) Ensure openness and transparency in the conduct of board and committee business	Review effectiveness of live streaming board meetings	Chair					Live streaming of board meetings continues. Arrangements for members of the public to observe committees in place, in the absence of live streaming. Papers published to website as routine.
	Consider accessibility of those committee meetings required to be held in public						
	Ensure meeting agendas, papers and summary notes are published in a timely manner						
d) Further improve the quality of information to the Board and its Committees	Board & Committee report templates to be reviewed to ensure assurance reports are distinguished from reports for management	Director of Workforce & OD					Report templates are in development.
	Report Writing and Presentation Masterclasses to be held for senior management team, via the Management Development Programme						Due to capacity constraints, this work has been delayed.
e) Implement an annual development programme for board members, focussing on awareness sessions as well as training and learning to support the development	Board review of effectiveness to be undertaken in April 2022	• Chair • Director of Workforce & OD					Board review of effectiveness undertaken in Board Development session undertaken in April 2022.

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
of individual roles and the board as a cohesive team	Implement a programme of development and a programme of briefings for 2022/23						Board Development and Briefing Sessions ongoing.
	Ongoing implementation of an Executive Director Development Programme						Programme of development ongoing.
	Design and implement training and development for Independent Members						IM specific training to be developed to supplement development of the programme of induction.
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required	Work with Public Bodies Unit to prepare and deliver recruitment campaigns for upcoming vacancies	Director of Workforce & OD					Active work ongoing with Public Bodies Unit.
	Implement an Induction Programme for Board Member appointments when required						WG Induction Programme in place. Local Induction arrangements have been developed and due to be trialled with incoming Director of Public Health.
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and engagement	Design and implement a schedule of visits to a range of clinical and non-clinical services and county-wide health board sites	• Chair • Chief Executive					CEO/Executive Director visits re-commencing. IM visits to be planned going forward.

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
h) Review and implement arrangements for the development, review, approval and publication of policies delegated by the Board	Policy Management Framework to be reviewed, confirming policy approval routes	Executive Director Policy Owners					Work is in progress linked to the introduction of Sharepoint.
	Policies section of intranet/internet to be refreshed						
	Policy toolkit to be rolled out with awareness raising						
	Training programme to be developed and implemented to support the organisation in developing and reviewing policies						
i) Review Board Champion Roles, ensuring clarity on purpose and responsibility.	Review delegation of Champion roles to Board Members	Chair					Board Champion roles clarified at March board meeting. Reporting arrangements to be established.
	Adopt role specifications for Champion roles						
	Establish reporting arrangements for Champions to Board						
3. EMBEDDING AN EFFECTIVE SYSTEM OF RISK AND ASSURANCE							
a) Ensure that the Risk Management Framework continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	Undertake an Annual Review of Risk Management Framework, ensuring alignment with the Board's Assurance Framework Principles	n/a					A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2021.
	Risk Management Framework to be updated to reflect Risk Appetite Statement						
	Establish Committee Risk Registers						Committee priorities informed by strategic risks (corporate risk

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
							register). Further work required to refine operational risk registers to inform committee risk registers.
b) Promote a Risk Management Toolkit to support staff in the identification, recording and management of risk	Publish a Toolkit including the process for escalation and de-escalation, examples of best practice to support moderation and consistency in measurement Toolkit to be updated in line with review of Risk Management Framework, Risk Appetite Statement and Board Assurance Framework Principles.	n/a					A Risk Management Toolkit has been developed and published to the Health Board's Intranet and will also be promoted through the Risk & Assurance Group, constituted by key leaders within the organisation. Periodic recommunication will be undertaken as highlighted by the recent internal audit review.
c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's	Risk Appetite Statement to be considered by Board in June 2021 Revised Statement to be presented to Board in July 2021 for approval	n/a					A reviewed and refreshed Management Framework and Risk Appetite Statement

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
capacity and capability to manage risks							has been prepared for presentation to Board in November 2021.
	Corporate Risk Register, Risk Targets to be reviewed to ensure alignment with the Board's Risk Appetite						Corporate Risk Register review ongoing with engagement with Board members in June.
	Risk Management Framework to be updated to reflect Risk Appetite Statement and communicated with the organisation						A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2021.
d) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints System [DATIX])	Risk Management Module to be developed in-line with Once for Wales Management System Programme, in readiness for implementation in 2022	n/a					Once for Wales Management System implementation underway, aligned to national work.
	Maximise the role of the Risk and Assurance Group to drive forward improvements in risk reporting arrangements						Risk & Assurance Group continues to meet where possible to maintain focus on operational risk management.

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

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2	Q3	Q4	Q1	
e) Embed the Board's Assurance Framework, aligned to the Corporate Risk Register and Organisational Risk, where appropriate	Undertake an Annual Review of Assurance Framework Principles, ensuring alignment with the Board's Risk Management Framework	n/a					The Board Assurance Framework is in the process of being reviewed. The Board continues to receive its Corporate Risk Register at each meeting and Board/Committee priorities have been determined based on risk.
	Board and committee workplans aligned to Assurance Framework						
	Assurance Framework updated quarterly, in-line with integrated performance reporting and delivery of audit programmes						
f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.	Establish Assurance Maps to identify assurances in place and any gaps in place at 1st, 2nd and 3rd line of defence for those responsibilities delegated to Executive Directors	All Executive Directors					This work has been delayed in light of the pandemic. However, work in relation to delegation and accountability arrangements continues (as per action 1b).
	Gaps in assurance to inform the Board's Assurance Framework						

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.8

Audit, Risk and Assurance Committee	**DATE OF MEETING: 18 July 2022**
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 29th June 2022

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to NOTE and DISCUSS the current position of outstanding audit recommendations and APPROVE the revised deadline requested.

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:

As a result of the Health Board's response to the COVID-19 pandemic, capacity to implement audit recommendations across services was inevitably previously reduced. To ensure a balance between managing capacity pressures and challenges presented by the COVID-19 pandemic and managing the 'business as usual' issues and risks, services previously reprioritised their outstanding audit recommendations according to the level of risk associated with delayed implementation, and in line with delivery of the Quarter 3 & Quarter 4 Winter Plan. Progress for periods prior to 2020/21 continue to be reported against this reprioritised timescales.

INTERNAL AUDIT

The summaries below provide an assessment of current outstanding recommendations. The reporting periods 2017/18, 2018/19 and 2019/20 are summarised by the re-assessed COVID-19 priority level (priority 1, priority 2 and priority 3). The COVID-19 priority levels have the following agreed timescales for implementation, with the exception of where the original agreed deadline exceeds these timescales: -

Priority 1	31st March 2021
Priority 2	30th September 2021
Priority 3	31st December 2021

It should therefore be noted that any recommendations outstanding from periods prior to 2020/21 according to this convention are, by definition, overdue. A final re-assessment of risk and revised deadlines are required in order to ensure that implementation is monitored effectively and will be incorporated into the next reporting cycle.

The reporting period 2020/21 and 2021/22 is summarised by Internal Audit priority level (high, medium and low) and the agreed implementation date. This approach will be taken for all new audit recommendations received going forward.

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

Overdue Internal Audit Recommendations								
Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21	2021/22		TOTAL OUTSTANDING
	Number				Number			Number
Priority 1	0	0	0	**High**	2	3		5
Priority 2	5	0	6	**Medium**	4	7		22
Priority 3	0	0	7	**Low**	3	2		12
Not Yet Prioritised	0	0	0					0
TOTAL	**5**	**0**	**13**		**9**	**12**		**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	TOTAL OUTSTANDING
	Number	Number	Number	Number	Number
Priority 1	0	0	0	0	0
Priority 2	2	0	1	2	5
Priority 3	1	0	0	0	1
Not Yet Prioritised	0	0	2	0	2
TOTAL	**3**	**0**	**3**	**2**	**8**

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix G – External Audit Recommendations that remain OUTSTANDING
Appendix H – External Audit Recommendations COMPLETED since the previous report
Appendix I – External Audit Recommendations NOT YET DUE for implementation

LOCAL COUNTER FRAUD SERVICES

The overall summary position in respect of **overdue** local counter fraud services recommendations is: -

Local Counter Fraud Services Recommendations		
	2021/22	TOTAL OUTSTANDING
	Number	Number
Overdue	3	3
TOTAL	**3**	**3**

Detail of local counter fraud recommendations can be found appended to this report as follows: -
Appendix J – Local Counter Fraud Audit Recommendations OVERDUE for implementation

NEXT STEPS:

