Audit, Risk & Assurance Committee

Tue 26 April 2022, 10:00 - 12:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_26Apr22_Final.pdf (2 pages)

1.1. Welcome and Apologies

Oral

1.2. Declarations of Interest

Oral *Committee Chair*

1.3. Minutes from the previous meeting held on 22 March 2022 for approval

Attached *Committee Chair*

ARA_Item_1.3_Minutes_22 March 2022_Unconfirmed.pdf (10 pages)

1.4. Matters arising from previous meeting

Oral *Committee Chair*

1.5. Committee Action Log

Attached *Committee Chair*

ARA_Item_1.5_Action Log_26 April 2022_v2.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

Attached *Director of Finance and IT*

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

2.2. Charitable Funds Annual Report and Accounts 2021-22

Attached *Director of Finance and IT*

ARA_Item_2.2_Agenda Item - CF Annual Report and Accounts ARA Apr 22.pdf (3 pages)
ARA_Item_2.2a_Appendix A - PTHB Charity Annual Report and Accounts to 31 March 21 Final Post Audit.pdf (40 pages)
ARA_Item_2.2b_Appendix B -2924A2022_Powys_THB_Charitable_Funds_Audit_Accounts_2020-21.pdf (24 pages)
ARA_Item_2.2c_Appendix C -Powys THB Letter of Representation Charitable Funds 2020-21 - Copy.pdf (3 pages)
ARA_Item_2.2d_Appendix D-2922A2022_Powys_THB_Charitable_Funds_Audit_Plan_2020-21.pdf (10 pages)

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Internal Audit Progress Report 2021-22

Attached *Head of Internal Audit*

ARA_Item_3.1_PTHB_ A&A Progress Report April 2022.pdf (9 pages)

3.2. Internal Audit Reports, 2021-22: a) Budgetary Control Report -Substantial Assurance; b) Machynlleth Report - Reasonable Assurance; and; c) NIS Directive Report – Reasonable Assurance

Attached *Head of Internal Audit/Executive Leads*

ARA_Item_3.2a_Budgetary Control Final Report.pdf (11 pages)
ARA_Item_3.2b_PTHB_2122_Machynlleth_Final Report.pdf (38 pages)
ARA_Item_3.2c_NIS Directive Internal Audit Report.pdf (14 pages)

3.3. External Audit Progress Report 2021-22

Attached *External Audit*

ARA_Item_3.3_External Audit Progress Report 2021-2022.pdf (10 pages)

3.4. Counter Fraud Annual Report 2021-22

Attached *Head of Local Counter Fraud Services*

ARA_Item_3.4_Counter Fraud Annual Report 2021-2022.pdf (3 pages)
ARA_Item_3.4a_Counter Fraud Annual Report Detail 2021-22.pdf (19 pages)

3.5. Audit Recommendation Tracking

Attached *Board Secretary*

ARA_Item_3.5_Audit Recommendations_March22.pdf (11 pages)
ARA_Item_3.5a_Appendix D-Internal Audit Recommendations remain Outstanding v2.pdf (4 pages)
ARA_Item_3.5b_Appendix E- Internal Audit Reccommendations Completed since previous Report v2.pdf (2 pages)
ARA_Item_3.5c_Appendix F - Internal Audit Recommendations NoT Yet Due for Implementation.pdf (1 pages)
ARA_Item_3.5d_Appendix G - External Audit Recommendations that remain outstanding.pdf (1 pages)

3.6. Welsh Health Circular Tracking

Attached *Board Secretary*

ARA_Item_3.6_WHCs March 2022_v2.pdf (3 pages)
ARA_Item_3.6a_Appendix 1 - Current Outstanding WHC's.pdf (2 pages)
ARA_Item_3.6b_Appendix 2 - WHC's Implemented since last Report.pdf (1 pages)

3.7. Draft Committee Work Programme 2022-23

Attached *Board Secretary*

ARA_Item_3.7_Committee Work Programme_2022-23_March 2022 190422.pdf (4 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

There are no items for information

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: 17 May 2022

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 26th APRIL 2022 10.00 – 12.00
VIA MICROSOFT TEAMS

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

AGENDA

Time	Item	Title	Attached /Oral	Presenter
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the Previous Meeting, held 22 March 2022	Attached	Chair
	1.4	Matters Arising from the Previous Meeting, held 22 March 2022	Oral	Chair
	1.5	Committee Action Log	Attached	Chair
	2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	2.1	Application of Single Tender Waiver	Attached	Director of Finance and IT
	2.2	Charitable Funds Annual Report and Accounts 2021-22 ISA260 Funds Held on Trust Audit 2021-22 and Funds Held on Trust Audit Plan	Attached	Director of Finance and IT External Audit
	3	**ITEMS FOR DISCUSSION**		
	3.1	Internal Audit Progress Report 2021-22	Attached	Head of Internal Audit
	3.2	Internal Audit Reports, 2021-22: a) Budgetary Control Report - *Substantial Assurance* b) Machynlleth Report - *Reasonable Assurance* c) NIS Directive Report – *Reasonable Assurance*	Attached	Head of Internal Audit/Executive Leads
	3.3	External Audit Progress Report 2021-22	Attached	External Audit

	3.4	Counter Fraud Annual Report 2021-22	Attached	Head of Local Counter Fraud Services
	3.5	Audit Recommendation Tracking	Attached	Board Secretary
	3.6	Welsh Health Circular Tracking	Attached	Board Secretary
	3.7	Draft Committee Work Programme 2022-23	Attached	Board Secretary
	4	**ITEMS FOR INFORMATION**		
	There are no items for information			
	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: • 17 May 2022 at 01:00pm, Microsoft Teams		

Key:

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

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

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

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact James Quance, Board Secretary, James.Quance2@wales.nhs.uk).

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 22 MARCH 2022 VIA MICROSOFT TEAMS MEETING

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Ian Virgil	Internal Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	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
Alice Rushby	External Audit
Anne Beegan	External Audit
Claire Powell	Powys CHC
Kirsty James	Local Counter Fraud
Matthew Evans	Swansea Bay Counter Fraud
Amanda Legge	NHS Wales Shared Services (Item 3.3 only)
Sue Tilman	NHS Wales Shared Services (Item 3.3 only)

Observers:

Vivienne Harpwood	PTHB Chair (Part-meeting only)
Kirsty Williams	PTHB Vice Chair

Committee Support

Stella Parry	Interim Corporate Governance Manager

Apologies

Matthew Dorrance	Independent Member – Local Authority

ARA-21-109	**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-21-110	**DECLARATIONS OF INTERESTS** The Committee Chair INVITED Members to declare any interests in relation to the items on the Committee agenda. None were declared.
ARA-21-111	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 20 January 2022 were RECEIVED and AGREED as being a true and accurate record.
ARA-21-112	**MATTERS ARISING FROM PREVIOUS MEETINGS** The following matter arising was discussed: ARA-21-100: The Director of Finance and IT reported that the audit of the Charitable Funds Accounts 2021-22, which had been delayed due to a technical issue, had now been completed. The final accounts and audit report will be brought to the appropriate future committee meeting and the Board.
ARA-21-113	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA-21-95: It was confirmed that this action was included on the meeting agenda under item 2.1. This action was recorded as complete.
ARA-21-114	**APPLICATION FOR SINGLE TENDER WAIVERS (STWs)** The Head of Financial Services presented the previously circulated report and sought the Committee's ratification of STW requests made between 1 January 2022 and 28 February 2022. Four STW requests were considered by the Committee, summarised within the table below:

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
POW-2122-014	Tender	Powys County Council	Gritting Services	Continuation of Arrangements-Value for Money	26-01-2022	£46,000	4 months	Partly Retrospective	A1
POW-2122-017	Tender	Red Cortex	Consultancy	Urgent Interim Arrangement pending Procurement	26-01-2022	£33,260	3 Weeks	Prospective	A2
POW-2122-015	Quote	Sail Databank	Access to research data system	Sole Supplier	23-02-2022	£18,700	3 years	Prospective	A3
POW2122019	Tender	Parkway Clinic	Dental Surgical Interventions for Children and Young Adults	No NHS Provision available and clinical need	23-02-2022	£80,000	2 years	Prospective	A4

The Director of Finance and IT reported that additional information in relation to STW trends over the last 4-5 years had been included within the papers, as requested by Committee Members on 20 January 2022. It was noted that an official benchmark against other Welsh health boards had not been available. However, in anecdotal comparison to other health boards, Powys has reported low numbers of STWs. Committee Members welcomed the analysis, and it was AGREED that STW trend analysis would be brought forward to the Committee on an annual basis. **Action: Director of Finance and IT.**

The Committee RATIFIED the approval of the STWs as detailed within the report.

ARA-21-115

APPROACH TO 2021-22 ANNUAL ACCOUNTS

The Director of Finance and IT presented the Committee with an outline of the approach and principles to be adopted for completion of the 2021-22 Annual Accounts together with the planned approach to key financial areas. The approach was based upon Technical Advisory Group (TAG)

advice and built upon the approach implemented by the Health Board in 2020-21. The Director of Finance and IT highlighted two aspects of the report for the Committee's attention:

- In December 2019, Welsh Government confirmed that clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year (2019-20) faced a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold would be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31st July 2021). The NHS employer would then make a contractually binding commitment to pay them a corresponding amount on retirement. It was noted that Welsh Government was working with the NHS Pensions Agency to identify the estimated costs for each health body and there may be a requirement for each health body to disclose a provision in the 2021-22 accounts, together with identification of the number of staff who have taken up this option. In the event that a provision is required there will be no impact to the reported position of the health board as Welsh Government have advised that the provision will be offset within the financial statements by a debtor to Welsh Government similar to the process for the Welsh Risk Pool. Of concern, however, is the view of the Auditor General for Wales that any provision included within health board accounts for the cost of Scheme Pays will constitute irregular expenditure and lead to a qualification of the health board's accounts, with the qualification being in respect of the regularity opinion.
- Since the reorganisation of health authorities into health boards in 2003, Powys has accounted for the early retirement-permanent injury provision in respect of former members of staff. This provision although material within the accounts is fully funded by Welsh Government and therefore any financial impact on movement of this provision year on year is reimbursed to the Health Board via an allocation by Welsh Government and as such has no impact on the reported position of the Health Board. The Health Board has proposed to discharge the early retirement provision via a one-off payment during the year and, should this option be exercised, it will eliminate the provision from within the Health Board's Financial Statements with the exception of one remaining case that retired due to permanent injury as this category of retirement cannot be discharged via a one-off payment.

Had the Auditor General for England confirmed a position in relation to Scheme Pays?

It was reported that England had deemed the inclusion of Scheme Pays as not material. However, the Auditor General Wales has the authority to take a separate decision which would need to be adhered to by health

	boards. The Committee noted that the issue would affect the Annual Accounts of all Welsh health boards should any provision be included. *There was no mention of General Practice (GP) trainees within the approach; how were the trainees present in Powys resolved within the accounts?* The Head of Financial Services reported that placement contracts were held by Health Education and Improvement Wales (HEIW), who then place trainees into health boards and trusts. HEIW as Single Lead Employer are responsible for informing each health board what they are accountable for in each financial year. It was noted that Powys was yet to receive a request from HEIW. The Chief Executive highlighted that the previous two years had been highly unusual and assured the Committee that the lack of inclusion in the accounts did not reflect the enthusiasm of practices within Powys to accept trainee placements. It was noted that there was ambition to place an increasing number of trainees within Powys in the next few years. External Audit welcomed the report and recognised the improvements made to the approach since 2020-21. The Committee NOTED and APPROVED the approach to the 2021-22 Annual Accounts.
ARA-21-116	**COUNTER FRAUD WORKPLAN 2022-23** The Head of Counter Fraud presented the Counter Fraud Work Plan 2022-23 which had been developed in accordance with the new Counter Fraud Standards adopted by Welsh Government. It was noted that full compliance in with the standards was required by 2023-24 and the 2022-23 workplan sought to develop readiness for full implementation of the standards. An updated position against the 2021-22 plan was also provided. The Committee noted that assurance standards had been met for the year and stood Powys in a good strategic position into 2022-23. *Were there any associated risks with the use of photographic evidence for fixed asset audits?* The Head of Financial Services reported that due to safety precautions in hospital settings as a result of the pandemic the audit team had been unable to check fixed assets in person, therefore photo evidence was introduced. The Committee was assured that the photographic evidence provided both a time stamp and a geotag (which provided the geographic location of the asset at the time of the photograph). This approach had been successful in maintaining fixed asset auditing and had been utilised across Wales and the UK throughout the pandemic. *Had the impact of the pandemic over the previous two years generated any additional opportunities for fraud to take place?* The Head of Counter Fraud reported that adjustments in strategy and investigation had been made during the pandemic. Counter Fraud had implemented mitigations to discourage the occurrence of fraud. A key

	area of focus remained procurement and the Committee was assured that procedures in Wales had been robustly managed throughout the pandemic. It was noted that an additional area of concern was the potential for low level fraud in relation to home working, it was reported that proactive steps were due to be introduced in relation to this area of concern. The Committee welcomed and RATIFIED the Counter Fraud Work Plan 2022-23.
ARA-21-117	**INTERNAL AUDIT PLAN 2022-23** The Head of Internal Audit presented the item which provided a detailed overview of the work to be undertaken in the forthcoming year, the corresponding internal audit resources required to deliver the plan and the Internal Audit Charter. It was noted that the plan had been developed to comply with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the key annual objectives. The following key components were highlighted to the Committee: • consideration of key governance and risk areas; • organisation based audit work; • follow-up; • work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs; • the impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC; and • where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. It was reported that, in addition to the above, the Head of Internal Audit had met with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. The draft Plan had also been considered by the Health Board's Executive Committee to ensure Internal Audit focus was best targeted to areas of risk. Under the approach adopted in previous years, the top slice provided to Internal Audit to undertake the internal audit programme was supplemented by an additional charge for work over and above the top slice. To this end the Health Board would need to pay an additional £57,614 (£55,223 in 21-22) to cover this additional audit work. Under the approach adopted since the formation of NWSSP, Internal Audit charge for the specialist Capital and Estates work delivered as a part of the agreed plan. For 2022-23, this additional charge is £21,400 (£26,821 in 21-22). Therefore, the Health Board will be charged an additional amount

	of £79,014 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2022-23. The Committee APPROVED the Internal Audit Plan for 2022-23, the Internal Audit Charter and NOTED the associated Internal Audit Resource requirements and Key Performance Indicators (KPIs).
ARA-21-118	**AUDIT RECOMMENDATION TRACKING** The Interim Board Secretary presented the item which provided an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services. The Head of Internal Audit highlighted to the Committee that a review of the Audit Recommendation Tracker and the accuracy in relation to key actions and risks was due to be undertaken in the coming weeks as part of the Internal Audit Plan. The resulting report would be brought forward to a forthcoming meeting of the Committee. The Committee DISCUSSED and NOTED the position in relation to the implementation of audit recommendations.
ARA-21-119	**ANNUAL GOVERNANCE PROGRAMME REPORTING** The Interim Board Secretary presented the item which provided an update against the previously agreed priorities as of 31 December 2021. It was noted that progression against several items had lost momentum as a result of the pandemic and it was noted that this issue had been apparent across Welsh health boards. The programme would be refreshed in 2022-23 and it was reported that the implementation of the Board Assurance Framework remained a key priority; the Committee was assured that this was under development. The Committee RECEIVED and NOTED the Annual Governance Programme Report.
ARA-21-120	**POST PAYMENT VERIFICATION (PPV) UPDATE AND WORKPLAN 2022-23** Amanda Legge and Sue Tilman (NWSSP) joined the Committee and presented the item. An update was provided in relation to performance over the current, and two previous PPV cycles as well as overall performance against national benchmarking. It was noted that PPV provided assurance in all contractor disciplines, except for General Dental Services. The Committee RECEIVED and NOTED the Report.
ARA-21-121	**INTERNAL AUDIT PROGRESS REPORT 2021-22** The Head of Internal Audit presented the item which provided an overview of the progress to date against the 2021-22 Internal Audit Plan. It was noted that three audits had been finalised since January; 10 audits had been completed to date; one was in draft; five were ongoing and

	three were in the planning stage. At the meeting of the Committee on 20 January 2022 it was agreed that four audits would be removed from the 2021-22 plan. 19 audits remained in 2021-22 which provided sufficient coverage to produce the Head of Internal Audit Opinion 2021-22. It was confirmed that the four audits removed would be taken forward into the 2022-23 Internal Audit Plan. The Committee DISCUSSED and NOTED the Progress Report.
ARA-21-122	**INTERNAL AUDIT REPORTS:** **a) Waste Management (Reasonable Assurance)** Melanie Goodman (Internal Audit) presented the report which provided an assessment of compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets. The audit had undertaken a review of Brecon, Bronllys and Llandrindod Wells sites. A Reasonable Assurance rating had been achieved and it was noted that no high priority recommendations had been required. **b) Job Matching and Evaluation Process (Reasonable Assurance)** Jayne Gibbon (Internal Audit) presented the report which focused on the Job Matching and Evaluation process and sought assurance that systems and processes were managed appropriately. Three findings were reporting in relation to updating the policy to reference the recommended number of members for job evaluation panels and the make-up of the panel members. *Vivienne Harpwood left the meeting.* **c) Mortality Reviews (Reasonable Assurance)** The Head of Internal Audit presented the report which sought to establish the arrangements and preparedness within the Health Board for the introduction of the Medical Examiners Service. The review also provided an evaluation of the current systems and controls in place within the Health Board for the completion of mortality reviews. A Reasonable Assurance classification had been achieved and it was noted that no high priority recommendations had been required. The Committee RECEIVED and NOTED the Internal Audit reports.
ARA-21-123	**EXTERNAL AUDIT PROGRESS REPORT 2021-22** Anne Beegan (External Audit) presented the Report and noted that there were two financial audits underway; the audit of the 2021-22 Annual Accounts was at the planning stage and the draft Charitable Funds Accounts 2021-22 audit report was with the Heald Board's finance department for review.

	There was also an audit of the Health Board's Renewal programme which had completed field work and was due to be considered by the Health Board's Chief Executive prior to reporting to the next Committee. Four audits in relation to the system of unscheduled care were due to be completed by April 2022. The Committee NOTED that the forward workplan for the Audit General Wales was included within the report which was out for consultation at the time of the meeting. The Committee DISCUSSED and NOTED the External Audit Progress Report.
ARA-21-124	**EXTERNAL AUDIT ANNUAL PLAN 2022** Anne Beegan (External Audit) presented the item and highlighted the following audit of financial statement risks: • Management Override • Scheme Pays • Any errors in the Renumeration Report 2021-22 • COVID-19 pressures • Financial duty to break even over a three-year period • IFRS 16 The Committee NOTED that since the submission of the report changes had been made to Audit Management for the financial audits. Gareth Lucy had been appointed as Audit Manager and introductions had been held with the Director of Finance and IT. Gareth Lucy would attend the next meeting of the Committee. The Director of Finance and IT confirmed his support for plan and noted that the finance and audit teams had been and would remain in continuous liaison. Anne Beegan provided the Committee with the following overview of planned performance audit work in 2022: • NHS Structured Assessment • All-Wales Thematic work • Locally focus work • Implementing previous audit recommendations The Committee DISCUSSED and NOTED the External Audit Plan 2022.
ARA-21-125	**WELSH HEALTH SPECIALISTED SERVICES COMMITTEE (WHSSC) AUDIT TRACKER** The Interim Board Secretary presented the item to the Committee for information. It was NOTED that a further update was anticipated, and that good progress had been made against elements reported to the Audit, Risk and Assurance Committee and Patient Experience, Quality and Safety Committee. The Committee RECEIVED and NOTED the Report.