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

2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1							✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	2							✓
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0							✓
171806	Risk Management	Limited	2	1	0	2	1	0							✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0							✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0							✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0							✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1							✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1							✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0							✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1							✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0							✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1							✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3							✓
171817	Policies Management	Reasonable	0	4	1	0	0	1	0	4	1	0	5	0	×
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3							✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1							✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4							✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2							✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3							✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1							✓
171824	General Ledger	Substantial	0	0	1	0	0	1							✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1							✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1							✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	1							✓
171828	Personal Appraisal Development Reviews (PADRs)	Reasonable	1	1	0	1	1	0							✓
171829	Records Management Follow-Up	Reasonable	1	4	2	1	4	2							✓
TOTAL			**28**	**81**	**32**	**26**	**77**	**32**	**0**	**4**	**1**	**0**	**5**	**0**	

2018/19 Internal Audits

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

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	Not Yet Prioritised	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	1	0								✓
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1								✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0								✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3								✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3								✓
192006	Records Management	No Assurance	6	0	0	4	0	0	2	0	0	0	2	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3								✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	3	0								✓
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2								✓
192010	111 Service	Reasonable	2	3	0	2	3	0								✓
192011	Catering Services Follow-up	Reasonable	0	3	2	0	3	2								✓
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	1	3	1	1	0	0	0	0	1	0	×
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4								✓
192014	Care Homes Governance	Limited	1	2	3	0	0	3	1	2	0	0	3	0	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	1	3	1								✓
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	2	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	0	1	0	1	2	0	0	0	3	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**	**18**	**57**	**31**	**5**	**6**	**1**	**0**	**6**	**6**	**0**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0										✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	2	5	0										✓
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	3	2										✓
202104	Annual Quality Statement	Not Rated	0	1	0	0	1	0										✓
202105	Advanced Practice Framework	Not Rated																✓
202106	Capital Systems	Substantial	0	0	4	0	0	4										✓
202107	GP Access Standards	Substantial	0	0	1	0	0	1										✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	1	1	1	2	0	0				0	0	0	×
202109	IM&T Control and Risk Assessment	Not Rated	0	0	13	0	0	10	0	0	3				0	0	0	×
202110	Freedom of Information Follow Up	Substantial																✓
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	0	2	0	0	0	0	0	2	0				0	0	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				0	0	0	×
202116	Llandrindod Wells Project	Limited	0	5	1	0	5	1										✓
202117	Covid-19 Mass Vaccination Programme	Not Rated																✓
TOTAL			**5**	**26**	**24**	**3**	**22**	**20**	**2**	**4**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	

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	0	0	0	1	0	0	0	×
212202	Control of Contractors	Limited	4	2	1	4	2	1							✓
212203	Medical Equipment and Devices	Reasonable	3	3	1	0	0	0	1	3	1	2	0	0	×
212204	Midwifery – Safeguarding Supervision	Reasonable	0	2	0	0	1	1	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	1	0	2	1	1	0	1	0	×
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	1	0	0	1	0	1	2	0	×
212208	Waste Management	Reasonable	0	5	0	0	2	0	0	0	0	0	3	0	×
212209	Job Matching and Evaluation Process	Reasonable	0	2	1	0	0	0	0	0	0	0	2	1	×
212210	Mortality Review	Reasonable	0	5	1	0	4	0	0	0	0	0	1	1	×
212211	Machynlleth Hospital Reconfiguration Project	Reasonable	1	5	1	0	5	1	0	0	0	1	0	0	×
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	✓
TOTAL			**12**	**36**	**9**	**5**	**22**	**4**	**3**	**6**	**3**	**4**	**9**	**2**	

2018/19 External Audits

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

2019/20 External Audits

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

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	2	3	Not Yet Prioritised		
202151	Effectiveness of Counter-Fraud Arrangements	3	3							✓
202152	Structured Assessment 2020	11	7	2	0	1	1	0	0	×
202153	Audit of Accounts	6	6							✓
TOTAL		**20**	**16**	**2**	**0**	**1**	**1**	**0**	**0**	

2021/22 External Audits

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

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

APPENDIX C

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	0	3	0	×
TOTAL		**6**	**3**	**3**	**0**	

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?					
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and how feedback received has been incorporated into the policy. The recommended consultation period of a minimum of 14 days should be applied to ensure that consultation with relevant stakeholder groups has been conducted thoroughly and that comments have been incorporated into the policy.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	3	May-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content checks have been carried out.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. As set out in recommendation 4 below, the ability to upload polices onto the intranet will be restricted to members of the Corporate Governance Department.	May-18	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	3	May-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. Going forward policies submitted to the Corporate Governance Department without the submission and approval form will be returned to the relevant Executive	May-18	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	3	May-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate Governance Department. The Policy and Procedures Index should be published on the intranet at regular intervals and consideration given to widening the scope of this document to include	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed and will be updated by the end of April 2018.	Apr-18	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		47	3	May-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	May-18	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	3	May-22	Feb-19
192006	Records Management	No Assurance	Director of Finance, Information and IT		R4	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained and that the points raised in this report are addressed, where weaknesses are identified.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Apr-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	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	1	May-22	19/11/2022
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-	Apr-22	Apr-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	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group	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	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		25	1	May-22	19/11/2022
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Board Secretary	Board Secretary	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability framework and governance systems for HRCW. (c) The health board ensures that the Welsh Government Hosting Agreements, and any signed replacement agreements, for the hosted functions are shared with all those health board staff managing and monitoring services provided to these hosted functions.	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to inform arrangements for other hosted arrangements, including HCRW.	Apr-20		Overdue	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement which was complete; however this work was then superseded by the intended transfer to the Citizens Voice Body in 2022. Renewed discussions are taking place in line with organisational governance to review the current position in relation to Health Care Research Wales and advice on hosting agreement is being sought from NWSSP Legal and Risk Services. Both aspects will be overseen by the Audit, Risk and Assurance	Obtaining tri-partite agreement	CHC - Interim Board Secretary supporting the governance workstream of the CVB. HCRW - Quarterly meetings have been put in place between Director of W&OD, Interim Board Secretary and HCRW, with focussed hosting agreement review being undertaken with advice from L&RS.	CVB by 1 April 2023, HCRW uncertain due to tri-partite nature of any agreements.		25	25	May-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance	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	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.	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	Delay in Lead Clinician for the complex care project to commence. Delay in CHC	Completed local review of scheme of delegation and sign off procedures in	Sep-21		17	8	May-22	
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	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.	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	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there	Jul-21		25	10	May-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health	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	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	LA have requested to review the SOP and have contested some areas of the SOP 4.2	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to	Apr-21		26	13	May-22	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and monitored.	The Executive Directors will develop detailed objectives and actions that will enable the achievement of each of the key priority deliverables within the Organisational Development Framework. For each action there will be action owners or leads along with defined timescales which will ensure the ability to monitor and evaluate progress against each action.	Mar-20	Sep-20	Overdue	3	Partially complete		This work has been paused due to the COVID pandemic and current winter pressures. – However a number of the OD priorities have been included in other plans; such as the wellbeing plan- leadership and team development. JUNE 2022: The ODF was refreshed in 2021 when we were in the midst of the pandemic response. As we come out of the pandemic our focus is on how the organisation and our staff can recover and how we use this opportunity for renewal and transformation of our core services. In parallel to this we have experienced turnover within our Executive Team and Independent Members and it is in this context that			This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		26	20	May-22	
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access	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.			Sep-22		14	2	May-22	Sep-20