ARA-21-126	**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-21-127	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA-21-128	**DATE OF NEXT MEETING** 26 April 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
(April 2022)

Minute	Date	Action	Responsible	Progress	Status
ARA-21-114	22 March 2022	An overview of Single Tender Waiver (STW) activity including trend analysis by month and year would be brought forward to the Committee on an Annual Basis.	Director of Finance & IT		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 26th April 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 March 2022 and 31 March 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 March 2022 and 31 March 2022 and consider additional information provided regarding the individual single tender documents.

Ratification	**Discussion**	**Information**
✓		

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its March 2022 meeting which covered the period from 1 January 2022 and 28 February 2022.

A summary of the use of Single Tender Action from 1 March 2022 and 31 March 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
POW2122018	TENDER	Adcuris Consulting	Demand Capacity and Financial Modelling In Support of service change for Strategic Outline Case	Continuation of work linked to previous undertaking and timescale	09/03/2022	£70,000	1 month	Prospective	A1

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

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

NEXT STEPS:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

AUDIT RISK AND ASSURANCE MEETING	**Date of Meeting:26 APR 2022**
Subject :	**CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS FOR YEAR ENDED 31st MARCH 2021**
Approved and Presented by:	Director of Finance
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	Charitable Funds Committee Audit Risk and Assurance Committee

PURPOSE:

The purpose of this paper is to provide the Charitable Funds Annual Report and Accounts for the period to 31 March 2021 for information.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to REVIEW the Charitable Funds Annual Report and Accounts for the period to 31 March 2021 and recommend that the Charitable Funds Committee requests Board approval as Corporate Trustee.

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 Powys Teaching Health Board (PTHB) as Corporate Trustee must provide to the Charity Commission an Annual Report and Accounts for the year ended 31st March 2021 for the Powys Teaching Local Health Board Charitable Fund that has been subject to Statutory Audit by External Audit and approved by the PTHB Board. The deadline for this submission was 31st January 2022 but due to additional testing and an historic issue with complex accounting adjustments to be dealt with this deadline has not been met. The Charity Commission have been informed by the THB of the reason for the delay in the submission.

DETAILED BACKGROUND AND ASSESSMENT:

The Charitable Funds Annual Report and Accounts has been compiled and is attached at **Appendix A** for the Board's consideration.

The Charity has exceeded the Charity Commission thresholds for statutory audit for the financial year to 31st March 2021 therefore a full statutory Audit has been undertaken by Audit Wales.

The 2020-21 ISA 260 report is attached at **Appendix B** for information.

As outlined within the ISA 260 report a number of issues have been worked through by the THB with the Audit Team which has led to a delay in the conclusion of the audit work. A number of recommendations have been raised in this respect and THB management responses provided to highlight the work already undertaken and ongoing to address the issues raised.

The Annual Report and Accounts are attached and will be considered by the Charitable Funds Committee at a meeting on 26th April 2022 and it is intended that a recommendation is made from the Charitable Funds Committee to the Board to approve the Annual Reports and Accounts as Corporate Trustee at its 28th April 2022 meeting.

The Annual Report and Accounts have to be signed by the Board Chair and Chief Executive, prior to the signing of the Auditor General for Wales at a date to be confirmed in May 2022.

As part of the signing process a Letter of Representation must be provided to the auditors at the time of signing. This has been drafted and is attached at **Appendix C**.

Once all parties have signed, the submission to the Charity Commission will be undertaken.

Also included within the papers is the Audit Wales Audit Plan which is provided for information at **Appendix D**.

NEXT STEPS:

- The Annual Report and Accounts will be considered by the Charitable Funds Committee on 26th April 2022
- The Annual Report and Accounts will be considered for approval by the Board as Corporate Trustee on 28th April 2022.
- The Audit Opinion will be signed by the Auditor General for Wales during May 2022 prior to submission the Charity Commission.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Local Health Board Charitable Fund

Annual Report and Accounts for the Year Ended 31st March 2021

Contents

Trustee Arrangements

Powys Teaching Local Health Board Charitable Fund (the Charity) is registered with the Charity Commission; Powys Teaching Local Health Board (Powys THB) is designated as Corporate Trustee.

The members of Powys THB who served during the financial year to 31st March 2021 were as follows:

Powys Teaching Local Health Board Board Members 2020/21			
	Chair	Vivienne Harpwood	
	Vice Chair	Mel Davies	
	Chief Executive	Carol Shillabeer	
Independent Members		**Officer Members**	
Third Sector	Trish Buchan	Executive Director of Finance & IT	Pete Hopgood
Trade Union	Susan Newport	Executive Director of Workforce & OD	Julie Rowles
University	Frances Gerrard	Executive Medical Director	Paul Buss
Finance	Anthony Thomas	Executive Director of Nursing	Alison Davies
Capital /Estates	Mark Taylor	Executive Director of Planning & Performance	Hayley Thomas
Local Authority	Matthew Dorrance	Executive Director of Therapies & Health Sciences	Claire Madsen
ICT	Ian Phillips	Executive Director of Primary, Community Care and Mental Health	Jamie Marchant

Community -	Owen James (to 4th September) (Vacant to present)	Executive Director of Public Health	Stuart Bourne
Legal	Vacant	Board Secretary	Rani Mallison

In order to assist the Corporate Trustee to fulfil its statutory duties under this registration, a Charitable Fund's Committee has been established with delegated powers to manage the Charity.

Charitable Funds Committee Membership

Current

Vivienne Harpwood	-	Interim Chairperson (from September 5th 2020)
Owen James	-	Chairperson (to September 4th 2020)
Mark Taylor	-	Independent Member
Trish Buchan	-	Independent Member
Tony Thomas	-	Independent Member
Pete Hopgood	-	Executive Director of Finance & IT
Alison Davies	-	Executive Director of Nursing

Registered Office

The registered office of the Charity is Bronllys Hospital, Bronllys, Brecon, Powys, LD3 0LY.

Registration Number

The Charity is registered with the Charity Commission – Registered Number 1057902.

Bankers

Barclays Bank
57 Frogmore Street
Abergavenny
Gwent
NP7 5AT

Internal Auditors

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

Investment Advisors

Brewin Dolphin Ltd
12 Smithfield Street
London
EC1A 9BD

External Auditors

Auditor General for Wales
Audit Wales
24 Cathedral Road
Cardiff
CF11 9LJ

Foreword

The Charity was formally created on 28th May 2004 by a 'Deed of Arrangement' which replaced the Powys Health Care NHS Trust Charitable Fund, which had been in existence since 26th July 1996.

These accounts have been prepared in line with Financial Reporting Standard 102 (FRS 102).

The Charity's annual report and accounts for the year ending 31st March 2021 have been prepared by the Corporate Trustee in accordance with Part VI of the Charities Act 2011 and the Charities (Accounts and Reports) Regulations 2005 (Statement of Recommended Practice (SORP) 2015). The Charity's report and accounts include all the separately established charitable funds for which the Local Health Board is responsible.

Administrative Details

The Charity has an umbrella registration with the Charity Commission under which funds are registered together under a single 'main' registration number. There are a total of 77 individual funds maintained within the accounting records as at the 31 March 2021, and the notes to the accounts distinguish the types of funds and disclose separately all material funds.

Charitable monies donated to the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

Trustee

Powys THB is the Corporate Trustee of the Charitable Fund governed by the law applicable to Local Health Boards, principally the Trustee Act 2000 and also the law applicable to Charities, which is governed by the Charities Act 2011.

The chair and independent members of the Board are appointed by the Welsh Government and the executive directors are appointed by the Board.

The Corporate Trustee devolves responsibility for the on-going management of the charity to the Charitable Funds Committee which administers the fund on behalf of the Corporate Trustee. Details of the Corporate Trustee and its Charitable Funds Committee are disclosed on pages 2 to 4.

Principal Charitable Fund Advisor to the Board

Under a scheme of delegated authority approved by the Corporate Trustee, the Executive Director of Finance of Powys THB has responsibility for the management of the Charity, and the Head of Financial Services is the principal officer overseeing the day-to-day financial management and accounting for the charitable fund and its specific charitable accounts during the year.

Professional Advisors

The principal professional advisors to the Corporate Trustee are detailed on page 4.

Structure Governance and Management

The Charity's unrestricted fund was established using the model declaration of trust. All funds held on trust as at the date of registration were either part of this unrestricted fund or registered as separate restricted funds under the main Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. Where funds have been received which have unique specific restrictions set by the donor, new unrestricted (designated) funds have been established.

The current structure of the individual funds reflects the fact that the majority of income and expenditure is focused where patients receive services. Operational managers exercise control over the funds donated to their management area. The charitable funds available for spending are allocated to service areas within Powys THB's management structure. There are, for example, specific allocations made for individual wards and for specific service areas such as Palliative Care and Brecon Cardiac Services.

Members of the Powys THB and its Charitable Funds Committee are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

- control, manage and monitor the use of the fund's resources for the public benefit having regard to guidance issued by the Charity Commission,
- provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income,
- ensure that 'best practice' is followed in the conduct of all its affairs fulfilling all of its legal responsibilities,
- ensure that the approved Investment Policy incorporated within the Charitable Funds Policy approved by the Teaching Local Health Board as Corporate Trustee is adhered to and that performance is regularly reviewed whilst being aware of ethical considerations,
- keep the Corporate Trustee fully informed on the activity, performance and risks of the Charity.

Powys THB is the main beneficiary of the charity and is a related party by virtue of being the Charity's Corporate Trustee. By working in partnership with Powys THB, the charitable funds are used to best effect and so when deciding upon the most beneficial way to use charitable funds, the Corporate Trustee has regard to its main activities, objectives, strategies and plans. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund that has been designated to respect the specific wishes of each donor.

The accounting records and the day-to-day administration of the fund is dealt with by the Finance Department located at Bronllys Hospital, Brecon, Powys, LD3 0LS.

A message from our Chair

You may or may not already be familiar with our Charity but PTHB Charity is the registered charity for the whole of the Powys Teaching Local Health Board and we look after all donations that are made to PTHB staff, services, and hospitals. We work with health board staff to use those donations directly, or distribute them through our different funding streams. It is our goal to support innovative staff and patient projects for the benefit of the health and wellbeing of Powys.

The Health Board and Charity have had a remarkable and perhaps the most challenging of years in 2020. Our heroic NHS staff have been at the heart of the nation's response to the pandemic. It goes without saying that we are incredibly proud of the way that staff and volunteers across Powys have dealt with adversity and risen to the occasion. We made it our goal to provide as much support for them as possible through the Charity. This year saw us introduce the very first full-time member of staff for the Charity, our Charity Manager, who started in April 2020 to help us do just that.

In 2020-21 we were able to fund 94 new projects and commit a total of over three hundred and fifty thousand pounds. An amazing total that would not have been possible without the support and dedication of our health board colleagues to bring those projects to fruition as well as an impactful national fundraising campaign by NHS Charities Together and galvanised local fundraisers. The outpouring of generosity and gratitude from our communities has allowed the Charity to deliver a more effective and impactful response to support both staff and patients during the pandemic.

I am pleased to now have this opportunity to pause, reflect and celebrate everything we have been able to achieve together. Thank you to everyone that has helped to make those achievements possible.

Vivienne Harpwood,

Chair of Powys Teaching Local Health Board and PTHB Charitable Funds Committee

Our objectives

The Charity's main fund has NHS wide objectives as follows:

"The Trustee shall hold the Trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service, wholly or mainly for the services provided by Powys Teaching Local Health Board (hereinafter referred to as "the objects")"

This means that the fund can be used for the benefit of patients and staff who receive or help deliver the services provided by Powys THB in accordance with the Deed of Trust.

The Charity is funded by donations and/or legacies received from patients, relatives and friends, the general public and other external organisations. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund. The trustee respects the wishes of our donors to benefit patient care and advance good health and welfare of patients and staff and ensuring that all expenditure fulfils public benefit criteria. The practice of the Charity is to provide support to the Powys THB by the following means: -

Patients' Expenditure:	by purchase of small equipment, and the provision of services and facilities not normally provided by or additional to the normal NHS provision.
Staff Expenditure:	by supporting staff to provide more effective services to patients, through (for example) additional education and training opportunities; and facilitating and promoting research.
Medical Equipment:	by purchase of equipment in addition to that normally provided by the NHS.

When there are changes in the delivery of a service, or when for some other reason it becomes impractical to maintain a separate fund, the Corporate Trustee has ultimate discretion, in accordance with Section 96 of the NHS Act 1977, to apply the charitable funds. Its objective, however, is to continue to respect the donor's wishes.

Building new local objectives

Establishing a new framework for the progression and development of the Charity across 2020-21 was a key objective for Powys Teaching Health Board. Until 2020, the Charity had operated with no dedicated full-time members of staff. There was, therefore, capacity to expand its scope and reach with the introduction of a full-time Charity Manager in April 2020 employed by the Health Board.

The objectives outlined below have been set out in-line with the strategic objectives of the Powys Teaching Health Board's Integrated Medium Term Plan and its core values.

The strategic objectives aim to:

- Provide clarity on the Charity's purpose and remit for PTHB staff and members of the public.
- Outline key areas for development.
- Establish a pathway for progression.

- Demonstrate the synergies between the objectives of the Charity and those of the PTHB as set out by the Integrated Medium-Term Plan (IMTP).

Placing the Charity in context

Until April 2020, the Charity was operating with no full-time members of staff and under the guidance of supporting health board staff and the commitment of the Independent Members that form the Charitable Funds Committee. As such, the scope of the Charity and its objectives were limited by its resources.

The appointment of a full-time Charity Manager in April 2020 afforded the opportunity to review and expand upon the existing objectives in line with the strategic aims of the Charitable Funds Committee and the Powys Teaching Health Board.

The single most influential factor on these strategic objectives has been the disruption and impact of the COVID-19 pandemic in 2020. Naturally, the pandemic greatly impacted operations and restricted engagement with stakeholders but it also emerged as a major priority for the Charity to address through the distribution of its funds.

Where possible, the Charity looks to take a lead from the most influential and impactful third sector organisations from across the UK, particularly those in the field of healthcare and medical support. More locally, the Charity will also look to the other health board charities in Wales for a steer on relevant issues and to coordinate campaigns and communications for the widest possible impact.

Maintaining a strong relationship and open dialogue with the aforementioned organisations can ensure the Charity is as knowledgeable, responsive and effective as possible within its field.

Key objectives

The following objectives have been chosen in order to outline a clear and consistent identity for the Charity, build a profile and increase its impact through greater engagement, and ensure it remains sustainable.

1) Ensure strategy, planning and governance are efficient and effective.

    a) Review all Charity governance and bidding arrangements to implement operational efficiencies.
    b) Establish clear Charity guidelines and policy for PTHB staff and independent members.
    c) Develop a new Stakeholder Engagement Strategy and Operational Framework for the Charity.
    d) Scale and adapt the Charity whilst ensuring its long-term viability and sustainability.

2) Develop a timely and effective charitable response to health and wellbeing issues across Powys, such as the COVID-19 pandemic.

a) Proactively engage with staff and patients to facilitate new charitable funding proposals.
b) Collaborate with third sector partners on fundraising and awareness raising campaigns.
c) Implement a new support programme for staff, volunteers and patients who are impacted by COVID-19.
d) Generate relevant engagement opportunities to allow the public to connect with the Charity.

3) Create and implement an engaging communication strategy.

a) Create a new brand identity for the Charity with input from key stakeholders (PTHB staff, third sector partners, service users, beneficiaries and local residents).
b) Establish a public fundraising presence and generate new fundraising opportunities for the Charity.
c) Produce effective and engaging campaigns to widen the Charity's reach and engage new audiences.

4) Develop and coordinate a comprehensive stakeholder network.

a) Build on existing regional partnerships in order to further the Charity's strategic objectives.
b) Form new partnerships with key stakeholders which support the implementation of the Charity's strategic objectives.
c) Manage the Charity's engagement network (staff, volunteers and public).

Delivery and monitoring

Delivery of these objectives is overseen and monitored by the Corporate Trustee as a key programme of work to support the Charitable Funds Committee and Health Board in achieving both wellbeing and charitable objectives.

Our year in review

Fundraising

2020/21 saw a large uptake of interest in supporting and donating to Powys Teaching Health Board and PTHB Charity. With COVID-19 impacting the NHS and particularly, frontline staff, there were thousands of fundraisers established to support various NHS Charities across the UK. The largest and most successful of these was established by the membership body, NHS Charities Together. Their COVID-19 fundraiser raised over £150 million, which is being distributed between over 200 NHS Charities across the UK. This was supported by Captain Sir Tom Moore, who raised £32.8m for NHS Charities Together by walking 100 laps of his garden before his 100th birthday – breaking the Guinness World Record for an individual's charity walk and inspiring the nation.

In April 2020, PTHB Charity became a member of NHS Charities Together. Since becoming a member, the Charity has received a total of £151,600 in COVID response funding. This grant funding has since been distributed amongst staff and patients as part of the first phase of response funding across the year.

In addition to the above, the PTHB Charity has plans to apply for a further £50-100,000 from NHS Charities Together to develop a programme to support community partnerships and aiding community recovery from COVID-19 across Powys. The fund has a strong focus on collaboration between multiple partner organisations and the PTHB Charity is exploring this opportunity through the Powys Regional Partnership Board for a programme which will begin in 2022, spanning a two-year period.

In the same timeframe, the Charity has also been part of an all-Wales NHS Fundraisers organised by the Swansea Bay Health Board Charity, which has raised over £195,000 to be distributed evenly between 9 NHS Charities in Wales. The PTHB Charity has received £24,662 of funding from this campaign.

PTHB staff members and the local community have also established several smaller Just Giving fundraisers, with walking and cycling challenges, knitting projects and even a skydive. Perhaps the most successful of these being Brecon RFC's shearing and 'name the ewe' competition which raised a combined £16,000 for PTHB Charity and local ambulance stations in May and June 2020.

In addition, there have been well-over 200 donations and contributions made to staff at various hospital sites from local and national business, organisations and community members. These donations have ranged from food and supplies to training, staff discounts and other amenities. In order to better manage and track these donations, a new organisational gifts register has been created.

Communications & Engagement

Developing the Charity's communication channels (both internal and external) was essential to establishing a foundation of support from staff members and the local community.

The PTHB Charity now has the following new online accounts which have grown significantly:

- A new Twitter handle to engage with the public and staff launched on the May 2020 (@PTHBCharity).

- A Facebook page (facebook.com/PTHBCharity) launched in October 2020.

- A Just Giving page (https://www.justgiving.com/PTHBcharity) to process online donations and allow community members to establish digital fundraisers with over 19 different fundraisers created during the year.

- A Work for Good profile (https://workforgood.co.uk/about/charities/view/powys-teaching-health-

board-charity/) which will allow business and organisations to engage with and donate to the Charity.

- An updated bilingual presence on the new Powys Teaching Health Board website (https://pthb.nhs.wales/about-us/our-charity/)

The Charity's social media channels have had over 70,000 impressions since their creation with an average engagement rate of 2.6% and a total of almost 250 active followers across all channels.

With expanded capacity, the Charity also has plans to boost engagement through a monthly newsletter for staff and the public. In addition to this, the Charity is preparing to launch its own website within the next 12-18 months.

COVID response fund

A new *COVID Response Fund* funding stream was launched for staff on the 26th May in order to utilise the NHS Charities Together funding from their hugely successful COVID appeal. The response fund was established in order for staff to be able to quickly access funding for urgent requirements, and to address the impact of COVID-19 on services, staff and patients.

The Charity sought the input of NHS and frontline staff across Powys on how the funds could be best used. This has led to over 50 different projects being implemented to date. These range from new staff wellbeing facilities at each of Powys' community hospital sites to an online leadership support programme for nursing staff. Other projects included using technology to help isolated patients contact their loved ones throughout lockdown and outdoor renovations to create new wellbeing gardens for patients and staff.

The response to a staff evaluation of the fund has been overwhelmingly positive, with the majority of applicants finding the process highly accessible. Applicants praised the ease of the process (all respondents found it either very accessible or accessible) and the good level of communication between themselves and grant administrators. The majority of applicants were applying for Charitable Funds for the first time and stated they would be more likely to apply again after their experience with the fund. This is important as many applicants stated that they were unsure of the existing processes and mechanisms to apply for funding.

Overall, the elements of the grant scheme that were criticised included delays on decision making and the difficulty in procuring items. Respondents stated they would be keen to see future grant schemes retain the same level of communication, indicate timescales for the procurement process and focus on specific themes for a set period of time. This feedback has helped the Charity to develop new guidelines for applicants and has helped to inform the progression of new and existing funds.

The renewed interest in Charitable Funds through the scheme has also led to the submission of additional proposals for the General Fund and development meetings to discuss future proposals. The scheme has also served as a good pilot for future charity funding initiatives and its evaluation will help to inform the Charity's ongoing Stakeholder Engagement Strategy.

All Wales NHS charities collaboration

The impact of COVID-19 has seen an increase in public interest and support for NHS Charities, which has led to new opportunities for collaboration in Wales. Led by the Swansea Bay Health Charity, Welsh NHS Charities have established an all Wales fundraising campaign to support with COVID-19. The campaign has been an excellent opportunity for PTHB Charity to establish a working relationship with the other Health Board charities in Wales, particularly those in Cardiff, Swansea and North Wales who have all developed new brands in the past 2-3 years.

Following the success of the campaign and the increasing pressure on NHS Charities, an all Wales NHS Charities Group has been formed. The Group will enable greater collaboration and communication between Health Board Charities and the ability to campaign at a national level. The inaugural meeting was on the 9th September 2020 and the Group continues to meet on a quarterly basis.

Additional governance measures

An internal audit into the effectiveness of governance arrangements in place during the response to Covid-19 in August 2020 highlighted the significant increase in community gifts and donations to PTHB staff across 2020 led to the need for new measures to ensure correct governance procedure is being followed throughout PTHB. The Charity Manager created new guidance for all staff members to help outline the appropriateness of charitable gifts and donations along with the steps to correctly record them. A Good Governance of Gifts & Donations document was created in September 2020 in line with existing PTHB guidance and the Healthcare Financial Management Association (HFMA) recommendations.

In order to ensure greater clarity and guidelines for Committee members, PTHB staff and the public, the Charity Manager has undertaken a comprehensive governance and funding review to help address any gaps in governance and procedures following the changes of the past year, which have impacted service delivery and numerous processes, such as holding virtual committee meetings and changes in consideration for core and non-core expenditure. This has led to the creation of a new staff policy for Charitable Funds in addition to new general funding guidelines, application forms and a new approval process for all proposals to ensure wider input and provide a structured timeline for applicants.

New staff appointment

The introduction of a Charity Manager earlier in the year led to a steady increase in the scope and reach of the Health Board's Charitable Funds with the addition of new internal and external communication channels, an increased public-facing presence and the development of new partnerships and commitments.

The scope of the Charity is planned to continue to grow over the next 12-24 months and beyond in line with its Annual Plan and strategic objectives. The Corporate Trustee, therefore, decided that an additional post should be a part of the efforts to scale and adapt the Charity whilst ensuring its long-term viability and sustainability

The Charity Administrative Support Officer post will provide crucial support to both the Charity Manager and Board Secretary, ensuring that day to day administration for the Charity can continue to function to a high standard, free of delays with the increased volume of work.

Following a targeted recruitment plan across January and February 2021, the Charity appointed a new Charity Administrative Support Officer on the 18th February with commencement in role in May 2021.

Charity Brand Development

A unified brand identity for the Charity is a key priority as the scope and reach of the Health Board's Charitable Funds steadily increases with the addition of new internal and external communication channels, an increased public-facing presence and the development of new partnerships and commitments. The development of a brand identity is an element of the long-term objectives identified earlier in the report.

Brand development will include the creation of new logos, typefaces and imagery for the Charity's use across internal documents, social media and other digital platforms (including any future website). These will be based on a specific tone and messaging which reflects the Charity's existing and target audiences as well as engagement objectives. The work will also include guidelines for the use of the brand in various scenarios and provide a platform from which to build campaigns and communications going forwards.

With the prioritisation of addressing COVID-19 response and recovery, the addition of new staff, existing governance and establishing a community presence, work on the development of the Charity's new brand has been delayed to late 2021 with a successful launch of the new brand currently planned for 2022.

Ongoing projects and partnerships

Expanding upon the number of third sector partnerships and external partnerships is a continued area of focus for the Charity, with the aim of expanding the scope of the funding proposals and potential projects presented to the Charitable Funds Committee. There are a number of strategic proposals in development which focus on collaborations with third sector partners that can address gaps in particular funding/project areas (based on applications over the previous 18 months) and engage audiences that are missing from current engagement such as projects with children and young people, creative collaborations in addition to advocacy and prevention work.

The Charity approved funding to support a holistic, renewed programme to improve End of Life Care across Powys in July 2020. The Charity Manager is supporting the development of this ongoing programme in an advisory capacity as a member of the project steering group, which was established in October 2020 and continues to meet on a monthly basis. The project has already resulted in a successful staff and public survey of End of Life care across Powys, a partnership with the National Museum of Wales and the implementation of new spiritual care considerations. The programme will continue on throughout 2021 and 2022 to

deliver enhancements to palliative care suites and establish a support network for staff, patients and relatives.

In December 2020, the Charity supported funding for a temporary position (nine months) of a digital project coordinator. The role is based within PAVO (Powys' Voluntary Sector Council), working closely with Powys Teaching Health Board. The role was created to strengthen accessibility to services by coordinating technical volunteers to be available virtually and face to face in a community setting to set patients up with their arranged appointment. The position is also responsible for communicating with Community Connectors, the Powys library service and other venues to establish support hubs in North Powys.

Continuing its aim to support greater collaboration between sectors, in March 2021 PTHB Charity also supported the Horizon Arts in Mental Health project which aims to strategically embed creativity at the heart of mental health, health and wellbeing practice. This collaboration between the Health Board, the local Council and the arts/voluntary sector will consult and engage with, and support the creativity of, mental health and other related patients and service users of all ages, their families, carers and health care staff. Artists will collaborate with individuals and/or groups, to devise therapeutic creative arts experiences with the intention of improving people's mental health, health and wellbeing.

Income & expenditure

Income

Voluntary income consists of donations and legacies from patients and their relatives and friends. Total income of £392,130 received during 2020/21 included £58,987 which related to two legacies.

Donations in 2020/21 include an amount of £17,217 received from various Leagues of Friends associated with Powys Hospitals (2020: £12,048).

The generosity of all those who made a donation or left a legacy is greatly appreciated. An analysis of total income is given below.

	2020/21 £	2019/20 Restated £
Interest and Dividends	79,104	86,295
Donations	102,439	56,048
Legacies	58,987	77,544
Grant Income	151,600	0
	392,130	219,887

Expenditure

Expenditure on charitable activities and Support Costs in 2020/21 was £256,685 (2020 Restated: £488,417).

An analysis of expenditure is shown below:

	2020/21 £	2019/20 Restated £
Staff Education, Welfare and Amenities	56,409	95,622
Patient Education, Welfare and Amenities	92,209	330,364
Medical Equipment	15,188	43,503
Building and refurbishment	1,584	0
Support Costs	91,295	18,928
	256,685	488,417

Gain/Loss on Investment Assets

An amount of £2.804M was invested via Brewin Dolphin Ltd in February 2020 and at the 31st March 2021 was valued at £3.328M (2020:£2.276M) the unrealised gain on Investment totalled £0.558M. Unrealised gains and losses are calculated as the difference between the market value of the investment at the year end and opening carrying value. Since the investments have not physically been sold, this change in valuation remains an unrealised gain/loss until a sale transaction realises the value and it becomes a realised gain/loss.

Elements of funds held

Expenditure was undertaken from the Charity's unrestricted and restricted income funds; these funds comprise two elements:

- **The General Purposes Fund**, which is constituted of funds received by the Charity with no particular preference expressed by donors. Applications can be made to this fund from any service area within Powys THB. Expenditure from this fund is targeted on projects in areas that do not have available Designated Funds to pay for them.

- **Designated Funds,** which usually contain donations where a particular part of a Hospital or Health Board activity was nominated by the donor at the time their donation was made. Whilst their nomination is non-binding on the Trustee, the designated funds reflect these nominations and are overseen by Service Managers who can make recommendations

on how to spend the money within their designated area. Service Managers' recommendations are duly considered and these funds can be spent at any time with the prior approval of the Charitable Funds Committee or Executive Directors/Assistant Directors.

Reserves policy

The Charity's reserves policy has the objective of ensuring that the Charity has sufficient funds available to maintain liquidity, cover unforeseen risks and provide for future opportunities.

The Charity relies heavily on income from donations, fundraising and legacies. These are unpredictable sources that can vary year to year. Therefore, the Charity needs sufficient reserves to be able to continue its activities in the event of fluctuations in its income.

The Charity has a target level of reserves of £0.708M. This is based on the following calculation, with average figures taken from the last three years of audited accounts:

- One year's administration cost (support costs, fundraising costs and investment management costs).
- 20% of the value of investments held.
- 25% of the grant funded activity expenditure.

The target level of reserves will be reassessed on an annual basis.

The Trustee will review the actual reserves held against the target at least annually, to ensure that sufficient funds are held within the Charity, whilst also continuing to utilise funds within a reasonable period of receipt.

A review of funds, performance & investments

The net assets of the Charitable Funds as at 31st March 2021 were £3,932,603 (2020 Restated: £3,251,839).

The charity continues to rely on donations and legacies and investment income as the main sources of income. Total incoming resources increased by £172,243 compared with the previous financial year. Legacy income decreased by £18,557.

Expenditure of £256,685 has decreased compared with the previous year (2020 Restated: £488,417). The total charitable expenditure on direct charitable activity, including support costs was £256,685 across a range of programmes.

Purchase of new medical equipment

The total spend on providing new equipment for Powys THB of £15,188 (2020 Restated: £43,503) represents a vital and valuable contribution to enhancing the provision of clinical care ranging from purchases of small items of rehabilitation

equipment through to patient monitors for use in the Minor Injury Unit at Llandrindod Hospital.

Provision of Staff Education, Welfare and Amenities

Of the total Staff Education, Welfare and Amenities expenditure in year of £56,409 (2020 Restated: £95,622), the Charity contributed £22,411 (2020 Restated: £23,710) towards the provision of education and training for Powys THB staff undertaking further professional education and training.

Provision of Patient Education, Welfare and Amenities

A significant amount of expenditure £92,209 (2020 Restated: £330,364) has been charged under this heading in the year from small initiatives such as increased patient activities at day hospitals to the purchase of televisions in Epynt Ward in Brecon Hospital**.**

Performance management

The Charity Manager has been employed in order to deliver a new strategy for the Charity and to support the development of new projects, partnerships and proposals to help the Charity to best fulfil its charitable aims and objectives. The Charity Manager will help the Trustee to monitor general progress and performance of charitable funds and their utilisation. The performance of the Charity Manager is regularly reviewed by both the Charitable Funds Committee and the Corporate Trustee in order to ensure to the Charity continues to achieve and deliver support to its full potential.

All general purpose funding proposals and significant proposals (above £10,000) are reviewed and approved by the Charitable Funds Committee with prior support from the PTHB Executive Committee. Local and designated fund requests that fall below the above threshold require support from Executive Directors/Assistant Directors for the delegated service managers who manage those funds.

Investments

The Corporate Trustee has considered potential risks to which the Charity is exposed. There are no major risks that have been identified other than those associated with the normal fluctuations in the value of investments. The Trustee believes these risks are appropriately managed. Independent investment advisors (Brewin Dolphin Limited) have been appointed, and investments are held in a diversified fund of investments.

The Corporate Trustee invests the funds of the Charity with Brewin Dolphin Ltd via a Portfolio arrangement. At the year-end 14%, 74%, 6% and 5% were invested in Fixed Income, Equities, Alternatives and Other Investments respectively with the remaining 1% held as cash assets.

The Corporate Trustee continues to consider its exposure to the fluctuations in the value of its equity-based investment, and receives a quarterly investments performance report at each Charitable Funds Committee meeting.

In line with the ethos of promoting patient wellbeing, the Corporate Trustee attempts to ensure that all investments are ethically and environmentally sound, and are not opposed to the core purpose of the Charity. This ethical mandate is interpreted by our Investment Managers and informs the makeup of our portfolio. These ethical considerations and regularly monitored on a quarterly basis.

This THB also has investment property assets left to the charity as part of a legacy estate. The Charity owns a 1/3 share of these properties and receives a 1/3 share of income and expenditure regarding these properties

The strategy of the Corporate Trustee is that funds are spent within a timely manner after receipt. The Charity has further developed this strategy to target funds that remained dormant for a period of over 12 months to ensure that the funds that have been built up over many years are being targeted and distributed equitably. This has been made possible by the introduction of a Charity Manager to support the Corporate Trustee's aims and to support service managers, Senior operational teams and Directorate Managers in developing strategic proposals to utilise funds throughout the year.

Looking ahead to 2021

This review of the Charity should be seen in the context of the Trustee vision to assist Powys THB to deliver health services that meet the needs of all its citizens.

The direction of the Charity will be shaped by the future provision of services and the need to redesign patient care. Powys THB is currently considering a number of proposed service direction changes as initially outlined within its published Integrated Medium Term Plan and updated with a new Annual Plan for 2021/22. This has been significantly influenced by the impact of the pandemic on health services.

PTHB Charity will further develop its strategic approach to utilising funds and build on its workplan for 2021/22 with its additional staff capacity, with a view to successfully launching its new brand and boosting engagement. This will include a renewed new focus on the strategic areas shaped by both the Health Board's Annual Plan and emerging priorities such as recovery and renewal.

The Charity will continue work with partners, donors, staff and other stakeholders to add benefit to the population of Powys receiving health care services. As such, income and expenditure plans will be the subject of continual review to ensure that future needs are prioritised accordingly.

Thank you for all your support

On behalf of the patients and staff who have benefited from improved services due to donations and legacies, the Corporate Trustee and the Charity would like to thank all patients, relatives, friends and staff who have made charitable donations or contributions during the year. We have been overwhelmed by the generosity of our communities this year and for that we cannot thank them enough.

PTHB Charity and the Powys Teaching Health Board has a clear view of how health services should be delivered to improve the health and wellbeing of Powys. We can only make this vision possible through Powys THB's partners, staff, patients, carers and our Powys communities and we invite you to join us to make this a reality. If you want to learn more about PTHB Charity and how you can support, please visit the Charity's website: pthb.nhs.wales/about-us/our-charity/ or contact Abe Sampson, Charity Manager at abe.sampson@wales.nhs.uk.

Professor V M Harpwood	Mrs C Shillabeer
Chair	**Chief Executive**
Powys Teaching Local Health Board	**Powys Teaching Local Health Board**

Statement of Trustee responsibilities in respect of the Trustee's Report and the financial statements

Under charity law, the Trustee is responsible for preparing the Trustee Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of income over expenditure for that period.

In preparing these financial statements, generally accepted accounting practice entails that the Trustee:

- selects suitable accounting policies and then applies them consistently;
- makes judgements and estimates that are reasonable and prudent;
- states whether the recommendations of the Statement of Recommended Practice FRS 102 have been followed, subject to any material departures disclosed and explained in the financial statements;
- states whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepares the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The Trustee is required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The Trustee is responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the Trustee to ensure that, where any statements of accounts are prepared by them under section 42(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The Trustee has a general responsibility for taking such steps as are reasonably open to it to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the financial and other information included on the Powys Teaching Local Health Board website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 26 to 40 attached have been compiled from and are in accordance with the financial records maintained by the Trustee.

By Order of the Trustee

Signed: ……(Chair) Date:……

Parry Stella 04/21/2022 15:59:48

Signed: ……(Chief Executive) Date:……

The independent auditor's report of the Auditor General for Wales to the trustee of Powys Teaching Health Board Charitable Fund

Opinion on financial statements

I have audited the financial statements of Powys Teaching Health Board Charitable Fund (the Charity) for the year ended 31st March 2021 under the Charities Act (2011). These comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31st March 2021 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis of opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Report on other requirements

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustee report;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee responsibilities, the trustee is responsible for preparing the financial statements in accordance with the Charities Act 2011, for being satisfied that they give a true and fair view, and for such internal control as the trustee determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the charity's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Charity's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and posting of unusual journals.
- Obtaining an understanding of the Charity's framework of authority as well as other legal and regulatory frameworks that the Charity operates in, focusing on those laws and regulations

that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Charity.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and those charged with governance about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Charity's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Adrian Crompton
Auditor General for Wales
[Date]

24 Cathedral Road
Cardiff
CF11 9LJ

Powys Teaching Local Health Board Charity Statement of Financial Activities for the year ended 31 March 2021

	Note	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total Funds 2020/21 £000
Incoming resources from generated funds:					
Donations and legacies	3	313	0	0	**313**
Investments	5	79		0	**79**
Total incoming resources		**392**	**0**	**0**	**392**
Expenditure on:					
Raising Funds	6	13	0	0	**13**
Charitable activities	7	256	0	0	**256**
Total expenditure		**269**	**0**	**0**	**269**
Net gains / (losses) on investments	13	557	0	1	**558**
Net income / (expenditure)		**680**	**0**	**1**	**681**
Transfer between funds	18	0	(2)	2	**0**
Net movement in funds		**680**	**(2)**	**3**	**681**
Reconciliation of Funds					
Total Funds brought forward	19	3,250	2	0	**3,252**
Total Funds carried forward		**3,930**	**0**	**3**	**3,933**

Powys Teaching Local Health Board Charity Statement of Financial Activities for the year ended 31 March 2020

	Note	Unrestricted funds Restated £000	Restricted Income funds £000	Endowment funds £000	Total Funds 2019/20 Restated £000
Incoming resources from generated funds:					
Donations and legacies	3	134	0	0	**134**
Investments	5	86	0	0	**86**
Total incoming resources		**220**	**0**	**0**	**220**
Expenditure on:					
Raising Funds	6	1	0	0	**1**
Charitable activities	7	488	0	0	**488**
Total expenditure		**489**	**0**	**0**	**489**
Net gains / (losses) on investments	13	144	0	0	**144**
Net income / (expenditure)		**(125)**	**0**	**0**	**(125)**
Transfer between funds	18	0	0	0	**0**
Net movement in funds		**(125)**	**0**	**0**	**(125)**
Reconciliation of Funds					
Total Funds brought forward	19	3,375	2	0	**3,377**
Total Funds carried forward		**3,250**	**2**	**0**	**3,252**

Powys Teaching Local Health Board Charity Balance Sheet as at 31 March 2021

	Note	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 31 March 2021 £000	Total 31 March 2020 Restated £000
Fixed assets:						
Investments	13	3,387	0	3	**3,390**	2,829
Total fixed assets		**3,387**	**0**	**3**	**3,390**	**2,829**
Current assets:						
Debtors	14	32	0	0	**32**	22
Cash and cash equivalents	15	657	0		**657**	591
Total current assets		**689**	**0**	**0**	**689**	**613**
Liabilities:						
Creditors: Amounts falling due within one year	16	146	0	0	**146**	190
Net current assets / (liabilities)		**543**	**0**	**0**	**543**	**423**
Total assets less current liabilities		**3,930**	**0**	**3**	**3,933**	**3,252**
Creditors: Amounts falling due after more than one year	16	0	0	0	**0**	0
Total net assets / (liabilities)		**3,930**	**0**	**3**	**3,933**	**3,252**
The funds of the charity:						
Endowment Funds	19			3	**3**	0
Restricted income funds	19		0		**0**	2
Unrestricted income funds	19	3,930			**3,930**	3,250
Total funds		**3,930**	**0**	**3**	**3,933**	**3,252**

The notes on pages 29 to 40 form part of these accounts

Signed : .....