192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R3	The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This should include reference to anomalies	The CAF report sets out the RTT position for Powys patients in each of the different providers attended (due to geography) even though the waiting times are different. The waiting time differences are recorded in the public	Mar-21	Mar-22	Overdue	3	Partially complete			COVID-19 delays		Jul-22		14	2	May-22	Sep-20
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R4	Continue to work with the commissioned health boards and trusts in Wales and England to enhance the reporting of commissioning services data to include Powys outpatient follow-up appointments waiting times and to discuss exceptions with them.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Jan-22	Overdue	3	Partially complete		As reported to EQS and P&R committees the CAF has been partially reinstated. Work is underway to ensure information about follow-up. Furher information is now being reported by acute hospital sites for follow up performance including those overdue. Information will be included in the next D&P Committee Report		Follow-up is discussed in CQPRMs.	Jan-22		14	4	May-22	Sep-20
192023	Estates Assurance Follow Up	Reasonable	Director of Environment	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		Jan-21	Feb-22	Overdue	3	Partially complete		Policy now updated and approved with Asbestos Management Plan to be agreed in August Asbextos Management Group	COVID-19 delays	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and introduce site specific	Aug-22		16	3	May-22	Sep-20
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary / Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and, • the relevant committees have regular oversight of the strategic objectives and risks assigned. b. Consider enhancement of the Board Assurance Framework review process by implementing and presenting a detailed BAF report at Board meetings. c. Establish the concept of Local assurance frameworks into the risk management hierarchy and then introduce them as a process documentation and discussion at	Agreed	Mar-21	Mar-22	Overdue	2	Partially complete		High level work has been initiated to outline the framework and principles.	COVID-19	Agendas for all meetings continue to be scrutinised in order to ensure that the Board is receiving appropriate assurance.	May-22		12	0	May-22	Sep-20
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement	R3	The health board should continue raising awareness of the Standards, including through: • the roll of out awareness sessions, keeping records of attendance;	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	Mar-21	Mar-22	Overdue	3	Partially complete		Work is ongoing. Covid-19 has disrupted implementation, particularly around staff training and developing a	Lack of resources to fully implement the WL Standards. Additional	Regular monitoring and reporting via the Executive Lead for WL.	Implementation will be ongoing		14	2	May-22	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	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.					8	2	May-22	
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R5	Arrangements for reporting assurance to the Health Board on the effectiveness of the Live Well: Mental Health partnership need to be determined.	Reporting arrangements will be reviewed and clarified through the Partnership Governance Framework development and ongoing implementation. This reporting mechanism will also need to reflect existing reporting arrangements to Welsh Government and the RPB in order to reduce duplication.	Sep-21	Mar-22	Overdue		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.					8	2	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R2	Consideration should be given to providing reports identifying risks that are not scored to escalation level due to low likelihood, however contain a severe worst case scenario. In doing so, this shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.	The Directorate maintains a local risk register (that captures lower level risks as referenced) and this is held within the department and reported up via the risk process for the Health Board. The current register will be reviewed and consideration given to how worst case scenario identification and potential impact can be included as	Oct-21		Overdue		No progress							7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R3	The organisation should consider assigning the responsibility of CCIO.	There is a Clinical Informatics Lead Nurse who is part of the Informatics team. The potential for a CCIO role will be reviewed and an options paper prepared for the Executive Committee to consider how best to establish within current establishments.	Oct-21		Overdue		No progress							7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R10	A suite of cyber security KPIs should be developed in order to show the status of cyber security and the progress of the team in managing issues.	Appropriate KPI's are included as part of the work to review the current S33 and is ongoing to ensure that appropriate.	Dec-21		Overdue		Partially complete		KPI's for Cyber are in progess and some are reporting daily and weekly. There is still work to do with S33 ICT performance KPIS and with the introduction of a new IT Service Delivery Manager this will help better define and implement, and report	Awaiting Recruitment of ITService Delivery Manager	Automated reports already in place and reviewed by Cyber Security compliance manager	Request extension to Sept 22 to ensure the KPI are part of S33 monthly reporting as well as local PTHB reporting		5	5	May-22	
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	Nov-21		Overdue		Partially complete		Meetings continue to include clinical representation from a frontline, management and Director level across organisations. The focus of Phase 2 has been Maternity and Neonatal with a clinically led workstream established. This approach has been embedded in the programme and will continue. The		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		6	6	May-22	
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2	We concur with management and recommend the development of a documented framework that the health board can use in future collaborative change programmes to assist in the management of the programme and to ensure the use of a consistent and controlled approach.	This recommendation is accepted and a collaborative change programme framework will be developed and considered through the PTHB Executive Group for Strategic Planning and Commissioning.	Sep-21	Mar-22	Overdue		Partially complete		Standard PIDs have been agreed for the 9 Renewal Programmes including key stages in collaborative change such as identification of stakeholders, engagement and communication, consultation and formal written notice.	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		8	2	May-22	
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R2	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update	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	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			01/09/2022	Yes via meeting minutes & action logs	2	2	May-22	
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R3	3.1 As part of formalising the PFCU business cycles (see MA1), the health board should consider the key performance metrics for patient flow performance (including delayed transfers of care) to be used for reporting at each level within the health board and how frequently these should be reported. 3.2 The health board could refer to the 2017 Audit Wales report (Discharge Planning, Powys Teaching Health Board) in identifying metrics, recognising some of the metrics	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	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			02/09/2022		0	0	May-22	
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R2	Staff should be reminded to provide accurate information for staff who move roles. Consideration should be given to replacing the paper forms with electronic and removing the free text option to ensure that moves are properly reported.	We are working on using Power Automate and E-Forms. There is a change to be made within DHCW which has been logged for the use of power automate, once the change is	Mar-22		Overdue		No progress		There is a starters/leavers/.movers process and associate policy being developed. There is work to do to			Request this be closed as this is progressed and in place but being		2	2	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R2	Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include:	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	Dec-21		Overdue		No progress							5	5	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads	R3	All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service	Nov-21	Feb-22	Overdue		Partially complete		Meeting held with Governance Leads and Medical Device & Point of Care Testing Manager 06/12/21. Example of	Limited resources to undertake audits to gain assurance that all	Regular monitoring and reporting into Medical Devices Group.	Review of compliance to be undertaken at next Medical Devices		6	3	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Ward Manager – Graham Davies Ward / Governance	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.	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	Mar-22		Overdue		No progress							2	2	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Head of Clinical Education / Medical Device & POCT	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.	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	Mar-22		Overdue		No progress							2	2	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R6	The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators	Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The	Apr-22		Overdue		No progress							1	1	May-22	