Name : .....(Chair of Trustees)

Date : .....

Powys Teaching Local Health Board Charity Statement of Cash Flows for the year ending 31 March 2021

	Note	Unrestricted funds	Restricted Income funds	Endowment funds	Total Funds 2020-21	Total Funds 2019-20 Restated
					£000	£000
Cash flows from operating activities:						
Net cash provided by (used in) operating activities	17	(9)	0	(1)	**(10)**	**(272)**
Cash flows from investing activities:						
Dividend, interest and rents from investments	5	79	0	0	79	86
Proceeds from the sale of investments	13	804	0	0	804	3,192
Purchase of investments	13	(1,586)	0	0	(1,586)	(2,804)
Movement of Cash held as part of investment portfolio	13	779	0	0	779	0
Net cash provided by (used in) investing activities		76	0	0	**76**	**474**
Change in cash and cash equivalents in the reporting period		67	0	(1)	**66**	**202**
Cash and cash equivalents at the begining of the reporting period	15	591	0	0	591	389
Cash and cash equivalents at the end of the reporting period	15	657	0	0	**657**	**591**

Note on the accounts

1 Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information).

The Charity meet the definition of public benefit entity under FRS 102.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from donations or legacies for specified purposes.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the Trustees have the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment).

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the charity's reserves. The major funds held in each of these categories are disclosed in note 19.

(c) Incoming resources

Income consists of donations, legacies, income from charitable activities and investment income.

Donations are accounted for when received by the charity. All other income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(e) Incoming resources from endowment funds

The income received from the investment of endowment funds is attributed to unrestricted funds to be spent on charitable purposes. Any gains or losses arising from the valuation of investment of the endowment capital amount are attributed to the endowment fund

(f) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(g) Recognition of expenditure and associated liabilities as a result of grants

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised.

(h) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 10.

(i) Fundraising costs

There has been £13K fundraising costs incurred by the Charity during 2020/21 (2019/20 £1K). This relates to investment management costs.

(j) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 7.

(k) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

(l) Fixed Asset Investments

Investments are a form of basic financial instrument. Fixed Asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposal throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current mid price market value quoted by the investment analyst, excluding dividend. The SORP recommends that the bid price market price be used in valuing stocks and shares, although the difference between the bid and mid market price is not material. Other investments are included at the trustees' best estimate of market value.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to the wider economic conditions, the attitude of investors to investment risk and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the charity's investments can be found in note 13.

(m) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in no notice interest bearing savings accounts.

(n) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

(o) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value. Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value.

2. Related party transactions

During the year none of the trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Powys Teaching Local Health Board Charitable Funds other than those disclosed below.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

The Charitable Trust Fund has made payments to Powys Teaching Health Board of £0.172M. As at 31 March 2021 the total owed to the Health Board was £0.116M (2020: £0.087M), and owed by the Health Board was £0.002M (2020:£0.000M).

The Charity's Board members have related party interests in the the following:

Name	Details	Related Party Interests
Trish Buchan	Independent Member	Powys Association of Voluntary Organisations (Ex officio Trustee)

The Total value of transactions with related parties during 2020/21 are as follows:

Related Party	Payment to related party £	Amounts received from related party £	Amounts owed to related party £	Amounts due from related party £
Powys Association of Voluntary Organisations	58,191	0	0	0

3. Income from donations and legacies

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	**Total 2020-21** £000	Total **2019-20** Restated £000
Donations	102	0	0	**102**	56
Legacies	59	0	0	**59**	78
Grants	152	0	0	**152**	0
	313	**0**	**0**	**313**	**134**

4. Role of volunteers

Like all charities, the THB Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform the following role:

- Fund advisors – there are about 13 THB staff who manage how the charity's designated funds should be spent. These funds are designated (or earmarked) by the trustees to be spent for a particular purpose or in a particular ward or department. Each fund advisor has delegated powers to spend the designated funds that they manage in accordance with the trustees wishes subject to the approval of their Executive Director/Assistant Director or the Charitable Funds Committee. The trustees determine through its Strategy the key aims that expenditure should be utilised for. Fund advisors who spend more than £10,000 are required to seek approval from the Charitable Funds Committee setting out what they intend to spend the money on and the difference it will make to the patients and staff of the THB services.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

5. Gross investment income

	Unrestricted funds £000	Restricted Income funds £000	Total 2020-21 £000	Total 2019-20 Restated £000
Fixed asset equity and similar investments	79	0	**79**	**86**
Short term investments, deposits and cash on deposit	0	0	**0**	**0**
	79	**0**	**79**	**86**

6. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted Income funds £000	Total 2020-21 £000	Total 2019-20 Restated £000
Investment management	13	0	**13**	1
	13	**0**	**13**	**1**

7.Analysis of charitable activity

	Grant funded activity £000	Support costs £000	Total 2020-21 £000	Total 2019-20 Restated £000
Medical research				
Purchase of new equipment	15	8	**23**	44
Building and refurbishment	2	1	**3**	0
Staff education and welfare	56	31	**87**	101
Patient education and welfare	92	51	**143**	343
	165	**91**	**256**	**488**

Support costs are apportioned based on %age of Grant funded activity

8.Analysis of grants

The charity does not make grants to individuals. All grants are made to the Health Board to provide for the care of NHS patients in furtherance of our charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 7.

The trustees operate a scheme of delegation for the majority of the charitable funds, under which fund advisors manage the day to day disbursements on their projects in accordance with the directions set out by the trustees in charity standing orders and financial instructions. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards.

9. Movements in funding commitments

	Current liabilities	Restricted Non-current liabilities	Total 31 March 2021	Total 31 March 2020 Restated
	£000	£000	£000	£000
Opening balance at 1 April (see note 16)	190		**190**	96
Movement in liabilities	(44)		**(44)**	94
Closing balance at 31 March (see note 16)	**146**	**0**	**146**	**190**

As described in notes 7 and 8, the charity awards a number of grants in the year. Many grants are awarded and paid out in the same financial year. However, some grants which are awarded for example funding a specific post can span financial years. For such grants whilst the award may be for more than one year, it is only the annual amount that is paid out in year and recorded as expenditure within charitable activities.

The charity at present does not issue formal grant letters to recipients and therefore the expectation of the recipient in recognition of this grant as defined by the SORP is not met with certainty.

10. Allocation of support costs

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity.

	Raising funds £000	Charitable activities £000	Total 2020-21 £000	Total 2019-20 £000	Basis
Governance					
External audit	0	25	**25**	2	Charged to Central Fund
Finance and administratior	0	3	**3**	4	Charged to Central Fund
Other professional fees					
Total governance	**0**	**28**	**28**	**6**	
Finance and administratior	0	63	**63**	13	Charged to Central Fund
	0	**91**	**91**	**19**	

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total Funds 2020-21 £000	Total Funds 2019-20 Restated £000
Charitable activities	91	0	0	**91**	19
	91	**0**	**0**	**91**	**19**

11. Staff Costs, Trustees' remuneration, benefits and expenses

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustee.
The charity has no employees. Staff services are provided to the charity from Powys Teaching Local Health Board, the corporate Trustee of the Charity , which has received reimbursement from the Charity of £0.066M (2019/20: £0.019M).

12. Auditors remuneration

The External auditors remuneration of £25,000.00 (2019-20: £1,650.00) related solely to the Audit of the Statutory Annual Report and Accounts. Due to the Charity exceeding the threshold requirements during 2020/21 a full audit of the Annual Report and Accounts was required. Previous years has seen an Independent Examination being undertaken as the thresholds had not been exceeded.

The Internal Auditors remuneration of £0 (2019-20: £0) seeks to provide the Health Board with assurance that operational procedures are compliant with the Health Board's Charitable Funds Policy and Guidance, along with its underlying Standing Financial Instructions, and wider NHS Charities guidance. A full review was undertaken during November 2015 and the report received 'yellow' assurance which indicates : *"The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved"*

During the year the Local Counter Fraud Service undertook a risk assessment of controls for charitable funds. NHS Protect has issued a RiskAssessment tool to guide Local Counter Fraud functions to undertake a Risk Assessment of the Counter Fraud arrangements in place at their own organisation. The Assessment of Charitable funds indicated a low risk rating of 1x4 with the only recommendation being to *'maintain the robust controls that are in place and consult with Counter fraud prior to any amendments being initiated'.*

13. Fixed asset investments

Movement in fixed assets investments

	Total 2020-21	Total 2019-20 Restated
	£000	£000
Market value brought forward	**2,829**	3,073
Add: additions to investments at cost	**1,586**	2,804
Less disposals at carrying value	**(804)**	(3,192)
Add net gain / (loss) on revaluation	**558**	144
Movement of Cash held as part of investment portfo	(779)	0
Market value as at 31st March	**3,390**	**2,829**

Fixed Asset by Type

	Total 2020-21	Total 2019-20 Restated
	£000	£000
Investment Properties	**62**	62
UK Bonds	**269**	186
Overseas Bonds	**193**	123
UK Equities	**931**	522
Global Equities	**1,444**	766
Emerging Market Equities	**71**	18
Global Investments	**0**	54
Absolute Return	**149**	91
Property	**67**	88
Other Investments	**155**	91
Cash	**49**	828
	3,390	**2,829**

All investments are carried at their fair value.

The Charitable Trustee has considered potential risks to which the Charity is exposed. There are no major risks that have been identified other than those associated with the normal fluctuations in the value of investments. The Trustee believes these risks are appropriately managed. Independent investment advisors (Brewin Dolphin Ltd) have been appointed, and investments are held in a diversified fund of investments, including 14% in fixed interest mainly government stock

The Corporate Trustee invests the funds of the Charity with Brewin Dolphin Ltd via a Portfolio arrangement. At the year-end 74% (2020:49%), 14%(2020: 11%), 6%(2020:7%), and 5% (2020:3%), were invested in Equities, Fixed Income, Alternatives and Other Investments respectively with the remaining 1% (2020:30%), held as cash assets.

The Corporate Trustee continues to consider its exposure to the fluctuations in the value of its equity based investment, and receives a quarterly investments performance report at each Charitable Funds Committee meeting.

The charity during 2018/19 undertook a re-tender of its investment manager services. This has resulted in a change of Investment Management services to Brewin Dolphin Ltd with the investment with CCLA Ltd being sold during October 2019 and a new portfolio investment with Brewin Dolphin Ltd from February 2020.

This note has been restated in 2019/20 to include the recognition of investment property assets left to the charity as part of a legacy estate which was omitted from the financial statements in prior years. The Charity owns a 1/3 share of these properties and receives a 1/3 share of income and expenditure regarding these properties.

The valuation of investment properties, consisting of freehold ground and property rents is based on a professional assessment of fair value by an independent valuer. A prior year adjustment to 2019/20 brought forward Funds balance has been undertaken and subsequent movements on valuations at 31st March will be recognised as a gain or loss within the Statement of Financial Activities for the corresponding year

During the year an unrealised gain of £0.558M was recognised in the accounts.

In line with the ethos of promoting patient wellbeing, the Corporate Trustee attempts to ensure that all investments are ethically and environmentally sound, and are not opposed to the "purpose" of the charity. The performance of the investments are regularly monitored and reported on a quarterly basis by our investment managers.

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14. Analysis of current debtors

Debtors under 1 year	Total 31 March 2021 £000	Total 31 March 2020 Restated £000
Prepayment	**28**	0
Other debtors	**4**	**22**
	32	**22**

15. Analysis of cash and cash equivalents

	Total 31 March 2021 £000	Total 31 March 2020 £000
Cash in hand	**657**	591
	657	**591**

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

16. Analysis of liabilities

	Total 31 March 2021 £000	Total 31 March 2020 Restated £000
Creditors under 1 year		
Trade creditors	**146**	190
	146	**190**
Creditors over 1 year		
Trade creditors	**0**	0
	0	**0**
Total creditors	**146**	**190**

17. Reconciliation of net income / expenditure to net cash flow from operating activities

	Total 2020-21 £000	Total 2019-20 Restated £000
Net income / (expenditure) (per Statement of Financial Activities)	**681**	(125)
Adjustment for:		
(Gains) / losses on investments	**(558)**	(144)
Dividends, interest and rents from investments	**(79)**	(86)
(Increase) / decrease in debtors	**(10)**	(11)
Increase / (decrease) in creditors	**(44)**	94
Net cash provided by (used in) operating activities	**(10)**	**(272)**

18. Transfer between funds

The transfers indicated in Note 19 relate to the reclassification of a previous fund held as restricted has which has been reclassified as an endowment fund during the year.

19. Analysis of funds

a. Analysis of endowment fund movements

	Balance 1 April 2020 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2021 £000
Endowment Funds	0	0	0	2	1	3
	0	**0**	**0**	**2**	**1**	**3**

A previous fund held as restricted has been reclassified as an endowment fund during the year. There is a small capital in perpetuity donation which specifies that the capital amount is to be invested and any income from this is to be utilised by the Charity. The original donation amount cannot be discharged and must remain as an investment. The income received from this endowment is added to unrestricted funds to be spent on charitable purposes. Any gains or losses arising from the valuation of investment of the endowment capital amount are attributed to the endowment fund

b. Analysis of restricted fund movements

	Balance 1 April 2020 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2021 £000
Restricted Funds	2	0	0	(2)	0	0
	2	**0**	**0**	**(2)**	**0**	**0**

A previous fund held as restricted has been reclassified as an endowment fund during the year and now is included within Note 19a

c. Analysis of unrestricted and material designated fund movements

		Balance 1 April 2020 Restated £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2021 £000
8010	Ystradgynlais General Purposes	27	9	(1)	0	0	35
8102	Ystradgynlais Geriatric Ward Fund	53	6	0	0	0	59
8011	Welshpool General Purposes	188	4	(1)	0	0	191
8330	North Powys District Nursing Fund	26	4	0	0	0	30
8012	Machynlleth General Purposes	12	63	(3)	0	0	72
8003	Llandrindod General Purposes	55	0	(5)	0	0	50
8067	Llandrindod Hazels Legacy	272	0	0	0	0	272
8005	Knighton General Purposes	72	0	0	0	0	72
8016	Powys General Purposes	726	122	(158)	0	557	1,247
8040	Palliative Care	40	6	(2)	0	0	44
8321	Mid & South Powys Community and Palliative Care Fund	1,051	0	(18)	0	0	1,032
8323	Mental Health General Purposes	354	0	0	0	0	354
8324	Covid General Purposes	0	152	(45)	0	0	107
8140	Bronllys AMI Legacy	195	0	(3)	0	0	192
8001	Brecon General Purposes	41	0	(4)	0	0	38
8325	Estate M R Morgan Properties Fund	62	0	0	0	0	62
	Other Unrestricted Funds	76	26	(29)	0	0	73
		3,250	**392**	**(269)**	**0**	**557**	**3,930**

The objects of the unrestricted funds are as follows:

The unrestricted Funds usually contain donations where a particular part of a Hospital or Health Board activity was nominated by the donor at the time their donation was made. Whilst their nomination is non-binding on the Trustee, the designated funds reflect these nominations and are overseen by Service managers who can make recommendations on how to spend the money within their designated area. Service Managers' recommendations are duly considered and these funds can be spent at any time with the prior approval of the Charitable Funds Committee or Executive Directors/Assistant Directors.

Estate M R Morgan Properties Fund is a fund that holds the valuation of investment properties at the balance sheet date. This note has been restated in 2019/20 to include the recognition of investment property assets left to the charity as part of a legacy estate which was omitted from the financial statements in prior years. The Charity owns a 1/3 share of these properties and receives a 1/3 share of income and expenditure regarding these properties. All gains and losses relating to the valuation of these properties are charged to this fund. All rental income and investment management expenditure in relation to these properties is allocated to the unrestricted General Purpose funds so that it can be used for the furtherence of general charitable purposes.

The material funds specified in the above note will vary from year to year dependent on the closing year end balance.

We consider that a closing fund balance of £25,000 or greater are material for disclosure in these accounts.

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Powys Teaching Health Board Charitable Funds and Other Related Charities

Audit year: 2020-21

Date issued: April 2022

Document reference: 2924A2022

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

Contents

We intend to issue an unqualified audit report on your Accounts There are some issues to report to you prior to their approval.

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2020-21 accounts in this report.

2 We have already discussed these issues with the Director of Finance.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £7,200 for this year's audit.

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

- Related Parties £1,000

6 We have now substantially completed this year's audit.

7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and, our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

Impact of COVID-19 on this year's audit

8 The pandemic has unsurprisingly affected our audit and we summarise in **Exhibit 1** the main impacts. Other than where we specifically make recommendations, the detail in **Exhibit 1** is provided for information purposes only to help you understand the impact of the COVID-19 pandemic on this year's audit process.

Exhibit 1 – impact of COVID-19 on this year's audit

Electronic signatures	Due to restrictions arising from the COVID-19 pandemic, Audit Wales haa accepted electronic signatures supported by e-mail confirmations from the relevant officers.
Audit evidence	In previous years, the audit team would have accessed both paper and electronic working papers and supporting audit evidence whilst working at the Health Board's offices. However, due to the working restrictions arising from COVID-19, we have devised alternative audit methodologies to obtain and confirm the validity of appropriate audit evidence. This has included: • officers provided electronic working papers in accordance with our agreed Audit Deliverables Report using Inflo; • officers provided audit evidence to the audit team via secure e-mail; • officers were available by video conferencing for discussions, and for the sharing of on-screen information/evidence

9 We will be reviewing what we have learned for our audit process from the COVID-19 pandemic and whether there are innovative practices that we might adopt in the future to enhance that process.

Proposed audit opinion

10 We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation based on that set out in **Appendix 1**.

11 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise we issue an unqualified opinion.

12 The Letter of Representation contains certain confirmations we are required to obtain from you under auditing standards.

13 Our proposed audit report is set out in **Appendix 2**.

Significant issues arising from the audit

Uncorrected misstatements

14 There are no misstatements identified in the accounts, which remain uncorrected.

Corrected misstatements

15 There were initially misstatements in the accounts that have now been corrected by management. These are set out with explanations in **Appendix 3**.

Other significant issues arising from the audit

16 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. During the course of the audit, we identified a number of issues which resulted in significant delays to the original audit timetable including the providing the final audit report.

17 The nature and number of issues identified from the audit have led to an increase in the audit fee charged to the Charity from an estimated fee of £10,583 to £25,000. This is due to the significant increase in auditor time required to complete our audit.

18 These issues have been outlined in **Exhibit 2**:

Exhibit 2 – significant issues arising from the audit

Using the financial system on a cash basis	We identified during our audit planning work that the Charity uses a cash-based financial system. However, per the accounting framework, the financial statements are required to be prepared on an accruals basis. As a consequence, manual adjustments are required at the year-end to ensure that income and expenditure are recorded in the correct financial year. However, despite these manual adjustments, our initial testing identified a number of transactions, which were material in value, that had not been recognised in the correct financial year. These have been described in **Appendix 3**. In consultation with the Director of Finance, it was agreed that additional work would be undertaken by the Health Board to obtain assurance that the financial statements were materially accurate. This work identified further transactions which had not been recognised in the correct financial year. This additional work was tested by the audit team and no further issues were identified from our testing.

	We have recommended 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. This has been included within our recommendations in **Appendix 4**.
Recognising donated assets	Our audit identified that the Charity had not recognised within the financial statements four properties previously donated. The Charity had recognised the rental income received from the properties but had not reported the assets within the balance sheet. The omission of these properties was significantly material and their subsequent recognition in the financial statements required external valuation and several complex accounting adjustments. The Charity should ensure there are robust processes in place to record and report within the financial statements any assets left to the Charity. This has been included within our recommendations in **Appendix 4**.
Quality of the financial statements	In addition to the issues described above, the draft financial statements contained a number of other errors. The Charity should ensure that the draft accounts presented for audit are of a good standard and meet the requirements of the relevant accounting framework. This has been included within our recommendations in **Appendix 4**.

Recommendations

19 The recommendations arising from our audit are set out in **Appendix 4**. Management has responded to them and we will follow up progress against them during next year's audit. Where any actions are outstanding, we will continue to monitor progress and report it to you in next year's report.

Appendix 1

Final Letter of Representation

Auditor General for Wales

Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

28 April 2022

Representations regarding the 2020-21 financial statements

This letter is provided in connection with your audit of the financial statements of Powys Teaching Health Board Charitable Funds and Other Related Charities for the year ended 31 March 2021 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- the preparation of the financial statements in accordance with legislative requirements and the Charities Act 2011, in particular the financial statements give a true and fair view in accordance therewith; and
- the design, implementation, maintenance and review of internal control to prevent and detect fraud and error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and

  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Powys Teaching Health Board Charitable Fund and Other Related Charities and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by those charged with governance, the Trustee of Powys Teaching Health Board Charitable Funds and Other Related Charities

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Powys Teaching Health Board on 28 April 2022.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Carol Shillabeer	Vivienne Harpwood
Chief Executive and Accountable Officer	Board Chair
Date:	Date:

Parry Stella
04/21/2022 15:59:48

Appendix 2

The independent auditor's report of the Auditor General for Wales to the trustee of Powys Teaching Health Board Charitable Fund and Other Related Charities

Opinion on financial statements

I have audited the financial statements of Powys Teaching Health Board Charitable Fund and Other Related Charities (the Charity) for the year ended 31st March 2021 under the Charities Act (2011). These comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the Charity as at 31 March 2021 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis of opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the Charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt

on the body's ability to continue to adopt the going concern basis of accounting for a period of at least 12 months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Report on other requirements

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustee report;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee responsibilities, the trustee is responsible for preparing the financial statements in accordance with the Charities Act 2011, for being satisfied that they give a true and fair view, and for such internal control as the trustee determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustee is responsible for assessing the Charity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- enquiring of management, the Charity's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Charity's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and posting of unusual journals.

- obtaining an understanding of the Charity's framework of authority as well as other legal and regulatory frameworks that the Charity operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Charity.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all the audit team and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Charity's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Adrian Crompton
Auditor General for Wales
[Date]

24 Cathedral Road
Cardiff
CF11 9LJ

Appendix 3

Summary of Corrections Made

During our audit we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Exhibit 3: summary of corrections made

Value of correction	Nature of correction
Previously Unrecognised Investment Properties	
£62,000 – Investment Property	We have identified four Investment Properties that were historically donated to the Charity, but which were not recognised within the Balance Sheet. This has led to an understatement of assets totalling £62,000. Subsequent valuations were provided to ensure the recognition of the assets complied with the accounting framework, the Statement of Responsibility (SoRP). In addition, the Fund balances of 2019-20 were restated to correctly reflect the historic nature of the donation.
£5,000	We identified the rental income from the investment properties described above has been incorrectly classified as 'Legacy Income' when it related to 'Investment Income'.
£1,000	We identified that the rental income described above had been reported net of the property management company's management fee. However, the income and fees should be reported separately under the appropriate income and expenditure lines within the Statement of Financial Activities and supporting notes. This led to an understatement of Legacy Income (reclassified to Investment Income) and Expenditure on Raising Funds of £1,000.

Value of correction	Nature of correction
Income and Expenditure recognised in the incorrect year	
£17,000 – Investment Income	The investment management report from identified dividends valued at £17,000 related to the period January – March 2021. The cash dividend was not drawn down by the Charity until April 2021, however, it met the requirements of the SoRP to be recognised as income in the 2020-21 financial year. However, this income had not been recognised in 2020-21 and had been recognised as income in 2021-22. This led to an understatement of income in 2020-21 totalling £17,000. We found the same treatment of income for dividends relating to January – March 2020, however, the value of this was trivial.
£10,000 – Legacy Income £9,000 – Donated Income	We identified one transaction within both Donated and Legacy Income that had been recognised in 2020-21 when it related to income from 2019-20 and 2018-19 respectively. This led to an overstatement of income in 2020-21 totalling £19,000. In addition to these audit findings, the Charity undertook further testing (described in **Exhibit 2**) and identified a transaction totalling £600 that was recognised in 2020-21, when it should have been recognised in 2019-20, and a transaction totalling £600 that was recognised in 2021-22 that should have been recognised in 2020-21
£88,000 – Expenditure on Charitable Activities	We identified six transactions relating to 'Expenditure on Charitable Activities' that were recognised in 2020-21 when they related to expenditure incurred in 2019-20. This led to an overstatement of expenditure in 2020-21 totalling £88,000. In addition to these audit findings, the Charity undertook further testing (described in **Exhibit 2**) and identified a further two transactions totalling £177 that were recognised in 2020-21 when they should have been recognised in 2019-20, and four transactions totalling £792 that were recognised in 2019-20 that should have been recognised in 2020-21.

Value of correction	Nature of correction
Income and Expenditure recognised in the incorrect year	
£28,0000 – Expenditure on Charitable Activities	We identified two transactions relating to Expenditure of Charitable Activities where the expenditure should have been apportioned across 2020-21 and 2021-22, as the services were to be provided across the two financial years. However, the Charity recognised the entire transaction within the current financial year. This led to an overstatement of expenditure in 2020-21 totalling £28,000. In addition to these audit findings, the Charity undertook further testing (described in **Exhibit 2**) and identified one further transaction totalling £180 that was recognised in 2020-21 when it should have been recognised in 2021-22.
Errors in the Disclosure of Investments	
£1,600,000 – Additions £800,000 – Disposals	We identified that investment balances for additions and disposals within the investment fund were reported as nil within Note 13 to the accounts. However, the valuation report provided by the custodians of the portfolio included a transaction statement detailing additions and disposals throughout the year. This led to an understatement of additions and disposals of £1,600,000 and £800,000 respectively.
£12,000 – Investment Income £12,000 – Expenditure on Raising Funds	We identified that the investment income in relation to the investment properties described above had been reported net of the Investment management company's management fees. However, the income and fees should be reported separately under the appropriate income and expenditure lines within the Statement of Financial Activities and supporting notes. This led to an understatement of Investment Income and Expenditure on Raising Funds of £12,000.
£4,000 – Gain on Investment	We identified that the calculation of the gain or loss on the investment portfolio had incorrectly included the management fees described above and excluded investment income from January – March 2021 (described below). In addition, the resulting gain or loss had then not been apportioned between the Investment Portfolio and the Endowment Fund. This led to an overstatement of the gain of £4,000.

Value of correction	Nature of correction
Misclassification of Restricted Funds, Income and Expenditure	
£2,000 – Restricted Fund	We identified that a Capital in Perpetuity Fund had been recognised as a Restricted Fund within the financial statements, when it met the definition per the SoRP of a Permanent Endowment Fund. As this Fund was not material, the Charity has chosen to reclassify this Fund from Restricted to Permanent Endowment as a movement between funds in the year, rather than restating the 2019-20 position. This is allowable under the SoRP.
£152,000 – Donation Income	We identified five income transactions relating to 'NHS Charities Together' had been misclassified as 'Donated Income' when they related to 'Grant Income'.
£57,000 – Patient and Education Wellbeing Expenditure	We identified four expenditure transactions that had been misclassified as 'Patient Education and Welfare' when they related to 'Building and Refurbishment'.
Errors within or Omission of Disclosures required per the Accounting Framework	
Disclosure	We identified that the Charity had not made the required disclosures for each individual material fund held by the Charity per the requirements of the SoRP. The Charity has deemed the material threshold to be funds greater then £25,000 to align with updates provided to the Charitable Funds Committee.
Disclosure	There were no suitable disclosures in relation to staff within the notes to the financial statements, nor any disclosures regarding the sums reimbursed to the main Health Board relating to staff costs as required by the SoRP.

Value of correction	Nature of correction
Errors within or Omission of Disclosures required per the Accounting Framework	
Various – narrative	In addition to those described above, we identified several disclosures that were not in line with the requirements of the SoRP or were not included when required per the SoRP.
Various	We identified a number of material casting, rounding and comparative figure errors which required correction.
Other issues identified	
Documentation	We have identified a discrepancy between the threshold for expenditure that can be approved by officers on behalf of the Charitable Fund Committee per the Scheme of Delegation compared to the threshold that was approved by the Board. The Scheme of Delegation gives the threshold as expenditure under £5,000 whereas the threshold approved by the Board (and used by the Charity) is expenditure under £10,000.
£1,650 – Annual Audit Fee	£1,650 of the estimated annual audit fee had not been accrued for within the creditors balance.
£9,000 – Movement in Funding Commitments	The movement in funding commitments should correspond with the movement in the creditors balance during the year. We identified a £9,000 understatement as the movement in funding commitments per note 9 was £20,000 and the movement in the creditors balance per note 16 was £29,000. Subsequently, amendments to the year-end creditor position from other issues identified during the audit were required. The movement in funding commitments was correctly updated to reflect this.

Appendix 4

Recommendations

We set out all the recommendations arising from our audit with management's response to them. We will follow up these next year and include any outstanding issues in next year's audit report:

Exhibit 4: matter arising 1

Matter arising 1	
Findings	The Charity uses a cash-based financial system, and manual accruals have to be identified and adjusted for. This has resulted in material misstatements to the financial statements.
Priority	High
Recommendation	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.
Accepted in full by management	Yes
Management response	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.
Implementation date	September 2022

Exhibit 5: matter arising 2

Matter arising 2	
Findings	We have identified material investment properties left to the Charity, that were previously not recognised within the financial statements.
Priority	High
Recommendation	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.
Accepted in full by management	Yes
Management response	Noted – This recommendation will be actioned as and when assets are transferred to the Charity.
Implementation date	Immediate

Exhibit 6: matter arising

Matter arising 2	
Findings	In addition to the specific issues and recommendations above, we identified various other issues within the financial statements. These included: • errors in the disclosure of investments and the calculation of the gain or loss in year; • misclassification of restricted funds, income and expenditure; • errors within or omission of disclosures required per the accounting framework; • discrepancy between the approval threshold for expenditure in the scheme of delegation and threshold approved by the board; • omission of a creditor; and • incorrect calculation of the movement on funding commitments.
Priority	High
Recommendation	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.
Accepted in full by management	Yes
Management response	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 requirements. This employee started in post in February 2022.
Implementation date	Actioned.

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

Vivienne Harpwood, Cadeirydd / Chair
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Carol Shillabeer, Y Prif Weithredwr / Chief Executive
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GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Final Letter of Representation

Auditor General for Wales

Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

28th April 2022

Representations regarding the 2020-21 financial statements

This letter is provided in connection with your audit of the financial statements of Powys Teaching Health Board Charitable Funds and Other Related Charities for the year ended 31 March 2021 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- The preparation of the financial statements in accordance with legislative requirements and the Charities Act 2011, in particular the financial statements give a true and fair view in accordance therewith; and
- The design, implementation, maintenance and review of internal control to prevent and detect fraud and error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Powys Teaching Health Board Charitable Fund and Other Related Charities and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by those charged with governance, the Trustee of Powys Teaching Health Board Charitable Funds and Other Related Charities

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Powys Teaching Health Board on 28 April 2022.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Carol Shillabeer	Professor Vivienne Harpwood
Chief Executive and Accountable Officer	Board Chair
28th April 2022	28th April 2022

Parry Stella
04/21/2022 15:59:48

Archwilio Cymru
Audit Wales

2021 Audit Plan – Powys Teaching Local Health Board Charitable Fund

Audit year: 2020-21

Date issued: April 2022

Document reference: 2922A2022

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

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

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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

Contents

2021 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2021 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic continues to have an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 Audit Wales staff will continue to work pragmatically to deliver the audit work set out in this plan. In response to the government advice and subsequent restrictions, we will continue to work remotely until such time that it is safe to resume on-site activities. I remain committed to ensuring that the work of Audit Wales staff will not impede the vital activities that public bodies need to do to respond to ongoing challenges presented by the COVID-19 pandemic.

Audit of financial statements

4 I am required to issue a report on the Charity's financial statements which includes an opinion on their 'truth and fairness'. In preparing such a report, I will:

- give an opinion on your financial statements; and
- assess whether the Trustee's Annual Report presented with the financial statements is prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit, Risk and Assurance Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

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

Audit of financial statements risks

9 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statements risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
The Charity uses a cash-based financial system rather than an accruals-based system. This increases the risk that income and expenditure will be misstated and accounted for in the wrong financial year.	The audit team will test the recognition of income and expenditure to ensure it is recorded in the correct financial year.
Other areas of audit attention	
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Fee, audit team and timetable

10 My fees and planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate facilities and access to documents are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

11 Fee rates for 2021 are unchanged from last year. The estimated fee for 2021 is set out in **Exhibit 2**.

Exhibit 2: audit fee

This table sets out the proposed audit fee for 2021, alongside the actual audit fee for 2020. The increase in the fee is due to the income received by the Charity in 2021 exceeding the limit that requires a full external audit of the financial statements compared to an independent examination of the financial statements in 2020.

Audit area	Proposed fee for 2021 (£)[2]	Actual fee for 2020 (£)
Audit of financial statements	£10,583	£1,650

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

13 Further information on my fee scales and fee setting can be found on our website.

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

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

Audit team

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

Exhibit 3: my audit team

This table lists the members of the local audit team and their contact details

Name	Role	E-mail address
Derwyn Owen	Engagement Lead	derwyn.owen@audit.wales
Mike Jones	Audit Manager	mike.jones@aduit.wales
Alice Rushby	Audit Lead	alice.rushby@audit.wales

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

Timetable

16 We will continue to undertake such remote work as is possible during the COVID-19 national emergency and may need to revise the timetable as work progresses.

Exhibit 4: timetable

This table sets out the original milestones for the planned audit outputs

Planned output	Work undertaken	Report finalised
2021 Audit Plan	• November – December 2021	• December 2021

Planned output	Work undertaken	Report finalised
Audit of financial statements work: • Audit of Financial Statements Report and Management Letter • Opinion on Financial Statements	• November – December 2021	• December 2021

Appendix 1

Other future developments

Future changes to UK GAAP

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there have been only limited changes to FRS 102 since.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instruments and leases.

Good Practice Exchange

Audit Wales' Good Practice (GPX) helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. This year the work has focused on COVID-19 learning. Further information on this can be found our website.

Brexit: The United Kingdom's future outside the European Union

The United Kingdom left the European Union on 31 January 2020 under the terms of the Withdrawal Agreement. Between then and 31 December 2020, the UK entered a transition period, during which it continued to participate in EU programmes and follow EU regulations. On 31 December 2020, the transition period ended, and a new relationship between the UK and EU started, on the basis of a new free trade agreement.

The new agreement means some substantial changes in the trading relationship between the UK and the EU. There will also potentially be changes in administrative areas previously covered by EU law. In the short term, the UK has incorporated EU rules into domestic law. However, it is likely than in some key areas, such as public procurement, agricultural support and state aid, the UK will seek to diverge over time. In changing these rules, there will be some important constitutional issues around the relationship between the UK Government and devolved governments.

The wider opportunities and risks for Wales' economy, society and environment will become clearer as public services move from managing the short-term risks, especially around disruption to supply chains, to adapting to a different relationship with the EU and the wider world. We are also awaiting further details on the UK Government's plans to replace EU funding schemes for regional development and rural development.

The Auditor General will continue to keep a watching brief over developments. In November, he wrote to the Chair of the External Affairs and Additional Legislation Committee setting out some observations on the latest position with respect to preparations for the end of the transition period. His letter can be found here. His previous report on public bodies Brexit preparations can be found here with his follow up on progress here.

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Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee April 2022

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2021/22 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 2021/22 was agreed by the Audit Risk & Assurance Committee in April 2021 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

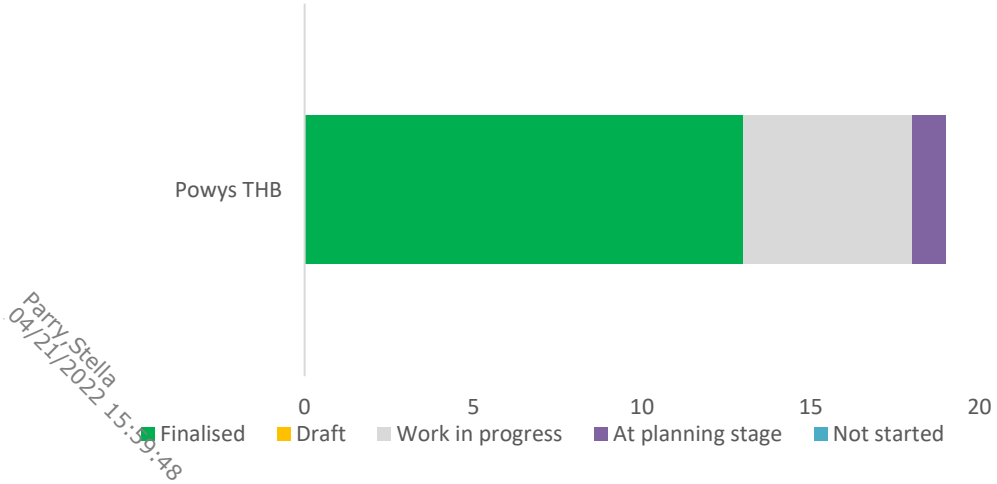
Since the March 22 meeting of the Committee, three reviews have been finalised. Details of these are included in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Budgetary Control	Substantial	
Machynlleth Hospital Reconfiguration Project	Reasonable	
Network and Information Systems (NIS) Directive		

3. Delivery of the 2021/22 Internal Audit Plan

There are a total of 19 reviews included within the 2021/22 Internal Audit Plan, and overall progress to date is summarised below.