212204	Midwifery – Safeguarding Supervision	Substantial	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding	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	Dec-21		Overdue		No progress						5	5	May-22	
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Medical Director	R1	Further work should be undertaken to take forward the consideration regarding appointment of a part time Clinical Director for Endoscopy and Theatres to improve the oversight and discussion of clinical issues. Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board	To explore opportunities for a Clinical Director role for Planned Care (including Endoscopy and Theatres)	Mar-22		Overdue		No progress		Options being considered			01/09/2022		2	2	May-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director of Community Services Group	R2	Progress on delivering the Theatres and Endoscopy Recovery Plan should be appropriately controlled and monitored to ensure that the 2021/22 Renewal Priorities are achieved.	Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board.	Mar-22		Overdue		No progress		currently being scoped. Will need additional finance to resolve or diversion of funds allocated to Health Boards 'back' to afford delivery			01/07/2022		2	2	May-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director Community services	R3	The Service Level Agreements for the in-reach staff should be reviewed and updated as soon as possible.The assumptions and calculations within management information should be reviewed and updated as soon as possible. Agreed Management Action 3	To review service level agreement with in reach providers, this is challenging due to current seasonal pressures focus and all providers re-aligning/transforming services and implanting recovery plans. Management reports will be aligned with updated SLAs as part of 2022/23 service planning.	Mar-22		Overdue		No progress					01/09/2022		2	2	May-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Planned Care Manager	R5	The Health Board should develop a protocol which describes the administrative processes which are in place regarding theatre utilisation.	Terms of Reference for Theatre Planning Meeting will be formalised and admin processes for list planning added to the SOP.	Jan-22		Overdue		No progress		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			Jul-22		4	4	May-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Sciences	Business Manager, Mental Health	R4	Management must ensure that the Performance measures are subject to appropriate independent review prior to submission.Good practice in data collection should be shared between the teams.	This process will be reviewed to ensure that Performance Measures are independently and rigorously tested prior to submission.The MHLD business manager will facilitate the	Mar-22		Overdue		No progress							2	2	May-22	Jan-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete,	Progress being made to implement recommendation				If action is complete, can evidence	No. of months past agreed	No. of months past Revised	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementation be					
181909	Occupational Therapy Service	Reasonable	Director of Finance and ICT		R5	The Records Management Policy, Health Records Procedure and Safe Haven and Information Policies should be reviewed and updated as necessary so that they comply with General Data Protection Regulations (GDPR). A consistent approach to records management should be adopted in Occupational Therapy.	The policies and procedures will be updated to ensure compliance with GDPR. Occupational Therapy Teams will be reminded of the standards for records management to promote a consistent approach.	Apr-19	Dec-21	Complete		Complete		A revised Records Management Framework is being developed. The Save Haven & Information Policy has been superseeded by the National Information Security Policy and supporint ICT procedures.	Impact of COVID-19 on the IG team None	IG advice and support is provided to the organisation when requested. As above	31/12/2021 Recommendation to close this action as complete		37	5	May-22	26/02/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R6	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	Apr-20	Apr-22	Complete		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	COVID-19	A Records Management	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		25	1	May-22	14/11/2019
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and IT		R2	The health board should investigate options for the implementation of an electronic referral management system as a replacement for the manual activities that currently cover the processes from initial patient referral up to booking of a patient's	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	Mar-21	Mar-22	Complete		Complete		Electronic Referrals is being covered with the 'All Wales' work being undertaken on the Welsh Admin Portal	This is driven by the WCP programme led by DHCW		We are bound by national programme progression and this is		14	2	May-22	Sep-20
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R1	The deed of variation to the Overarching Agreement requires completion and signing to demonstrate agreement by both the health board and county council of the amendments proposed during 2019/20. The Reablement agreement needs to be brought up to date and signed ASAP. This	There has been an inevitable impact on the signing of 2020/21 S33 Agreements by April 2020, in light of the COVID-19 Pandemic. 2020/21 Agreements will therefore be signed later in the year. PTHB will therefore work towards	Apr-21		Complete	3	Complete		Updated S33 Agreements approved by the Joint Partnership Board in April 2022 and signed by Chief Executive Officers.				Yes				
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R4	The health board should review its published ICT policies for completeness and where necessary develop or adapt and publish additional polices to provide a full suite.	This is an ongoing process. The recently established team will help to provide the ongoing focus in ensuring that relevant policies and procedures are in place, these will	Oct-21		Complete		Complete		Full review of the ICT policies has been undertaken and will be ongoing as we fully migrate to O365 and continue to	None		This is now in BAU and managed via Digital Governance Board		7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R5	The necessary work to define and approve the strategic direction for the use of ICT within the organisation should be completed as a priority. In doing so the health board should explore opportunity for synergy and overlap of strategy with colleagues	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21		Complete		Complete		A draft Digital Strategic framework has been submitted for consultation, June/July and will aim to be approved	None		Request this be closed as now submitted for consultation		7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R6	The development of the strategy should consider the wider ICT strategy implications and the supporting technical infrastructure.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21		Complete		Complete		Possible duplication of line above Digital Strategic Framework includes ICT Infrastructure & support provision - An			Request this be closed as now submitted for consultation		7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R7	As part of the Strategy development, work should be carried out to ensure it is fully costed and appropriate resource made available to deliver the organisations strategic ambitions with a fair and equitable system of allocating costs to the enterprise.	Action already been completed in this area to ensure that the Informatics structure and establishment are as needed to meet objectives and there has been ongoing work with	Apr-22		Complete		Complete		Once the Digital Strategic Framework is approved there will be a number of business cases submittted to support			Request this be closed as this is progressed and in place		1	1	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R8	A full assessment of the current skills within ICT, alongside the required resource and skills for the ICT Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21		Complete		Complete		This is covered as part of the Structure remapping to support the Digital service offering going forward. S33 ICT			Request this be closed as this is progressed and in place		7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R9	As part of the strategy development and approval the organisation should ensure the resourcing requirements are fully defined and a gap analysis is included so as to ensure the requirements are fully known and provisioned.	Action already been completed in this area to ensure that the Informatics structure and establishment are as needed to meet objectives and there has been ongoing work with	Oct-21		Complete		Complete		A full structure has been designed and is financially supported via Business case and programme funding. Newly			Request this be closed as this is progressed and in place		7	7	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R11	The health board should encourage appropriate groups of staff to complete the all wales NHS cyber training.	This is available on ESR and all staff encouraged to complete, we will continue to explore if this can be made mandatory.	Dec-21		Complete		Complete		It was requested at exec Board to make Cyber Training Mandatory, however there is a review of the IG and Cyber	National improvement to combine IG and Cyber which will		Request closure as changes being made nationally to cover this		5	5	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R12	Critical assets should be identified and be subject to enhanced monitoring an assessment for risk / replacement.	Action to completed with PCC partners as part of S33 arrangements.	Dec-21		Complete		Complete		This is now complete with the introduction of an Asset Management solution and Solar winds. Weekly			Request this be closed as this is progressed and in place		5	5	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R13	In order to ensure best value approach, differing continuity options should be defined and the differing options to deliver this assessed/ costed.	The current procedures and process will be reviewed with PCC partners to ensure up to date and different options identified if available.	Apr-22		Complete		Complete		Business Continuity is in place not sure what this action is referring to			Request this be closed as this is progressed and in place		1	1	May-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation &	R14	The health board must ensure resource is available to deliver and report upon the ICT programme.	The 20/21 Digital Plan as presented and approved by Executive Committee included the additional resource required to support implementation (note the newly	Oct-21		Complete		Complete		Already covered in Line 13			Request this be closed as this is duplication of line 13		7	7	May-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and	R1	a) Guidance on the process that services need to undertake should be drafted to ensure that staff are clear on the considerations and key contacts when planning and implementing changes. Consideration should be given to include the following:	The recommendation will be actioned as part of the process of establishing the newly formed Digital Governance Board. Appropriate communication will be	Sep-21	Dec-22	Complete		Complete		A Digital Governance process was established in April 2021, and has now been effective for 6 months with KPI			Request this be closed as this is progressed and in place		8	#NUM!	May-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and	R2	a) The Digital Transformation Sub-Committee should be established and include oversight and monitoring of digital solutions implemented throughout the health board.	a) Noted and agreed – Action already in place to establish the Digital Transformation Sub-Committee known as the 'Digital Governance Board' which reports into the Digital	Dec-21		Complete		Complete		A Digital Governance process was established in April 2021, and has now been effective for 6 months with KPI			Request this be closed as this is progressed and in place		5	5	May-22	
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R3	The setup of users should transition into normal practice and transfer from the PCC project team to the PCC service desk to action requests.	This is a work task within the Digital Project plan to complete the hand over.	Mar-22		Complete		Complete		BAU handover is part of the PMO process - complete and in place as agreed with S33			Request this be closed as this is progressed and in place		2	2	May-22	
212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R2	The Waste & Recycling Group should continue to seek improved attendances wherever possible. If non-attendances affect performance, this should be escalated as appropriate	Agreed. We will review the current membership and attendances to ensure this supports the group's intended function.	Mar-22	N/A	Complete	N/A	Complete	N/A	Actions complete	Actions complete	Actions complete		Yes.	0	0	May-22	Apr-22
212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R5	Waste audit recommendations should be centrally logged and monitored	Agreed. We will liaise with the Environment & Sustainability Manager to incorporate pre-acceptance audit recommendations into the existing ISO14001 audit tracker, to provide a central log for ease of monitoring. This will help ensure that all points are addressed.	Mar-22	N/A	Complete	N/A	Complete	N/A	Actions complete	Actions complete	Actions complete		Yes.	0	0	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	Medical Director, Assistant Director of Quality & Safety, Lead Nurse Community	R1	The Standard Operating Procedure should be finalised and formally distributed to all relevant staff as soon as possible. The issue of the new Standard Operating Procedure can be used to reiterate to the staff members / doctors who are completing the medical records information such as: • which sections the Patient information should be filed within; • that the cause of death must be clearly identified; and that the medical notes must be legible. It may be appropriate to highlight in the Standard Operating	A SOP is being finalised. This has been shared with the Medical Examiner Service. A pilot will shortly commence on 2 hospital sites in collaboration with the Medical Examiner service so that any outstanding issues can be identified. This includes the referral form to the ME service which contains all of the information required. There have been ongoing updates to primary care but the finalised SOP will be formally	Apr-22		Complete		Complete							1	1	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	Medical Director	R2	should be produced which: • Identifies the pathway for all cases referred back from the Medical Examiner Service; • Clarifies the role of the Multi-Disciplinary Panel and who will sit on the Panel. • Confirms the reporting arrangements for the Multi-Disciplinary	The new Assistant Director for quality and safety has started in post since conclusion of the audit. The process for receiving and dealing with referrals back into the Health Board has therefore been agreed and incorporated into the SOP.	Apr-22		Complete		Complete							1	1	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	Medical Director, Assistant Medical Director Quality and Safety	R3	the next of kin along with the relevant care organisation for further action, so there will need to be a process in place within the Health Board to ensure that all issues are fed back to the relevant people. Where further investigation is required, there should be an adequate audit trail to show that these issues are being monitored and addressed to provide reassurance to the bereaved family along with the Medical Examiners Service and the Board.	All patients will be logged on the datix mortality module which will document all process, communication and actions. This will be therefore available to audit	Apr-22		Complete		Complete							1	1	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	Medical Director	R4	The Health Board should ensure that where issues have been raised and presented in the Mortality Report, further updates are consistently provided to the Patient Experience, Quality and Safety Committee in order to provide assurance that issues are being addressed and that there is an appropriate audit trail.	All significant issues are reported through PEQS and will continue to be reported once the ME process has been rolled out. Themes from less significant issues are discussed and fed back. The method for recording this will be reviewed.	Apr-22		Complete		Complete							1	1	May-22	Apr-22