From the graph above, it can be seen that thirteen audits have been finalised so far this year.

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

Due to the Covid related pressures faced by the Health Board during the year and resourcing issues within the Internal Audit team, the agreed plan has been subject to ongoing review and adjustment. At the meeting in February 22, the Committee formally agreed the deferral of four audits from the 2021/22 plan, these are recorded within the assignment status schedule under Appendix A.

The remaining nineteen audits within the 2021/22 plan still provide sufficient coverage across the Health Board to allow for the provision of a full Head of Internal Audit annual opinion at the end of the year. The draft Opinion is scheduled to be reported to the May 22 meeting of the Committee.

On the basis of the outcomes of the audits already completed and the current position of those that are in progress, it is anticipated that the annual opinion will be positive, with a likely rating of Reasonable Assurance. This will however be subject to confirmation as the outstanding audits are completed.

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

Appendix B shows the current level of performance against the Audit & Assurance Key Performance Indicators.

4. Engagement

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

Board / Sub Committees

- Board – 30 March

Health Board Meetings

- James Quance, Interim Board Secretary – 5 & 11 April
- Sarah Powell, Assistant Director of Workforce & OD – 5 April

5. Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Note the outcomes from the finalised 21/22 audits; and
- Note the progress with delivery of the 21/22 plan.

ASSIGNMENT STATUS SCHEDULE

Planned output	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Received	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Access to Systems	Q1	07/06	16/07	21/07	19/08	19/08	Reasonable	September	Final
Estates Assurance – Control of Contractors	Q2	05/07	05/08	12/08	20/10	21/10	Limited	November	Final
Midwifery – Safeguarding Supervision	Q2	21/07	18/10	27/10	04/11	05/11	Reasonable	November	Final
Medical Equipment & Devices	Q2	15/07	12/10	19/10	28/10	29/10	Reasonable	November	Final
Theatres Utilisation	Q2	13/07	08/11	09/11	21/12	04/01	Reasonable	January	Final
Covid Recovery and Rehabilitation Service	~~Q2~~ Q3	04/10	15/12	17/12	07/01	10/01	Substantial	January	Final
Dementia Service – Dementia Home Treatment Teams	Q2	23/08	29/11	09/12	11/01	11/01	Reasonable	January	Final
Waste Management	Q4	15/11	10/12	21/12& 20/01	27/01	27/01	Reasonable	March	Final
Job Matching & Evaluation Process	Q3	03/11	05/01	19/01	08/03	08/03	Reasonable	March	Final
Mortality Reviews	~~Q2~~ Q4	10/01	17/02	02/03	09/03	10/03	Reasonable	March	Final
Machynlleth Hospital Reconfiguration Project	Q2	27/09	22/11	23/11	06/03 & 03/04	08/04	Reasonable	April	Final
Budgetary Control	Q4	03/02	21/03	30/03	12/04	12/04	Substantial	April	Final
Network and Information Systems (NIS) Directive	Q4	10/01	21/03	30/03	14/04	14/04	Reasonable	April	Final
Occupational Health	Q3	02/03						May	Work in Progress

Planned output	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Received	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Breath Well Programme	Q3	11/04						May	Work in Progress
Concerns Tracking/Monitoring Assurance	Q4	13/12						May	Work in Progress
Risk Management & Assurance	Q4	05/04						May	Work in Progress
Follow-up Action Tracker	Q4	07/04						May	Work in Progress
Site Management (Advisory)	Q4							July	Planning
Reviews Deferred / Removed from the plan									
Cancer Services	Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
Performance Management & Reporting	Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
North Powys Well-being Programme	~~Q3~~ Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
Looked after children with mental ill health	~~Q3~~ Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							

Key Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100% 13 out of 13	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		54% 7 out of 13	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		100% 13 out of 13	80%	v>20%	10%<v<20%	v<10%

Assurance Ratings

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

Office details:

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

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

Budgetary Control

Final Internal Audit Report

April 2022

Powys Teaching Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

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

Contents

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Distribution:	Andrew Gough, Deputy Director of Finance
Committee:	Audit, Risk and 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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for budgetary control.

Overview

Our overall rating of Substantial Assurance reflects that there is clear and concise guidance in place for budget holders, procedures are being adhered to and the Health Board's financial position is being reported internally and externally within agreed timescales.

We identified just one matter requiring management attention, and this concerns the recording of budget holder meetings.

Report Classification

	Trend
Substantial  Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.	 2019/20

Assurance summary[1]

Assurance objectives		Assurance
1	Budgetary Control Guidance	Substantial
2	Compliance with Procedures	Substantial
3	Reporting of Financial Position	Substantial

Matters Arising

		Assurance objective	Control Design or Operation	Recommendation Priority
1	Budget Holder Meetings	2	Operation	Medium

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

1. Introduction

1.1 The review of Budgetary Control was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Teaching Health Board ("The Health Board").

1.2 The budgetary control arrangements of the Health Board are designed to complement the management decision-making process, whereby financial responsibility is delegated to those officers responsible for the commissioning or management of services.

1.3 Whilst the Chief Executive of the Health Board is the Accountable Officer, effective financial control within the Health Board is the responsibility of all officers under the direction of the Director of Finance, Informatics and IT and the Health Board.

1.4 The Lead Executive for this review is the Director of Finance, Informatics and IT Services.

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

- The Health Board fails to meet its statutory requirement to break-even; and
- Failure to control expenditure due to a lack of budget management.

2. Detailed Audit Findings

Objective 1: Appropriate and up to date Budgetary Control procedural guidance is in place and is available to all staff.

2.1 The primary Budgetary Control procedural guidance is Financial Control Procedure (FCP) 021. It was confirmed that this document is readily available to all staff on the PTHB Intranet site.

2.2 The document was originally approved in September 2011 (v1) but has been subject to regular review and updating since then and was last reviewed and updated in August 2021 (V6). The updated policy was approved by the Audit Committee.

2.3 The FCP sets out the responsibilities of budget holders, and the duties they must discharge in order to ensure effective financial control, and to ensure that the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented.

2.4 The Health Board also has approved Standing Orders (SO's) and Standing Financial Instructions (SFI's) which include sections on financial management which must also be complied with. These are published on the Health Board's website.

Conclusion:

2.5 There is appropriate and up to date budgetary control procedural guidance in place that is readily accessible by all Health Board staff. We have provided substantial assurance for this objective.

Objective 2: The Budgetary Control Procedures are effectively complied with by all appropriate staff.

2.1 Budgetary control responsibility has been delegated to budget holders from the Chief Executive via the Director of Finance. This is clearly set out in the Scheme of Delegation and Reservation of Powers (SoD) and the Standing Financial Instructions (SFI's) which form part of the Health Board's Standing Orders (SO's).

2.2 These were updated and approved by the Board in July 2021. Section 5 of the SFI's includes detailed instructions for Budget Setting, Budgetary Delegation, Financial Management Reporting and Budgetary Control and Reporting to Welsh Government.

2.3 In addition to the SoD and SO's / SFI's, Financial Control Procedure FCP021 describes how financial management responsibilities placed upon the Chief Executive and Director of Finance are to be discharged and implemented within the Health Board.

2.4 The FCP requires Principal Budget Holders to be notified in writing of their budgets via a 'Letter of Accountability' detailing the services for which the budget is provided and the amount of the budget. This also requires the Principal Budget Holders to sign off the Letter of Accountability as acceptance of their budget and budget management responsibility. For 2021/22, it was confirmed that budgets had been formally signed off at lead Director level.

2.5 We were informed that induction training for all new staff undertaken by Workforce and Organisational Development (WOD) includes a half day on finance, and if applicable specific budget holder training is included in this session. A copy of the presentation given to budget holders was reviewed (An Introduction to NHS Finance & Budgetary Management). The presentation, which is prepared by Finance and provided to WOD for inclusion in staff induction training, was found to be comprehensive and fit for purpose.

2.6 We were informed that additional training is also provided to budget holders on an ad hoc basis, for example if guidance is requested for a particular topic, and this is done by Finance staff on a one-to-one basis. This is currently done using Microsoft Teams.

2.7 Budget monitoring reports are prepared for budget holders each month from the financial data held in the Oracle system, and these are available to view using the QlikView system. The system is 'read only', and budget holders are only able to see the information relating to the cost centres that have been assigned to them.

2.8 The reports, which are in the form of a dashboard, detail the year-to-date expenditure against the budget, and highlight any variance. There are separate figures for pay and non-pay expenditure, and for income.

2.9 The dashboard also has supplementary information such as the value of open purchase orders, the number of requisitions without a Purchase Order and invoices in dispute.

2.10 A supplementary report is also provided by WOD that provides a breakdown of staffing costs for the current pay period, and this details the costs that have been charged to each cost centre by individual employee.

2.11 Finance staff hold regular monthly meetings with Budget Managers / Budget Holders to discuss their budgets, provide them with information regarding their budgets and to obtain explanations for any significant variances. Where applicable these explanations feed into the commentary that accompanies the reporting of the financial position to the Board and Welsh Government.

2.12 Budgets virements can be made between cost centres with the same budget holder, or between budget holders with agreement, but we were informed that this would be a rare occurrence.

2.13 There was evidence in the form of a Meetings Record that regular meetings are being held between Finance business partners and budget holders to help them understand all income and expenditure in their monthly budget holder reports. Although records are maintained of budget holder meetings held, notes or actions of individual meetings are not kept **(Matter Arising 1).**

2.14 It was also noted that the Meetings Record does not include a comprehensive list of all budget holders, so it is difficult to identify budget holders that have not held meetings with Finance quarterly in line with the requirement of the FCP **(Matter Arising 1).**

2.15 A schedule of cost centres is maintained that lists each cost centre, its description, the Finance lead and the annual budget. The cost centre hierarchy is also documented, and this shows the positions linked to each cost centre, but not budget holder names as these are constantly changing and it would be too time consuming to maintain and keep accurate and up to date.

Conclusion:

2.16 Our review has concluded that overall, budgetary control procedures are being effectively complied with. Responsibility for budgetary control has been clearly assigned and suitable training is provided to new budget holders. Detailed budget holder reports are available and Finance staff hold regular meetings with budget holders to help them maintain effective control over their budgets, although meeting records could be improved. We have provided substantial assurance for this objective.

Objective 3: There are appropriate and timely arrangements in place for reporting the financial position of the Health Board both internally and to Welsh Government.

2.17 The Health Board's financial position is reported to each meeting of the Board by the Director of Finance via the Financial Performance Report that is prepared by the Deputy Director of Finance. The report is also presented to each meeting of the Delivery and Performance Committee.

2.18 We were informed that the Health Board's financial position is not reported to any other forum's internally on a regular basis, although they do from time to time provide an overview of the financial position to groups such as the Finance

Senior Leadership Team and several other service forums across the Health Board.

2.19 Our review of the Financial Performance Report confirmed that it is comprehensive and includes all the expected financial information including the cumulative financial position against the financial plan, a summary of budget variances and a commentary highlighting areas of focus and financial pressure. The report also includes as an Appendix, the supporting narrative for the Monthly Monitoring Return (MMR) submitted to the Welsh Government.

2.20 External financial reporting is done to the Welsh Government through completion of the MMR which is a standard Welsh Government template that is completed by all NHS organisations in Wales. The MMR submitted to the Welsh Government is accompanied by a commentary report prepared by the Deputy Director of Finance.

2.21 Guidance on completion and submission of the MMR and supporting narrative has been provided by the Welsh Government in Welsh Health Circular WHC (2021) 011. This requires health organisations to meet Day 5 and Day 9 submission deadlines for their data tables and supporting narrative.

2.22 The MMR commentary reports submitted to the Welsh Government for October, November and December 2021 (Months 7, 8 & 9) were obtained and reviewed. These were found to be a comprehensive summary of the Health Boards financial position at the end of each month and included a response to the actions raised by the Welsh Government in their Reply Letter for the previous month.

2.23 Our review of the Financial Performance Reports and the MMR Commentary Reports for months 7 and 9 confirmed that the summary financial position reported to the Welsh Government was the same as that reported to the Board.

2.24 The Financial Performance Reports submitted to the Board meetings held on the 24/11/21 (M7) and the 26/01/21 (M9) confirmed that the MMR and supporting narrative had been submitted to the Welsh Government by the Day 9 submission deadline.

Conclusion:

2.25 There are appropriate and timely arrangements in place for reporting the financial position internally to the Board and externally to the Welsh Government. We have provided substantial assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1 - Budget Holder Meetings (Operation)	Impact
There was evidence in the form of a Meetings Record spreadsheet that meetings are being held between finance staff and budget holders to support them and help them manage their budgets, although no meeting notes are kept. Paragraph 12.3 of Financial Control Procedure (FCP) 021 requires the Director of Finance to ensure that there are regular, evidenced meetings between budget holders and the Finance Directorate at least quarterly. The FCP states that evidence can be as simple as a summary of the meeting and the queries raised, sent via email to the budget holder. At present there is no record of what queries are raised and issues discussed during meetings. We also note that the Meetings Record does not include a comprehensive list of all budget holders, so it is difficult to identify budget holders that have not held meetings with Finance quarterly in line with the requirement of the FCP. The review of the meeting records also showed that whilst the meeting date, period, Finance staff and budget holder names and a description of the budget area is recorded for each meeting, the cost centre was not always being recorded.	Incomplete records. Non-compliance with Financial Control Procedures. Budgets are not effectively managed by budget holders.
Recommendation	**Priority**
1.1 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. 1.2 The Meeting Record template maintained by Finance should be amended to include all cost centres within each area of the Health Board. This should then be reviewed on a quarterly basis to	**Medium**

identify those budget holders for which no meetings have been held so that where appropriate meetings can be arranged.		
Agreed Management Action	**Target date**	**Responsible Officer**
1.1 Action notes will be made at each budget holder meeting using the meeting record template with agreed leads and timescales. 1.2 The meeting record template will be updated to include all cost centres and will be reviewed on a quarterly basis.	April 2022 April 2022	Deputy Director of Finance Deputy Director of Finance

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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Machynlleth Hospital Reconfiguration Project

Final Internal Audit Report

April 2022

Powys Teaching Health Board

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Contents

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Auditors:	NWSSP: Audit & Assurance – Specialist Services Unit
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Committee:	Audit, Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 was undertaken to review the delivery and management arrangements in place to progress the Machynlleth Hospital Reconfiguration project; and the performance, for the period March 2020 to December 2021,against its key delivery objectives i.e. time, cost and quality.

Overall Audit Opinion and Overview

Following discovery of unforeseen issues during the demolition works the project costs have risen significantly.

Project changes to date (including the unforeseen issues) have totalled £1.135m, giving a current reported forecast overspend of £180k. This includes full utilisation of the project contingency at the current stage of the project (i.e. 34% programme complete). These financial pressures necessitated the transfer of £349k from the discretionary capital budget.

Management have stated that the associated reported delays, 7 weeks to date, will not adversely impact on service delivery (recognising services continue to operate from alternative locations for the duration of the project).

The significant matters arising at the project include:

- The need to ensure the timely completion of contract documentation at future projects;
- The ongoing review / development of the project risk register to ensure key details are captured; as well as considering the remaining project risks and available contingencies.
- Procedures for signing of contract documentation need to be developed to ensure any specific additional risks highlighted (including the absence of liquidated and ascertained damages) are accepted at the appropriate level of delegation; together with the enhancement of existing checklists.
- Recognising the extent of the cost escalation at such an early stage of the progression of the works, there is a need to evaluate the sufficiency of the structural and condition surveys undertaken during the design development stages to assess the impact on the affordability of the project and to determine any future actions.

Noting the priority ratings of the issues identified at the current report **reasonable assurance** has been determined.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance **Low to moderate impact** on residual risk exposure until resolved.	 2019/20

Assurance summary [1]

Assurance objectives		Assurance
1	Follow up	Reasonable
2	Governance	Reasonable
3	Design Development	Reasonable
4	Target Cost / Valuation	Reasonable
5	Contract Management	Limited
6	Project Management	Reasonable

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

Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Appropriate representation at the Project Board continued to be an issue.	2	Operation	Medium
2.2	A significant compensation event (value: £171k) had not been assessed and discharged within the stated contractual requirements.	2	Operation	Medium
3.2	There is an absence of an acceptable procedure to facilitate the signing of agreements / contract documentation in a complete and timely manner.	5	Operation	Medium
6.1	An exercise needs to be undertaken to evaluate the issues that have been encountered to date at the project.	6	Operation	Medium
7.1	A number of the current risks (as per the construction risk register) had not been costed.	6	Operation	Medium
7.2	A THB risk register, including a wider range of risks than that of the construction register, required further development to ensure all relevant details were captured.	6	Operation	Medium

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	Formal approval of enabling works, instructed ahead of FBC approval, should be evidenced.	2	Operation	Medium
3.1	Contracts should be in place prior to works / duties commencing; and executed in accordance with the THB's delegated authority limits.	5	Operation	High

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report.

1. Introduction

1.1 The Machynlleth Hospital Reconfiguration project ('the project') presents an opportunity for the THB to reshape the way community health and well-being services are delivered; with the integration of primary care services and clinical reconfiguration to establish a community well-being hub to improve access to health & social care, wellbeing, prevention and health promotion facilities.

1.2 Approval of the FBC was initially provided by Welsh Government in September 2018; however, subsequent to this, progress was paused due to planning issues; revisions to the delivery timetable; and the appointment of a new contractor via the SCAPE Contractor's Framework.

1.3 A 'refreshed' Full Business Case (FBC) was submitted to the Welsh Government in September 2020, seeking capital investment of £14.923m:

- £4.269m: estates compliance and fabric issues; and
- £10.654m: clinical reconfiguration / refurbishment for the provision of a base for health, local authority and third sector teams.

1.4 Whilst the scope of the project remains largely unchanged, subject to some design enhancements, this demonstrated an increase of circa 90% from the previous FBC and an increase in the delivery programme from 56 weeks to 77 weeks.

1.5 Welsh Government approval (£15.188m: FBC request plus £0.265m for decarbonisation measures) was received in March 2021, with the main works commencing on site in May 2021.

1.6 This was the second audit of the project, with the 2019/20 review determining Reasonable Assurance.

1.7 The audit brief was issued to the Director of Planning & Performance (the previous responsible officer) in accordance with the Audit Charter. It is recognised that Executive responsibility for capital projects changed, mid-audit, to the newly established role of Director of Environment.

1.8 The potential risks considered in the review were as follows:

- Failure to achieve key project objectives (e.g. delivery to time, cost and quality);
- The target cost may not provide sufficient value for money;
- Appropriate approvals may not be in place to progress through key project development stages;
- The interests of the THB may not be adequately protected;
- Adequate monitoring and reporting may not be demonstrated; and
- The project may not be effectively managed.

2. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost and quality) for the period from the date of the previous audit report.

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 At this interim audit of the Machynlleth Hospital Reconfiguration Project, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 The project is anticipated to be delivered marginally outside of the original contract completion date – a move from 7 November 2022 to 23 December 2022. This seven-week delay has been caused by a number of unforeseen issues (including five weeks attributed to the discovery of a well on site) and it is recognised that the contractor has amended its work programme to minimise the wider impact on the project.

2.4 Whilst the delays to project completion will impact the moving-in dates for the services involved, management have confirmed they can continue to be provided from existing/alternative accommodation for the duration of the project.

Cost

2.5 The cost adviser report available at the date of fieldwork (November 2021), reported the cost position as follows:

	Approved budget	Current forecast	Variance
Construction works	£10,494,019[1]	£11,451,824	£957,805
External adviser fees	£184,785	£219,906	£35,121
THB other	£490,000	£478,729	(£11,271)
Costs expended against original FBC	£930,571	£930,571	£0
Contingency	£780,000	£0	(£780,000)
Additional Decarbonisation funding	£227,051	£205,399	(£21,652)
Total	**£13,106,426**	**£13,286,429**	**£180,003**

[1] *The figure approved in the FBC was subsequently reduced slightly through further analysis and market testing, to reach the agreed £10.316m contract price.*

2.6 At the date of reporting, changes (both incurred and forecast – including those resulting from the unforeseen issues), totalled £1.135m, have adversely impacted on the works cost /project budget giving a forecast project overspend of £180k.

2.7 The THB has sought to mitigate this position by:

- full utilisation of the project contingency;
- transfer of £349k from discretionary capital funds, providing a remaining contingency of £169k to the completion of the contract; and
- identification of cost reductions against other budget headings e.g. THB decarbonisation funding and THB other fees (*see* ***para 2.5***).

2.8 It is acknowledged that the additional works (and associated costs arising) would have been incurred regardless at the project, but the UHB may have been in a more informed position at an earlier date, enabling provisions within the original business case/contractual arrangements to address the same; and thereby reducing the existing cost pressures and draw down from its discretionary capital programme (see further detail at the ***Project Management*** section).

Quality

2.9 Noting the additional unforeseen works arising to date and the impact on the project, it has been recommended that the THB assess the performance of both its advisers and construction team to determine whether any of the issues could have been identified earlier (through surveys etc); or provided for within original contract/funding provisions. The same would determine any further actions to be taken by the THB at this or any future projects.

The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention, with moderate impact on residual risk exposure until resolved.

Follow Up: Assurance that previously agreed management actions have been implemented.

2.10 The status of actions arising from the previous review (report issued February 2020: *Reasonable Assurance*) was as follows:

	High	Medium	Low	Total
Closed	-	3	1	**4**
Superseded	1	1	-	**2**
Outstanding	-	-	-	**-**
Total	**1**	**4**	**1**	**6**

2.11 The detail in support of the above summary is included in **Appendix B.**

2.12 Whilst noting that two recommendations have been superseded by new issues raised at this report, and that four recommendations have been closed, **reasonable assurance** has been determined in respect of the actions taken to address previously agreed audit recommendations.

Governance: To ensure that appropriate governance arrangements were in place for the current project phase, including operation of effective reporting and accountability lines; and appropriate approvals were in place.

2.13 The project operated within a well-defined governance structure, as defined within the Project Initiation Document and Project Board Terms of Reference. The Project Board was supported by an Operational Sub-Group and Client Progress Team, with forums meeting regularly during the period reviewed.

2.14 Appropriate reporting channels were observed i.e. to the Project Board and onward to the Innovative Environments Group (which includes Executive membership).

2.15 Roles and responsibilities were operating as expected, with clear visibility from the Senior Responsible Officer, Project Director and internal Senior Project Manager.

2.16 However, as reported at the 2019/20 audit of the project (see **Appendix B**), there remained difficulty during the period in securing full representation at Project Board. At the time of the current review, there were notable absences from Primary Care and Operational staff members. Whilst recognising that engagement from these parties during the early demolition works was not essential, improved attendance should be sought moving forward (**MA1**).

2.17 Noting the delay to the anticipated FBC approval timeline (anticipated December 2020, received March 2021), the THB undertook enabling works (including ecology management and decanting), to the value of £202k, prior to Welsh Government FBC approval being received. We have not evidenced explicit approval for this work to be undertaken. Noting the same, the THB effectively progressed this work at risk (**MA2**).

2.18 Whilst noting some areas for improvement, the governance structure generally operated effectively during the period reviewed. **Reasonable assurance** has therefore been determined.

Design Development: Assurance that the design was sufficiently progressed and signed off by users in accordance with the development programme; that operational policies and critical care pathways were fully considered; that the design was sufficiently developed at the formulation of the target cost; and that equipment requirements were fully considered.

2.19 The original FBC was approved by Welsh Government in August 2018. Subsequent to this, the appointed contractor team underwent internal reorganisation, driven by their corporate financial position, and the project was assigned a new team. This had a significant impact on forecast project costs - the new team assessed costs as 40% higher with an associated prolonged programme (see **para 2.5** for summary of cost changes).

2.20 A decision was therefore taken to appoint a new contractor from the SCAPE framework. During this period, the original architect also entered administration, with a replacement appointed by the new contractor.

2.21 At the time of the prior audit (2019/20), the new contractor had been engaged to undertake a feasibility study, but formal contracts had not been entered into.

2.22 Recognising that the original FBC had already been subject to full design development and sign off processes, management advised that the Welsh Government requested the refreshed FBC to focus only on the provision of additional detail for newly designed areas, as follows:

- the road junction;
- enhancements resulting from Covid-19 learning; and
- decarbonisation measures.

2.23 These amended areas were clearly set out in the introductory narrative of the refreshed FBC.

2.24 It was confirmed that the new elements of design had been developed to 1:50 level and signed off by the Head of Capital. Associated operational policies and equipment lists had also been updated, reviewed and signed off, in consultation with the relevant departments.

2.25 A derogations register had been prepared, and was included within the Estates Annex of the refreshed FBC.

2.26 However, recognising the extent of the cost escalation at such an early stage of the progression of the works on site (see further detail at the ***Project Management*** section), the potential sufficiency of the structural and condition surveys undertaken during the design development stages (both by the original contractor and the new contractor) should be reviewed (see **MA6** which recommends a full evaluation be undertaken as to the identification of the extensive additional work items, the adequacy of original survey information, the

impact on time and cost parameters and any associated responsibilities/liabilities etc.).

2.27 **Reasonable assurance** has therefore been determined in this area.

Target Cost / Valuation: An assessment of the processes established to evaluate the initial tender packages prior to approval and the extent of benchmarking undertaken; consideration of the risk assumptions built into the target cost and confirmation that appropriate approvals were in place to accept the target cost. Evaluation of the interim valuation arrangements applied at the project.

2.28 As previously presented in the 2019/20 audit report for this project, the construction cost has significantly increased following a change in appointed contractor. This review has only considered the determination of the final agreed contract price.

2.29 The changing construction costs and programme duration can be summarised as follows:

Timeline	Construction cost	Programme Duration
August 2018 – FBC submitted	£5.8m	56 weeks
September 2018 - Revised cost plan	£6.5m	70 weeks
October 2018	Communication from SCAPE confirming that due to cost increases, the minor framework was no longer compliant for this project	
May 2019	£7.9m	86 weeks
August 2019 - Validation report from Feasibility Study undertaken by the new contractor	£9.975m	109 weeks
August 2019 - Update of validation report from Feasibility Study	£9.576m	93 weeks
September 2020 – Agreed cost resulting from the contractor's market testing exercise	£10.316m	72 weeks

2.30 The total cost was subject to appropriate market testing by the contractor, and subsequently scrutinised and substantiated by the THB's Cost Adviser.

2.31 It was noted that the level of competition was reduced at a number of packages, primarily recorded by the contractor as being due to the remote location of the project site. From a total of 34 packages market tested, three packages received only one quotation, and a further seven received two quotations, compared with the five quotations standard as per Standing Financial Instructions (noting the value of the packages in question).

2.32 A review of seven market tested packages (with a combined value of £2,391,835 / 32% of the total building works), was undertaken at this audit. Prices applied by the contractor were accurately supported by sub-contractor quotations, and at each package the lowest tender had been selected for inclusion within the total price.

2.33 The contract price and supporting risk and value for money information was appropriately presented to the THB in the cost adviser's 'Value for Money' report. This report was formally accepted as part of the overall refreshed FBC by the Project Board. Whilst noting that the reduced competition achieved at some packages was not summarised within this report, management confirmed that the detail was separately presented and considered.

2.34 **Reasonable assurance** has been determined in this area (see the ***Contract Management*** section in respect of valuation and timeliness of payments.

Contract Management: To ensure that contractual costs were robustly agreed; and that appropriate contract documentation was in place for the contractor and THB's advisers.

2.35 The following contracts were reviewed during the audit:

- Contractor Pre-Construction Delivery Agreement;
- Contractor Construction Delivery Agreement; and
- Project and Cost Management Services Delivery Agreement.

2.36 Each contract had been executed after works commenced, with delays ranging from five to 19 weeks. It was also noted that the Project and Cost Management Services agreement had not been executed within the THB's approved Scheme of Delegation (**MA3**).

2.37 The form of contract that is generally applied at major NHS Wales projects (as set out within the requirements for the NHS Wales national frameworks) is NEC Option C (Target Contract with Activity Schedule, including pain/gain share mechanism). However, at this project, recognising an alternative framework (SCAPE) has been used, the THB selected the NEC Option A (Priced Contract with Activity Schedule) form of contract.

2.38 This selection was agreed by the THB and the rationale documented within the FBC (as previously recommended in the 2017/18 Llandrindod Wells Reconfiguration Project audit report).

2.39 In evaluating the potential issues giving rise to the time and cost impact at the project (as recommended at **MA6**), the THB should also give consideration to whether the chosen form of contract has reduced the incentive for the contractor

to work collaboratively with the THB to achieve cost savings, noting they would not retain any "gain" from savings achieved.

2.40 It was confirmed that the project's contract price had been appropriately included within the Contractor Construction Delivery Agreement, following the market testing exercise.

2.41 A review of the Delivery Agreement noted:

- the Agreement allows for the inclusion of project specific 'additional Employer's risk' and this has been applied at the project. However the reporting and acceptance of the same has not been identified; and the project risk register does not accurately reflect the risk owner (**MA4**); and
- the Agreement does not include delay damages, – a decision taken by the THB following advice from the external Project Manager; and in line with that previously taken at the Llandrindod Wells Reconfiguration Project (and reported at our 2020/21 Llandrindod Project audit) (**MA5**).

2.42 To ensure awareness of key contract amendments / risk items included within contract documentation, the THB's existing checklist / cover document should be enhanced for such items to be highlighted when passed for execution (**MA3**).

2.43 At the date of the audit fieldwork, contractor payments totalled £1,705,918 (from the commencement of the project). The August 2021 valuation (£306,114) was reviewed, confirming the agreed monthly payment had been subject to appropriate scrutiny and adjustment by the cost adviser, in line with contract requirements.

2.44 A sample of four contractor payments (May 21-August 21) was additionally reviewed for timeliness of processing. All four had been paid after the contractual due date, however it is recognised the delays did not arise from within the THB, but attributed to the contractor in delays in generating the invoices. This should be formally recorded by the THB in the event of any future disputes, but no formal recommendation has been raised at this report.

2.45 Noting the areas for improvement and the continuing issues regarding contract execution within the THB, **limited assurance** has been determined in this area.

Project Management: To ensure that appropriate project management controls were applied, including in the management of contractor and adviser performance, project risks and change control.

2.46 Demolition works progressed on site during June and July 2021 as programmed, a number of issues emerged which had been reported as not foreseen when the contract price was determined. The issues, which have led to significant project cost increase, include:

- additional asbestos discovery;

- the structural integrity of the main façade;
- roofing issues,
- increasing decarbonisation costs; and
- the discovery of a previously unidentified well and sump in the hospital grounds (with the well incurring a five-week delay to the critical path).

2.47 The THB should undertake a full evaluation of the potential causes of these issues not having been identified earlier, both during the period of original FBC development, and the FBC refresh undertaken by the new Contractor. It should be ensured that any lessons can be learnt in a timely manner, to feed into this and other projects in development, and that any performance issues with the appointed advisers or contractor can be identified and managed (**MA6**).

2.48 Whilst recognising the improved budget position at the project, owing to the transfer from discretionary capital funds, management should ensure that a strengthened governance framework is operational for the remainder of the project (see **MA1, MA2 & MA7**).

2.49 Notwithstanding the above situation, expected project management processes were assessed as follows:

- Key performance indicators: these had been completed as required at the end of the FBC stage and following three months on site, with scores generally positive for all parties. Identified performance issues have also been referenced in Project Board minutes and the Project Manager's progress reports.
- Risk management arrangements: these were defined within the Project Initiation Document, and the risk register was routinely reviewed at Project Board. An enhanced risk register, combining construction and THB risks, was in development at the time of review. Whilst recognising the improved nature of this document, some detail (including accurate costs and risk ownership) remained to be captured (**MA7**).
- Change management: at the time of review, six changes had been instructed, totaling £92k in value (excluding the above-mentioned significant changes which had not been assessed / instructed). A sample of four changes were reviewed (total £74k: 81%] and confirmed to have been progressed in accordance with the formal contractual arrangements and defined delegated limits. However, the timely scrutiny and approval of costs in relation to Compensation Event No.1 in the sum of £202k (comprising a number of component parts, in relation to enabling works undertaken prior to main works commencing), has not been identified (see **MA2**).

- Reporting: Project Progress Reports had been submitted to Welsh Government bi-monthly as required, with reported information reconciling to other project reports (i.e. Cost Adviser and external Project Manager).

2.50 Lessons need to be learnt to ensure similar scenarios can be avoided, wherever possible, at future projects, and to identify whether any of the appointed parties hold responsibility for failure to consider the issues at an earlier stage. Recognising that the THB is committed to this evaluation process, **reasonable assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Governance - Project Board Attendance (Operation)	**Impact**
The role, responsibilities and membership requirements of the Project 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 routinely attended the Operational Sub-Group, where matters directly impacting their service lines, such as decant arrangements, were managed. It remains a priority for the THB to ensure appropriate representation at the Project Board going forward, as the project enters the build / refurbishment phase – particularly noting the challenges ahead in relation to management of the reduced project contingency. Noting that poor Project Board attendance was also identified at the prior audit of the project, this recommendation supersedes the previous recommendation (**Appendix B - MA3**).	Potential risk of: • Inability to make decisions in a timely manner; • Reduced ability to make the right decision for all parties.

Recommendations		Priority
1.1	The Project Board terms of reference should be reviewed to identify a smaller number of key individuals to form the core membership. The membership should be reviewed at appropriate intervals to ensure it remains relevant to the current stage of the project.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed. The terms of reference have been reviewed and updated; and were approved at the February 2022 Project Board meeting.	Actioned since fieldwork	Senior Responsible Officer & Project Director

Matter Arising 2: Governance – Enabling Works (Operation)	**Impact**
Welsh Government granted approval of the refreshed FBC on 24 March 2021, which management advise was a delay to the anticipated approval timeline (which had been expected circa December 2020). As cited in the NHS Wales Investment Infrastructure Guidance - Annex 9 (para. 1&2): *"In principle, there should be no enabling or advanced works commenced or committed on site before FBC approval. This is because there is no commitment to fund the total project cost until that approval has been given. In exceptional circumstances enabling or advanced works may be commenced before FBC approval but the case for such works must be included within the OBC and explicit written approval given by Welsh Government".* A package of enabling works was instructed ahead of FBC approval, to the value of £202k, via Compensation Event No.1, with a risk of the Main Contractor's team (having been assembled for the Machynlleth works) being reallocated to other projects, and time-critical ecology management issues to address. The potential for an enabling works package was raised at the Capital Resource Meetings with Welsh Government. However, formal agreement was not explicitly documented by Welsh Government recognising these meetings are not a recognised approval forum. Additionally, the allocation of early funding ahead of the main FBC has not been identified. Additionally reporting to the Board, outlining that the project (enabling works) was effectively proceeding at risk, was not evidenced. The Investment Infrastructure Guidance further states (Annex 9, para. 9): *"Enabling works or advanced works should not be let as Compensation Events. They need to be fully designed and market tested with complete Works Information. They should be let as a separate project contract based on the NEC3 ECC form of contract and associated Designed for Life: Building for Wales conditions. Liability for design and construction elements should be clearly identified and comprehensive insurance arrangements put in place for the construction works."*	Potential risk of: • Non-compliance with Welsh Government requirements. • The project progressing at risk without appropriate approvals cover in place. • Project time and cost is not appropriately controlled, with reduced ability to maintain an accurate project budget. • Compensation Events may be charged at contractor assessed values by default.

Formal assessment and approval of Compensation Event No.1 by the project team took place in August 2021 – significantly after the delivery of the work itself. It has been evidenced however that the THB was sighted on, and agreed to £171k, via Project Manager's Instructions 07 & 08, in December 2020. Being cognisant of the project's ongoing contingency challenges, the management of a robust and timely change process is imperative.		
Recommendations		**Priority**
2.1	***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.	**Medium**
2.2	Compensation events should be assessed and discharged within the stated contractual requirements.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	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 sensitive manner). Welsh Government gave no indication of risk to any expenditure during this period which may have warranted escalation.	At future schemes	Respective Senior Responsible Officer(s)

2.2	Agreed. Compensation events will be addressed in accordance with the contractual requirements.	Ongoing through to project completion	Project Director & Project Manager

Matter Arising 3: Contract Management - Contract Execution (Operation)	**Impact**

The following contracts were reviewed:

- Main Contractor pre-construction delivery agreement;
- Main Contractor construction delivery agreement; and
- Project and Cost Management Services delivery agreement.

A number of issues were identified in the execution of the contracts:

Contract	Value	Works start date	Contract date	Delay in execution	Signed within delegated limits?
Main Contractor pre-construction delivery agreement	£480,766	16/12/2019	2/3/2020	10 weeks	✓ Chief Executive & Chair
Main Contractor construction delivery agreement	£10,315,893	17/5/2021	19/5/2021	2 days	✓ Chief Executive & Vice Chair
Project & Cost Management Services delivery agreement	£144,786	6/1/2020	22/5/2020	19 weeks	*X* Chief Executive only [1]

[1] *The THB's Scheme of Delegation states that the Chief Executive has authority up to £100K, above which the Chair (or nominated deputy) should also be involved.*

Noting that issues with contract execution were also identified at the prior audit of the project, this recommendation supersedes the previous recommendation (**Appendix B - MA5**).

Impact

Potential risk of:

- The project progresses at risk without appropriate contractual cover in place.
- Non-compliance with the THB's Standing Orders.