212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Senior Responsible Officer and Project Director	R1	Board had been appropriately defined, in the current terms of reference (last reviewed and ratified in June 2021). Meetings were held routinely throughout the period reviewed (January-September 2021: covering the FBC approval period and early construction activities), and were well attended by a number of key parties, including the Senior Responsible Officer, Project Director, Senior Project Manager (THB), GP Practice Lead and Finance. Meetings were non-quorate in five of nine cases, with notable non-attendances from the Primary Care Lead and Operations representative. The terms of reference permits deputies, yet none had been sent. Whilst not in regular attendance at Project Board, these parties have	Agreed. The terms of reference have been reviewed and updated; and were approved at the February 2022 Project Board meeting.	Actioned since fieldwork		Complete		Complete							#VALUE!	#VALUE!	May-22	Jun-22
212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Senior Responsible Officer and Project Director	R2	Future Assurance. At future schemes, either: • The SRO should obtain formal written approval from Welsh Government to progress works in accordance with national guidance requirements; or • Board approval to projects proceeding at risk should be obtained in the absence of the former.Compensation events should be assessed and discharged within the stated contractual requirements.	Not agreed. PTHB liaised closely with Welsh Government in respect of the anticipated approval of the FBC at the end of 2020 through to actual approval on 24 March 2021. Welsh Government fully funded the additional enabling works, largely seasonal and due to ecology issues (issues which would have had led to delay and consequential costs to the main project had they not been dealt with in a time	Ongoing	Ongoing	Complete		Complete		ARAC was informed on 26/04/2022 that this reccomendation was not agreed by management. The Chief Executive supported this and confirmed that she would keep the matter under personal review.					#VALUE!	#VALUE!	May-22	Jun-22
212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Project Director, in liaison with Corporate Governance	R4	The THB's existing checklist / cover document should be enhanced to include a tick box to indicate key contract amendments / risk items included within contract documentation. See recommendation 3.2b 4.2 The development of the THB risk register should be finalised, ensuring key details such as risk owners (including those defined within the Construction Delivery Agreement), mitigating actions, and associated	Agreed	Ongoing		Complete		Complete		COMPLETE					#VALUE!	#VALUE!	May-22	Jun-22
212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Project Director, in liaison with Corporate Governance	R5	The THB's existing checklist / cover document should be enhanced to include a tick box to indicate key contract amendments / risk items included within contract documentation.	Agreed	Ongoing		Complete		Complete							#VALUE!	#VALUE!	May-22	Jun-22
212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Rsenior Responsible Officer and Project Director	R6	The THB should undertake an evaluation of the issues encountered to date, which have contributed to initial time and cost implications, and the reasons for the same. The evaluation should confirm whether there are any existing contract provisions that address the issues arising to date. The evaluation should determine whether the performance of the THB's appointed advisers, or the Contractor and its appointed team, adversely contributed to the issues arising to date.	Lessons learnt exercises are embedded in the project process for major schemes and undertaken as a routine at milestone stages of the project. A workshop was convened on 14 February 2022 to include the PTHB Project Director, Project Manager, client appointed consultant and senior representatives from the design and build team to specifically consider matters associated with the expenditure of the project contingency, largely associated with	Actioned since fieldwork		Complete		Complete							#VALUE!		May-22	Jun-22
212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Project Director, in consultation with External Project Manager	R7	The External Project Manager should ensure the construction risk register is fully and appropriately costed. The costed risk register should be reconciled to remaining project contingency. Any insufficiencies identified should be reported appropriately within the THB. The development of the THB risk register should be finalised, ensuring key details such as risk owners (including those defined within the	Agreed. Risk Register costing, this was the case at FBC and lapsed for a period during construction phase albeit this was replaced by a robust Contingency Tracker which was the mechanism by which the issues with structure were raised circa August with flagged circa £180K overspend (circa 1.37% of project value).	Ongoing		Complete		Complete		Risk Register in place					#VALUE!		May-22	Jun-22
212212	Network and Information Systems (NIS) Directive	Reasonable	Director of Finance, Information and IT	The Cyber Security and Assurance Manager,	R1	Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Noted and agree, the Cyber Security and Assurance function is a newly developed team, and this action will be implemented going forward.	Jun-22		Complete		Complete		Noted and agree, this was learning from the audit and the Cyber Security and Assurance function is a newly			Request this be closed as this is progressed and in place		#NUM!	#NUM!	May-22	Jun-22
212212	Network and Information Systems (NIS) Directive	Reasonable	Director of Finance, Information and IT	The Cyber Security and Assurance Manager,	R2	Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.	The Cyber Security and Assurance function will formalise the existing Cyber Security improvement plan, and ensure any additional actions are captured following the outcome	Jul-22		Complete		Complete		There is a formal SIP for Cyber Security that is actively updated and reports are generated to the Execs and D&P as part			Request this be closed as this is progressed and in place		#NUM!	#NUM!	May-22	Jun-22
212212	Network and Information Systems (NIS) Directive	Reasonable	Director of Finance, Information and IT	The Cyber Security and Assurance Manager,	R3	Management should consider the implementation of cyber security metrics that feed into the governance structure which track the status of cyber security and the efficiency in which issues or incidents are dealt with.	The Cyber Security and Assurance function will provide assurance against performance by the inclusion of both create critical success factors and key performance	Sep-22		Complete		Complete		This is in place as part of the Cyber KPIs c			Request this be closed as this is progressed and in place		#NUM!	#NUM!	May-22	Jun-22
212212	Network and Information Systems (NIS) Directive	Reasonable	Director of Finance, Information and IT	The Cyber Security and Assurance Manager,	R4	Management should ensure that a cyber security risk is included within the Corporate Risk Register to reflect the high-level risks identified from the self-assessment process.	The departmental risk register is under constant review and as relevant escalated to the Corporate Risk Register as appropriate. This will be updated to reflect the high-level	May-22		Complete		Complete		There is a cyber risk on the corporate reg			Request this be closed as this is progressed and in place		0	0	May-22	Jun-22
212213	Budgetary Control	Substantial	Director of Finance, Information and IT	Deputy Director of Finance	R1	In line with the FCP, a brief summary of the queries raised, matters discussed and any actions arising from meetings with budget holders should be drawn up by Finance and sent to the budget holder by email after the meeting.	Action notes will be made at each budget holder meeting using the meeting record template with agreed leads and timescales.	Apr-22		Complete		Complete		Action notes are being taken at each budget holder meeting using the meeting record template with agreed					1	1	May-22	Jun-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled	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	Jul-22		Not yet due		No progress							#NUM!	#NUM!	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT	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	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	Nov-22		Not yet due		No progress							#NUM!	#NUM!	May-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads / Medical	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	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	Dec-22		Not yet due		No progress							#NUM!	#NUM!	May-22	
212205	COVID Recovery and Rehabilitation Service	Substantial	Director of Therapies and Health Sciences	Head of Pain & Fatigue Management	R1	1.1 Management need to ensure that the budgets are reviewed and the £100k is appropriately utilised in support of long covid services.	1.1 The Long-Term Conditions Indicative Financial Plan will continue to be reviewed as part of the weekly meeting held between the service and the DOTH. This information will be	Ongoing		Not yet due		No progress							#VALUE!	#VALUE!	May-22	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		Not yet due		No progress							#VALUE!	#VALUE!	May-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Sciences	Assistant Director of Mental Health	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	Sep-22		Not yet due		No progress							#NUM!	#NUM!	Msay-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Sciences	Operations Manager, Mental Health	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	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	Apr-22		Not yet due		No progress							1	1	May-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Sciences	Assistant Director of Mental Health Services	R5	A review of the performance measures should be undertaken to ensure they are meaningful, and duplication is avoided.Guidance on how to interpret and evidence the performance measure should be provided. Management should consider standardising the performance measures across both teams to ensure meaningful and comparable	The review of performance measures will be undertaken as part of a wider MHLD service group's participation in Welsh Government's move to service user led outcomes and core data sets.Within the National move to service user led	Sep-22		Not yet due		No progress							#NUM!	#NUM!	May-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Sciences	Business Manager, Mental Health Services	R6	Consideration should be given to providing the Mental Health SMT information on the performance of the Dementia Home treatment team.	DHTT performance will be included in the SMT performance reporting on at least a quarterly basis.	Apr-22		Not yet due		No progress							1	1	May-22	Jan-22
212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R1	The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The THB should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements.	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	Oct-22	Not yet due	N/A	Partially complete	N/A	All changes and revisions to the document have been completed. The document is now going through the process that will close with consideration by the Board.	Now awaiting an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	Sep-22		0	0	May-22	Apr-22
212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R3	A training needs assessment should be prepared, identifying for each relevant staff group the level and frequency of training required and how this is to be delivered. Management should consider the option of developing an online training module, in conjunction with relevant parties.	Agreed. We will liaise with Workforce & Organisational Development to obtain advice on how best to take this forward, noting some training is also delivered by other departments and sits within their training records. A PTHB wide training needs analysis is a significant project which will take several months to	Jun-22	N/A	Not yet due	N/A	Partially complete	N/A	A meeting has been held with workforce & Environment & Sustainability colleagues to scope out the required changes to the BCUHB online training package colleagues.	Director of Environment has advised to focus on securing a formal general waste and recycling contract and to then seek advice and input from our strategic waste and recycling partner regarding	Clinical waste training is avialble via our Contractor Stericycle. General waste & recycling info and posters etc are currently avilable via the Support Services and Environment and	Oct-22		0	0	May-22	Apr-22
212208	Waste Management	Reasonable	Director of Environment	Assistant Director Support Services	R4	The THB should ensure compliance with SO/SFI and National Procurement Regulations at the award of all future waste management contracts i.e. participation in National Framework arrangements and / or, application of formal tender arrangements, completion of formal contract arrangements etc.	NWSSP Procurement Services confirmed on 17/1/22 that Powys County Council is precluded from joining the ESPO framework process which is currently the chosen All Wales procurement route. As this decision excludes our long-term partner from the tendering process Support Services are preparing an options appraisal paper	Aug-22	N/A	Not yet due	N/A	Partially complete	N/A	Contract Award Report for a 5 + 3 contract for general waste and recycling was issued by NWSSP Procurement on 07/06/22 recommending we award to the incumbent provider Powys County Council. Once PTHB corporate sign off of the award report has been obtained, the contract can hopefully be swiftly signed	WG approval due to cont	Single Tender Waiver is in place until 1st September covering the existing provider PCC	Sep-22		0	0	May-22	Apr-22
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing	R1	Consideration should be given by management to updating the policy to reference the recommended number of members for job evaluation panels and the make up of the panel members.	The job evaluation policy will be reviewed by the Workforce Policy Review group to consider this recommendation.	Jan-23		Not yet due		No progress		JUNE 2022: Recommendations on minimum panel levels have been suggested as part of a review of job evaluation activity. However, this is subject to approval through the organisations Workforce Policy Review Group	Interdependency in relation to approval via the Workforce Policy Review Group		On track for agreed implementation date if not sooner		#NUM!	#NUM!	May-22	Apr-22
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing, Executive Director	R2	Management should consider undertaking an evaluation that would determine the numbers and type of staff (management and staff side) required to deliver an effective job matching service. Representatives for all directorates need to be trained in job matching; this would ensure fairness in release time and allow wider ranging views to be included	A further evaluation of the number of required job matchers will be undertaken by the Job Evaluation team. A formal request to the Executive Team to release staff from each Directorate to participate in job matching training will be undertaken, to ensure that	Jun-22		Not yet due		No progress		JUNE 2022: An evaluation of the level of activity and required number of trained job matchers has been undertaken and shared with the Deputy Director of Workforce & OD and is awaiting formal agreement of the recommendations put forward. This includes identification of additional resource needed from directorates to support job matching	The Workforce & OD team have identified the required resource based on an evaluation, however, this requires the support and release of staff from across directorates. If this is not provided, there is	Current capacity is being provided via the current JE matchers, of which over half are from within the WOD directorate. This is being mitigated through the consistency checking process on an	end of Qtr 2 / beginning of Q3		#NUM!	#NUM!	May-22	Apr-22
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing	R3	Membership of the job matching panels should be representative of the Health Board and be as independent as possible. Staff should be reminded of the importance in sending the outcomes from panels to management within an appropriate timeframe.	Wider participants will be sought for job matching panels from across the health board's Directorates. Wherever possible, panels will have representatives from outside the Directorate for the role being evaluated, other than on rare occasions where this is not possible and would	Jun-22		Not yet due		No progress		JUNE 2022: The evaluation undertaken as part of recommendation 2 included a recommendations to source resource from directorates across the organisation and therefore, subject to approval of the recommendations and subsequent actions as agreed this action will be complete.		Current monitoring would suggest that outcomes are being released within the agreed timeframes. Current capacity is being provided via the	end of Qtr 2 / beginning of Q3		#NUM!	#NUM!	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	MDT review panel/learning group	R5	With the Medical Examiners Service shortly taking over the process of providing Stage 1 mortality reviews, the Health Board may want to use the Learning from Experience Group for discussing any feedback that is provided to identify whether there are any issues that could be quickly resolved i.e. missing documentation, illegible notes, missing patient / doctor information. Likewise, the Health Board may want to consider reporting Stage 2	Learning will be fed back to individuals and teams where appropriate. Themes and significant issues will be discussed and shared more generally via the MDT review panel and learning group.	ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	May-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	MDT review panel	R6	Management should ensure that going forward, all relevant staff are made aware of any issues raised by either the Medical Examiners Service or the Multi-Disciplinary Team, with clear and concise feedback provided and reported. A record of all issues that are identified should be recorded so that patterns / trends can be recognised and addressed.	This will be recorded on datix mortality review and shared via the MDT review panel and learning group.	ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	May-22	Apr-22

212211	Machynlleth Hospital Reconfiguuration Project	Reasonable	Director of Environment	Project Director, in liaison with Corporate Governanc e	R3	Future Assurance. Management should ensure that contracts are: • Dated where space is provided within the template; • In place prior to works / duties commencing; and • Executed in accordance with the THB's delegated authority limits. 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. The THB's existing checklist / cover document should be enhanced to	agreed	Ongoing		Not yet due		No progress							#VALUE!	#VALUE!	May-22	Jun-22

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PTHB Ref. No.	Report Title	Director	Respon sible	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority	Status	If closed and not complete, please provide justification	Progress being made to implement				If action is complete,	No. of months past	No. of months past revised	Reporting Date	Date Added to Tracker
													Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementati					
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		Reported intention to establish both stakeholder reference group and healthcare professionals forum at Board 30/03/22. A		Clinical and Stakeholder engagement is undertaken via other means	30-Jun-22		30	13	May-22	
181951	Structured Assessment 2018	Board Secretary		R4	The Health Board's internet pages do not provide access to current policies such as the counter fraud policy. The Health Board should update its internet site to provide easy access to current policies and strategies.	The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	Oct-19	Dec-21	Overdue	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	30-Jun-22		30	4	May-22	
181951	Structured Assessment 2018	Board Secretary		R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21	Overdue	3	Partially complete		Report templates are being reviewed as part of establishment of committees for 2022-23 and the development of a number of reporting	COVID-19 arrangements have taken priority over this work.		30-Jun-22		34	13	May-22	
202152	Structured Assessment 2020	Board Secretary		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	•Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.	Mar-22		Overdue	2	Partially complete		See R2 above	See R2 above	See R2 above	See R2 above		1	1	May-22	
202152	Structured Assessment 2020	Director of Nursing & Midwifery		41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received six formal concerns about commissioned services in quarter one. Work is ongoing to improve effective management of concerns as the Health	•Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Overdue		Partially complete		Paper to Clinical QG Group and EQS next week, shows progress in some areas, and other areas affected by COVID-19. CQFIP up to 2022.	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021.	Implementation overseen by QGG and EQS.			1	1	May-22	
202152	Structured Assessment 2020	Director of Nursing & Midwifery		43	The Health Board has a process for responding to national Patient Safety Alerts and Notices. A review of the system for implementation is underway and will be revised as necessary.	•Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Overdue		Partially complete	Corporate Governance Team leading this work currently ensuring that there is a clear process in place for managing alerts. All outstanding alerts have been actioned with the aim of all being closed by the end of June 22						1	1	May-22	
212252	Structured Assessment 2021	Board Secretary		R1	The Health Board is experiencing a period of significant change within its independent members cohort. Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them. To supplement the national	Review and strengthen the induction arrangements for Independent Members to improve early understanding of corporate business. To include: •Background information on establishment of the health board •Good governance and structure of Committees •Board Assurance Framework	Mar-22		Overdue	2	Partially complete		Work is nearing completion to be in place for the appointment of the new Independent Member (Third Sector) and pilot		nduction meetings with the Board Secretary, Executive Directors and other senior staff cover the items listed in the management response	30-Apr-22		1	1	May-22	
212252	Structured Assessment 2022	Board Secretary		R2	The Health Board does not currently have any associate Board members to assist it in carrying out its functions. Previously the Corporate Director (Children and Adults) from Powys County Council was as associate Board member but has not attended. The Health Board should work with Powys County Council to identify a suitable replacement as soon as possible.	Review and strengthen the induction Interim Board Secretary will engage with Powys County Council's Monitoring Officer to identify a replacement Associate Director.	Mar-22		Overdue	2	Partially complete		Broader assessment of the needs of the Board being undertaken in order to identify where associate members will add the most value.		Regular liaison is undertaken with the County Council and more formally through JPB and RPB.	30-Apr-22		1	1	May-22	

PTHB Ref. No.	Report Title	Director	Respon sible	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority	Status	If closed and not complete, please provide justification	Progress being made to implement				If action is complete,	No. of months past	No. of months past revised	Reporting Date	Date Added to Tracker
													Progress of work	Barriers to	How is the risk	When will					
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT		R1	Implement mandatory counter-fraud training for some or all staff groups.	Implementation of mandatory counter fraud training would be seen as gold standard in terms of assisting to develop a counter fraud culture within the Health Board. There are a range of options from face to face delivery of training to mandatory counter fraud e- learning. Mandatory learning could apply for all or sections of staff at higher risk of fraud that can be explored to supplement the established programme of awareness	Mar-21	Mar-22	Complete		Complete		12/4/21 The Counter Fraud Team now have a presence as part of the Health Board's Mandatory Induction Programme to deliver	Congested mandatory and statutory learning schedule for staff may be barrier to full implementation for all staff. Action put in place	Training has been or will be delivered to staff at higher irks of exposure to fraud.	Formalisatio n of Mandatory training for staff at higher risk of		13	1	May-22	
202152	Structured Assessment 2020	Director of Therapies & Health Sciences		44	The Health Board is undertaking a programme of work to refresh its patient experience framework as part of the improving clinical quality assurance framework.	•Linked to 2019 Structured Assessment actions. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee. June 22 This work is now complete.	Mar-22	Jun-22	Complete	3	Complete	NA	The patient experience group continued to meet during the pandemic and patent experience has been routinely collected	There are no dedicated staff to work on patient experience, it relies on the capacity of operational teams and the Quality Team. We	Complete	Jun-22	Yes	1	1	May-22	22-Jun
212253	Audit of Accounts Report - Charitable Funds and Other Related Charities	Director of Finance, Information and IT		R2	The Charity should ensure there are robust process in place to record and report within the financial statements any assets left to the Charity. The Charity should also ensure that income and expenses in relation to these properties are appropriately disclosed.	Noted – This recommendation will be actioned as and when assets are transferred to the Charity.	Apr-22		Complete		Complete							1	1	May-22	Jun-22
212253	Audit of Accounts Report - Charitable Funds and Other	Director of Finance, Information and IT		R3	The Charity should look to improve the quality of the financial statements presented for audit. A reduction of errors will reduce the auditor and officer time required to audit the financial statements.	It is acknowledged that the reporting and financial requirements of the Charity have increased over recent years, and in response to this the finance department has appointed an additional member of staff whose role is partly to facilitate the Charity accounting and reporting	Apr-22		Complete		Complete							1	1	May-22	Jun-22

PTHB Ref. No.	Report Title	Director	Respon sible	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority	Status	If closed and not complete, please provide justification	Progress being made to implement				If action is complete,	No. of months past	No. of months past revised	Reporting Date	Date Added to Tracker
													Progress of work	Barriers to	How is the risk	When will					
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		Not yet due		Partially complete							#NUM!	#NUM!	May-22	Jun-22

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PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	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?					
212281	Overpayments	Director of Finance, Information and IT		R1	The most common reason for overpayments was down to when a manager or supervisor submits a form when a change or termination takes place. There was a very vast time difference across the cases, ranging from a couple of weeks in advance, to 9 weeks after termination. When an online ESR form is completed it is tasked to an "approver" in the chain of command. If that approver doesn't action it within one week, it automatically escalates to the next in the chain of command and so on. This takes place all the way up to	Mar-22		Overdue		No progress							2	2	May-22	
212281	Overpayments	Director of Finance, Information and IT		R2	The debtors procedure policy states that after 3 months the matter should be referred to a debt collection agency to assist with recovery, however in a number of the cases reviewed, it took longer than 3 months for action to be instigated when the debtor had notified PTHB of an error. For existing employees consideration should be given to revision of the policy to recover overpaid amounts automatically over the same time frame as overpayment initially occurred this is in line with the approach taken in other NHS Wales Health Boards and	Mar-22		Overdue		No progress							2	2	May-22	
212281	Overpayments	Director of Finance, Information and IT		R3	The Counter Fraud Team should be referred cases where there is potential for fraud or theft to have occurred. Previously issued guidance by the CFS Wales Team outlines that case of overpayment of salary where that overpayment has occurred for 3 months or more should be referred to their financial investigators for consideration without contact to the individual. This should be used a referral point to the Counter Fraud Team to allow that onward referral and protect the integrity of potential cases.	Mar-22		Overdue		No progress							2	2	May-22	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

Audit, Risk and Assurance Committee	**Date of Meeting: 18 July 2022**
Subject:	**WELSH HEALTH CIRCULARS**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 29th June 2022

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

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✓

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

EXECUTIVE SUMMARY:

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

An overview of the position as of the 31 May 2022 is as follows:

- For those WHCs received in 2018 there are 47 Complete and 1 Partially Complete
- For those WHCs received in 2019 there are 36 Complete and 2 Partially Complete
- For those WHCs received in 2020 there are 14 Complete and 2 Partially Complete
- For those WHCs received in 2021 there are 20 Complete and 4 Partially Complete
- For those WHCs received in 2022 there are 1 Complete, 1 Partially Complete and 7 Not Yet Due

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

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

DETAILED BACKGROUND AND ASSESSMENT:

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

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

The following table provides an overview of the progress made against the implementation of WHCs received in 2018, 2019, 2020 and 2021 as of 31 March 2022. The table also provides an update on the progress made against WHCs received in 2021, including the position as of 31 May 2022.

	2018	2019	2020	2021	2022
	Position at 31/03/19	Position at 31/03/20	Position at 31/03/21	Position at 31/03/22	Position at 31/05/22
Not Yet Due	0	0	0	0	7
No Progress	0	0	0	0	0
Partially Complete	1	2	2	4	1
Complete	47	36	14	20	1
TOTAL NUMBER ISSUED	**48**	**38**	**16**	**24**	**9**

NEXT STEPS:

The Corporate Governance Team will continue to log and distributable Welsh Health Circulars from Welsh Government to the appropriate Executive Director for action as and when they are received. This process will now also include Ministerial Directions following review of the requirements for the reporting of their implementation in the Annual Report. An updated position will continue to be reported to the Audit, Risk and Assurance Committee on a quarterly basis, the next update report is due to be presented on 15th November 2022.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2018-022	Sharing Patient information between healthcare professionals – a joint statement from the Royal College of Ophthalmologists	03/09/2018	To note that on 20 March 2015 the Royal College of Ophthalmologists and the College of Optometrists issued a joint statement encouraging ophthalmologists to share clinical information with the referring	Medical Director		Partially Complete	**March 2022** For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout 22/23.	022- Sharing Patient Information - Royal College of opthamologists and College of Optometrists.pdf
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery	Medical Director		Partially Complete	**March 2022** See also 2021/028 AMR & HCAI Improvement Goals For 2021-22 for more detialed update 5 year National Action Plan 2019 – 2024 underpinning the UK AMR Strategy 20: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024	019 - HCAI AMR Targets 2019-20 FINAL.pdf
2019-034	National Optimal Pathways for Cancer (2019 tranche 1)	02/10/2019	Executive Board note and discuss the NOPs as part of the implementation of the single cancer pathway. Executive leads for cancer use the NOPs to support the planning, delivery and	Medical Director		Partially Complete	**March 2022** A key renewal priority of PTHB is cancer services. A Renewal Cancer Transformation Programme Board has been established, chaired by the Medical Director. The priorities for the Programme Board have been agreed by PTHB and the Executive Committee as set out in the PTHB Annual Plan. This includes work in	034 - Cancer - Policy - Single Cancer Pathway - English.pdf
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care	Medical Director	Immediate	Partially Complete	There have been meetings with the Welsh Value in Health Centre to help ensure that national dashboards fully reflect the Powys population including services used in England and Wales as there is no district general hospital in County. There will be a further meeting with the PTHB VBHC Programme as the Director of Welsh Value in Health Centre will assist in seeking national solutions between NHS Digital and DCHW	003 - Value Based Health Care Programme - Data Requirements -
2020-014	Ear Wax Management	29/09/2020	Determine and report on current service provision across Wales. Develop a national integrated pathway for the safe and effective management of ear wax to provide consistent patient outcomes across Wales and ensure:	Director of Primary, Community and Mental Health		Partially Complete	Business Case for the model had been approved by Executive Committee. Model wil now be recruited to and implemented. Likely service will not be in place until late in Q4 2021/22. WG have been informed of this progress and position. Paper due into executives during June 2021.	J:\ Corporate_Services\Risk & Assurance\Au
2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be	Director of Primary, Community and Mental Health	30/07/2022	Partially Complete	Led by the PTHB Head of Audiology, in conjunction with School Nursing service with Powys, this has already progressed some key elements. Expectation of quarterly updates prior to full implementation no later than April 2022.17.06.2022 - Discussions ongoing, Head of Audiology leading, SBAR completed by Head of Audiology with Standard	J:\ Corporate_Services\Risk & Assurance\Au
2021-021	Introduction of Shingrix® for Immunocompromised Individuals (From September 2021)	27/08/2021	From 01 September 2021, general practices should offer the non-live shingles vaccine Shingrix® to all those who are eligible for shingles vaccination but are clinically contraindicated to receive the live vaccine	Director of Public Health	15/10/2021	Partially Complete	Circular was sent to primary care by WG. Medicines Management have confirmed that PGD for Shngrix is in place. Awaiting confirmation from PTHB Primary Care that there are no changes required to existing service agreements with primary care.	J:\ Corporate_Services\Risk & Assurance\Au
2021-022	Publication of the Quality and Safety Framework	17/09/2021	Can you please share this Framework, link attached below, with all health and care staff within your organisations and continue to embed the ethos of good quality, safe care above all else.	Director of Nursing and Midwifery		Partially Complete	Met on 27 September 2021 about this and a paper would be presented to the Executive Committee Mid October 2021. Claire Roche (new DoNM) commenced in post 7.3 22. Advised a paper was with Exec colleagues to be completed. CR will liaise with colleagues to understand what further action is required. This framework will be shared via our Learning Group and our Incident	J:\ Corporate_Services\Risk & Assurance\Au
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Partially Complete	**March 2022** Following submission of a development plan for this WHC, an implementation group was formed. Concerns were raised regarding the ability to embed the assessment measure advised within the WHC into primary care at such a busy time operationally and advice was sought from other HBs MSK leads to determine how this was being	J:\ Corporate_Services\Risk & Assurance\Au
2022-007	Recording of Dementia READ codes	15/02/2022	Annex 1 sets out the READ codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their	Director of Primary, Community and Mental Health	30/07/2022	Partially Complete	28.03.22 Circular shared with General Practice. GP already familiar with the READ codes as need to be caputured for QAIF. READ coded dementia registers in place. 30.03.22 The READ codes are included in the Dementia Care Pathway of Standards. The Dementia Lead is working with Improvement Cymru and PTHB	WHC 2022 007 - READ codes
2022-005	Data Requirements for Value Based Health Care	24/03/2022	The basis of the WHC and subsequent processing of information is made in consideration of: Section 1 of the National Health Service (Wales) Act 2006 which places a duty on the	Director of Finance and IT, Medical Director and Director of PCCMH	31/03/2025	Not Yet Due	Action on going to develop PROM and PREM data within the Health Board and to ensure alighed to WHC requirements, also linking in with Value in Health to align to national approach re PROM and PREM. Agreement from VBHC Programme Board on 24.05.2022 to link and track through VBHC Programme Plan.	WHC 2022 005 data requirements for Valu WHC 2022 005 - data requirements for Valu
2022-010	Reimbursable vaccines and eligible cohorts for the 2022/23 NHS seasonal Influenza (flu) Vaccination Programme	29/03/2022	General practices, community pharmacies and health boards/trusts should review influenza vaccine orders in light of this update to attain levels of uptake at least equivalent to those achieved in 2021-22.	Public Health Director	01/03/2023	Not Yet Due		WHC_2022_010 - Reimbursable vaccines and
2022-009	Prioritisation of COVID-19 patient episodes by NHS Wales Clinical Coding Departments	14/04/2022	Due to the need for COVID-19 information to be as real-time as possible all NHS Wales Clinical Coding departments are asked to ensure that processes are put in place as soon as possible to ensure the following:	Director of Performance	28/02/2023	Not Yet Due		WHC 2022 009 - Covid 19 Priority Clinical
2022-014	AMR & HCAI IMPROVEMENT GOALS FOR 2021-23	01/03/2022	Wales remains committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action PlUK AMR Strategy an 2019-24 to combat antimicrobial resistance, through lowering	Director of Nursing and Midwifery	31/03/2023	Not Yet Due		WHC_2022_14 - AMR HCAI Improvement Goals
2022-015	Changes to the vaccine for the HPV Immunisation Programme	25/05/2022	Forthcoming changes to the human papillomavirus (HPV) immunisation programme. The vaccine supplied for the programme will change from Gardasil® to Gardasil®9 during the 2022/23 academic	Medical Director and Director of Nursing & Midwifery	30/06/2022	Not Yet Due		WHC 2022 015 - Changes to the vaccine for
2022-016	The National Influenza Vaccination Programme 2022-23	01/06/2022	Health Boards are asked to take a strategic approach to identify and exploit opportunities for a single programme, including co -administration of Flu and COVID-19 vaccines. This may entail taking key	Public Health Director	31/03/2023	Not Yet Due		WHC2022-016 - The National Influenza Vacc

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2022-011	Patient Testing Framework	24/03/2022	Within this current context, this update to guidance set out in Annex 1 is based on the need to introduce proportionate and effective changes which balance the risks from SARS-CoV-2 against the need to deliver	Director of Nursing and Midwifery	01/06/2022	Complete	New guidance has been developed and launched across the health Board from 1st June. This is in line with new PHW SARS-COV2 Specific guidance	WHC 2022 011 Patient Testing Framework.pd

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2022-23

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in HM Treasury's Audit and Risk Assurance Committee Handbook (March 2016), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board;
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts;
- ensure compliance with key statutory, national and best practice audit and assurance requirements and reporting arrangements.

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	13 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Governance & Assurance:								
Approach to 2022-23 Annual Accounts	DF&IT							✓
Annual Accountability Report 2021-22	BS	✓	✓					
Annual Accounts 2021-22, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Losses and Special Payments Annual Report 2021-22	DF&IT			✓				
Losses and Special Payments Update report	DF&IT						✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS			✓				
WHC Tracking	BS	✓		✓		✓		
Review of Standing Orders	BS	✓						
Update on Risk Management Arrangements	BS					✓		
Internal & Capital Audit:								
Head of Internal Audit Opinion 2021-22	HoIA	✓	✓					
Internal Audit Progress Report 2022-23	HoIA	✓		✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2022-23**						
Internal Audit Plan 2023-24	HoIA							✓
External Audit:								
External Audit Annual Report 2022	EA						✓	
External Audit of Financial Statements 2021-22	EA		✓					
External Audit Plan 2022	EA							✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	13 June	18 July	27 Sept	15 Nov	31 Jan	21 March
External Audit Progress Report 2022-23	EA	✓		✓	✓	✓	✓	✓
External Audit Review Reports	EA	**In line with External Audit Plan 2022-23**						
External Audit Structured Assessment	EA					✓		
Anti-Fraud Culture:								
Bribery Policy	HoLCF			✓				
Counter Fraud Annual Report 2021-22	HoLCF	✓						
Counter Fraud Update	HoLCF			✓			✓	
Counter Fraud Workplan 2023-24	HoLCF							✓
Post Payment Verification Update	PPVO				✓			
Post Payment Verification Workplan 2023-24	PPVO							✓
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2021-22	BS				✓			
Development of Committee Annual Programme of Business	BS	✓						
Review of Committee Programme of Business	BS		✓	✓	✓	✓	✓	✓
Annual Self-assessment of Committee effectiveness 2022-23	BS						✓	
Committee Annual Report 2022-23	BS							✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓
Local Counter Fraud Team				✓			✓	

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	13 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Post Payment Verification Team			✓					

KEY:

BS:	Board Secretary
DF&IT:	Director of Finance and IT
HoIA:	Head of Internal Audit
HoLCF:	Head of Local Counter Fraud
EAO:	External Audit Officer
PPVO:	Post Payment Verification Officer