Recommendations		Priority
3.1	***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.	**High**
3.2a	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.	**Medium**
3.2b	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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed.	At future contracts	Project Director, in liaison with Corporate Governance
3.2a	Agreed.	May 2022, for subsequent application at future contracts	
3.2b	Agreed.		

Matter Arising 4: Contract Management - Additional Employer's Risks (Design)	**Impact**
The standard form to the Construction Delivery Agreement allows for the inclusion of project specific 'additional Employer's risks'; and this has been applied at the project. Following advice and guidance from the appointed professional advisers, the THB has accepted ownership of six specific additional risks in the contract, including: • S278 works; • Exclusion from works information for the re-roofing of the Adult Mental Health building and the ramped linked corridor building; • The finish to the existing wall of the Adult Mental Health building, courtyard area and East entrance / admin block – will receive decoration as part of the works but no guarantee is offered by the contractor; • Existing building structure (definition as to what is included as part of the works information and what would be treated as a compensation event under the contract should the need for additional works / surveys arise); • Fire Safety Strategy and implications of any changes post the contract date; and • Brexit (implications of any delays to works / increase in cost). The reporting and acceptance of the same in accordance with THB delegated limits has not been identified. The THB's existing checklist /cover document (supporting contracts for signature) could be enhanced to highlight key contract documentation amendments and / or associated risks. This would ensure the signatories are appropriately informed of decisions taken by the project team. From review of the project risk register, it was noted that not all of the above risks had been defined appropriately – three had been allocated as contractor risks. Should the risks come to fruition, the expectations for mitigation will be misaligned. Similarly the contingency provisions may not be adequate.	Potential risk of: • An informed decision cannot be taken by relevant parties.; • Contractual risks accepted by the THB not being managed effectively.

As per MA7, the THB is further developing its own risk register to ensure all relevant details (both construction and operational risks) are captured. This exercise should also ensure appropriateness of allocation of contractually accepted risks.		
Recommendations		**Priority**
4.1	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 costs (where appropriate) are captured.	**See recommendation 7.2**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	See recommendation 3.2b		
4.2	See recommendation 7.2		

Matter Arising 5: Contract Management - Delay Damages (Operation)	**Impact**
The SCAPE NEC Option A Construction Delivery Agreement, as completed at this project, specifically excluded delay damage clauses X5 and X7. The exclusion of delay damages was previously discussed at the 2020/21 Llandrindod Wells Reconfiguration Project audit report with the recommendation that: *"In the event the THB decides not to include delay damages at future individual contracts, there should be evidence of the associated risk assessment and senior approvals of the decision at an appropriate stage of contract negotiations (in accordance with THB delegated limits)."* In considering the exclusion at the Machynlleth project, the Project Director received advice from the External Project Manager, which was shared with the Project Board and Senior Responsible Officer. This approach complied with the THB's response to the recommendation, but, whilst acknowledging the same, it is considered that such should be approved at Chief Executive / Chair level. It is noted that at other Health Boards, this is managed via a summary checklist attached to the contract, when provided for signature. This will highlight the selection of any secondary options i.e. with a financial impact such as delay damages to ensure the signatories are appropriately informed of decisions taken by the project team.	Potential risk of: • An informed decision cannot be taken by relevant parties.

Recommendations		**Priority**
5.1	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**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	See recommendation 3.2b		

Matter Arising 6: Project Management – Evaluation Exercise (Operation)	**Impact**
Significant and unforeseen issues have emerged at the project as the demolition works progressed. At the date of reporting, changes (both incurred and forecast – including those resulting from the issues above), totalled £1.135m. This gives a forecast project overspend of £180k (including full utilisation of the project contingency); and a 7-week delay after 26 weeks on site (34% into the original 77-week programme). There may be several factors which could have contributed to the failure to identify these issues, including: • Insufficient designs / surveys (as undertaken by either the original contractor or the current contractor; • Insufficient challenge by the appointed advisers (both the THB's team and the contractor's, e.g. structural engineer); • Insufficient costings and risk allowance by the contractor; and • Late market testing of the decarbonisation package. To date, the costs associated with the unforeseen issues have been borne by the THB. It should be confirmed that there was no provision within the contractor's risk allocation that may cover some of these issues. The application of the NEC Option A form of contract in contributing to the current cost position should also be considered, to inform contract selection at future projects. The THB has already acknowledged there are questions to answer, and an initial overview of potential causes were included in the briefing paper to the Executive Team dated 17 November 2021. The THB should now fully evaluate these matters, to ensure lessons learnt are captured and to establish whether there are any adverse performance issues associated with appointed duties to date.	Potential risk of: • Lessons are not learnt from issues experienced at this project. • The THB may incur increased costs as a result of the poor performance of appointed experts.

The evaluation should also ensure the THB has sufficient information to deal with any future potential claims / disputes if the same arises at this project.			
Recommendations			**Priority**
6.1	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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	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 unforeseen demolition works. Further analysis is required, and whilst some lessons learnt have been identified, there is no clear indication of any significant attributable fault to the Project Team.	Actioned since fieldwork	Senior Responsible Officer & Project Director

6.1	In general, the refurbishment work on the aged PTHB building stock is providing good evidence of the required, enhanced, level of contingency needed going forward, and this was also supported by the WG Gateway Review in early 2021 for Llandrindod Wells. As demolition was substantially complete, it was unlikely that any benefit would be derived by bringing this forward to the busy 'delivery' period of the project when there was always a clear commitment to consider on completion. Also, it was unlikely that any clear action would have had any substantial basis for success, particularly in the arena of anticipating 'unforeseen' risks once a reasonable approach was evident to surveys and balance of risk vs cost of undertaking surveys.		

Matter Arising 7: Project Management – Risk Register (Operation)	**Impact**
A costed risk register was submitted to Welsh Government within the FBC.. However, review of the current risk register (maintained by the External Project Manager), noted that a number of current risks (assigned to both the THB and contractor) remained to be costed. Noting the current project budget issues, and to aid risk and contingency management going forward, all risks should be costed. The THB has also developed its own risk register, recognising the need for a wider range of risks (i.e. operational, design, planning, strategic and financial) to be addressed. At the time of reporting, this document required further development to ensure all relevant details are captured (including detail such as the risk owner, mitigating actions in place etc). On completion of the above exercises, remaining project contingency (currently reported as £169k following the recent allocation of discretionary capital funds) should be reconciled with the costed risk register, to ensure the sufficiency of remaining contingency to project completion.	Potential risk of: • The Project Board is not able to effectively manage the key risks to the project. • Project risks may exceed available contingency funds.

Recommendations		**Priority**
7.1a	The External Project Manager should ensure the construction risk register is fully and appropriately costed	**Medium**
7.1b	The costed risk register should be reconciled to remaining project contingency. Any insufficiencies identified should be reported appropriately within the THB	
7.2	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 costs (where appropriate), are captured.	

Agreed Management Action		Target Date	Responsible Officer
7.1a	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, through to project completion.	Project Director, in consultation with External Project Manager
7.1b	The updated risk register (March 2022) details that the project is operating within contract budget with £162K contingency remaining. The current value is around the original value of the project whilst major concern flagged by Audit, in late 2021 (during fieldwork), was that the contingency had been largely expended in the front end of the project. It is contended that this is always where the contingency comes under pressure as this is where demolitions and groundworks (unforeseen) are undertaken. It is evident that the Audit concern has not come to fruition as some 6 months after the audit concern, the financial position remains around £180K over the original contract value and it should be noted that the current risk value also includes £50K for legislative change and £130K for un-concluded design, which may not be expended.	Ongoing, through to project completion	

7.2	Agreed. The Head of Capital has consolidated and updated the risk register accordingly.	Actioned since fieldwork but ongoing review / scrutiny needs to be maintained for the remainder of the project.	Head of Capital

Appendix B: Follow up of previously agreed management actions

Previous matter arising 1: Project Execution Plan	
Original recommendation and management response	Original priority
Prior to the commencement of the next stage of the project, a Project Execution Plan should be prepared in accordance with the Capital Procedures and best practice. **Management response:** Accepted. The Project Execution Plan has now been produced and will be kept updated for the next stage of the project at Machynlleth.	**Medium**
Current findings	**Residual risk**
A Project Initiation Document (equivalent to a Project Execution Plan), with appropriate content, was in place for the project. **Conclusion:** Closed.	N/A

Previous matter arising 2: Project Board	
Original recommendation and management response	Original priority
The THB should review the effectiveness of the Project Board prior to the conclusion of the revised FBC, to ensure the expectations are clearly outlined in respect of scrutiny and endorsement of the FBC (including the increased cost plan and programme). **Management response:** Accepted. The Project Board briefing, review and sign off process will be documented in relation to the refresh of the FBC; the document will include an updated programme and cost plan which will also be subject to review in relation to the original submission	**Medium**
Current findings	**Residual risk**
An appropriate process of review and sign-off of the changes made from the original FBC was evidenced with relevant parties consulted, with formal sign-off documented at Project Board. **Conclusion:** Closed.	N/A

Previous matter arising 3: Project Board attendance	
Original recommendation and management response	Original priority
As the project is re-established, and the Project Board reviewed, members should be reminded of the importance of attendance (or sending an appropriate deputising officer) to ensure all discussions taken are suitably informed. **Management response:** Accepted. The THB has undertaken a re-alignment in the period since the Project Board was originally convened. The revised Project Board Terms of Reference will review the core membership and monitor attendance to maintain quoracy to ensure suitable discussion and decision making.	**Medium**
Current findings	**Residual risk**
A review of Project Board meetings from January to September 2021 found continued poor attendance from certain individuals (primarily Primary Care / operational representatives), with 5/9 meetings non-quorate. It is recognised that the Project Board minutes reviewed have appropriately documented the attendance issues, and it is also acknowledged the period within which these meetings took place (awaiting FBC approval, progression of demolition works) was a period of low risk in relation to the parties not in attendance. Wider work within the THB to improve responsibilities at site level, linked to reviews of fire safety and health and safety arrangements, is also expected to improve representation going forward. This has been discussed further at the new recommendation within Appendix A. **Conclusion:** Superseded (see **MA1, Appendix A**).	See **MA1, Appendix A**

Previous matter arising 4: Workstreams	
Original recommendation and management response	Original priority
Management should review the narrative reflecting the internal reporting stream and ensure the re-submitted FBC reflects the agreed, operational structure. **Management response:** Accepted. The Full Business Case documentation along with the Project Execution Plan will define any Workstreams associated with the next phase of the project.	**Low**
Current findings	**Residual risk**
Current workstream arrangements, whilst updated slightly from the structure set out in the refreshed FBC, were appropriately defined and operating as intended at the time of review. **Conclusion:** Closed.	N/A

Previous matter arising 5: Completion of Contract Documentation	
Original recommendation and management response	Original priority
a. Contract documentation should be appropriately retained by the THB. b. Noting timeliness of contract documentation 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. **Management response:** Accepted. It is acknowledged that contract documentation requires to be retained and be accessible for project activity and this will be held centrally by the PTHB Head of Capital. The timeliness of signing of contract documentation was discussed in detail and whilst the documents are sometimes not signed by all parties before the dates on which they become active, it is acknowledged that the intent of the parties is clear to the key signatories and PTHB will endeavour to ensure that documents are signed before or as close to the appropriate date as possible.	**High**
Current findings	**Residual risk**
a. All contract documentation requested for the current stage of the project had been retained by the THB. b. A review of the contract documentation for the current stage found further issues with timeliness and execution. These matters have been discussed within the main body of the report, superseding this prior recommendation. **Conclusion:** a. Closed b. Superseded (see **MA3, Appendix A**).	See **MA3, Appendix A**

Previous matter arising 6: Review of Issues	
Original recommendation and management response	Original priority
A lessons learnt exercise should be undertaken in consultation with appropriate parties and reported to Board. **Management response:** Accepted. As PTHB develops a major project pipeline, it is important that the organisation employs a lessons learned regime. A review will be undertaken of the project at Machynlleth from inception to the point of the FBC resubmission.	**Medium**
Current findings	**Residual risk**
A lessons learnt template for major capital projects was developed for the Llandrindod project, and following endorsement at the Innovative Environments Group the document has now been applied to the Machynlleth project. Management advised that following review by Project Board, the document will be shared at the next meeting of the Innovative Environments Group. *Note: This review does not intend to provide feedback to the THB on the content of the lessons learnt template: this will be undertaken as a separate exercise.* **Conclusion:** Closed.	N/A

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives (time, cost and quality) and 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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Network and Information Systems (NIS) Directive

Final Internal Audit Report

April 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

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Committee:	Audit, Risk & Assurance Committee

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

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Executive Summary

Purpose

Review arrangements in place for the implementation of the NIS Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Overview

An appropriate process was in place to complete the CAF and cyber security improvement actions have been identified and progressed.

The matters requiring management attention include:

- No retention of supporting information provided to the Cyber Resilience Unit as part of the self-assessment process.
- Absence of cyber security reporting metrics.
- Cyber security risk not included on the corporate risk register and limited visibility of the directorate risk register.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A First Review

Assurance summary[1]

Assurance objectives		Assurance
1	CAF completion and maintenance of evidence	Reasonable
2	Accurate self-assessed position supported by evidence	Substantial
3	Improvement plan implementation	Reasonable
4	Governance	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Supporting information retention	1	Operation	Medium
2	Improvement Action Plan	3	Design	Medium
3	Cyber Security Reporting Metrics	4	Design	Low
4	Cyber Security Risk	4	Design	Medium

1. Introduction

1.1 In line with the 2021/22 Internal Audit Plan for Powys Teaching Health Board ('the Health Board') a review of Network and Information Systems (NIS) regulation arrangements was undertaken.

Cyber security and resilience is the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

A core piece of legislation relating to cyber security are the Network and Information Systems Regulations of 2018 (NIS Regulations), transposed into UK law in May 2018 from the EU Security of Networks & Information Systems (NIS) Directive, with the intention to raise levels of cyber security and resilience of key systems across the EU.

At the core of this piece of legislation is the aim to drive improvement in the protection of the network and information systems which are critical for the delivery of digital services and essential services in the UK. These regulations require bodies to have processes in place to protect themselves from attack, detect potential intrusions and react appropriately when intrusions occur.

Although cyber security is not a devolved matter, Welsh Government (WG) is the competent authority for the NIS Regulations in the case of essential health services in Wales. Within NHS Wales, Digital Health and Care Wales (DHCW) takes a leading and coordinating role for the maintenance and improvement of cyber security on behalf of WG. They are responsible for establishing the compliance framework for Operators of Essential Services (OES), which includes defining the scope of the regulations, reporting thresholds, and processes for reporting and dealing with cyber incidents. The individual Trusts and Health Boards which fall within scope must adopt and comply with these arrangements.

1.2 The potential risks considered in the review were as follows:

- poor or non-existent stewardship in relation to cyber security;
- failure to ensure that structures are developed to enable compliance with regulations; and
- loss of data or services and inappropriate access to information.

1.3 We note that the purpose of the audit is to provide assurance on the processes within the Health Board for assessing its current position in relation to cyber security and developing an improvement plan that will address the key identified weaknesses. This internal report does not assess the current state of cyber security within the organisation and this function is the responsibility of the Cyber Resilience Unit (CRU) within DHCW.

2. Detailed Audit Findings

Objective 1: a process exists for completion of the self-assessment and maintenance of appropriate evidence.

2.1 As part of the initial process, the Digital Transformation and Informatics (DT&I) team was required to identify all services deemed critical, which excluded national services provided by DHCW and was limited to the OES. We noted that the Health Board has a formal partnership with Powys County Council (PCC) and employs a section 33 agreement to jointly deliver information and communications technology (ICT). PCC is the host of the ICT joint service and the agreement.

2.2 Once the critical services had been identified, the DT&I team shared the list of systems with all Heads of Services and requested an assessment of criticality for each. It was noted that most services had been scored as business and clinically critical, therefore, further work was undertaken by the DT&I team together with the Cyber Partner from PCC and Digital Governance / Clinical Application Team leads, to review the definition of 'critical' and to devise a rationale based on the following assumptions:

- no distinction between clinical critical and business critical due to risk impact on patient safety, finance, and reputation; and
- the overall impact of an outage results in a failure of activity, such as saving lives, preventing serious harm, breached contracts, financial/legal penalties. Both clinical and business deemed not to alter the definition of 'critical' as both are vital.

2.3 Each system was reviewed in detail and scored on the following:

- the impact of outage times ranging from one hour to one week;
- disaster recovery procedures; and
- back-up procedures including time to restore systems from back-ups.

2.4 Following engagement with the CRU, the Health Board was requested to select one internal and one external system to complete the Cyber Assessment Framework (CAF), and the decision was taken to assess the Welsh Patient Administration System (WPAS) and infrastructure. The Health Board's Cyber Security Compliance Manager completed the WPAS assessment with input from the application specialists and engaged with the Cyber Partner in PCC to complete the infrastructure assessment.

2.5 We were informed by the Cyber Security Compliance Manager that information to support each CAF objective was provided through discussions with the CRU via Microsoft Teams calls. The CRU did not specifically request evidence in the form of documentation as part of the assessment, however, we noted that records of the discussions and information provided have not been retained. As the self-assessment will be repeated annually, the lack of recorded information and clarifications sought from the CRU may hinder the timeliness and efficiency of future iterations. **See Matter Arising 1 at Appendix A.**

Conclusion:

2.6 Our review highlighted the work undertaken by the Cyber Security Team to prepare for and complete the self-assessment. However, records of discussions have not been appropriately retained for future iterations of the CAF. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 2: the self-assessed position is accurate and supported by evidence.

2.7 As part of this review, we conducted interviews with the Cyber Security Compliance Manager. Prior to the submission of the CAF to the CRU, it was reviewed internally by the Assistant Director of Digital Transformation and Informatics.

2.8 During this review, as noted above, there was no retention of information provided to the CRU in support of the statements against the CAF objectives and so we were unable to appropriately evaluate the Health Board's self-assessed position. However, we tested a sample of three objectives within the CAF assessment for WPAS, to ensure appropriate scoring and discussed the position and the information that was originally provided:

- A1.c Decision Making
- B6.b Cyber Security Training
- D2.a Incident Root Cause Analysis

2.9 Using our professional judgement and information gleaned from interviews, we consider the self-assessment to be an accurate reflection of the Health Board's current cyber security position.

Conclusion:

2.10 Whilst we consider the self-assessed position to be accurate, as noted above, we were unable to verify through evidence. However, discussion confirmed the appropriateness of the self-assessed responses. Consequently, we have concluded **Substantial** assurance for this objective.

Objective 3: an improvement plan is in place to improve the cyber security position within the organisation and is being implemented appropriately.

2.11 Our review highlighted positive developments within the Health Board to improve its cyber security position. Following the appointment of a Cyber Security Compliance Manager in October 2021, several enhancements have been made including:

- the introduction of a digital asset management system to record and track digital assets in a central location;
- regular full network scanning which allows visibility of all devices connected to the Health Board network;
- automated ICT joiner and leaver process; and
- weekly Executive Report shared with key stakeholders from the Health Board and PCC.

2.12 Whilst a formal improvement action plan is not yet in place due to the Health Board awaiting the outcome of the CAF from CRU, we noted that arrangements for cyber security improvements were included on the established *Digital Transformation Programme Plan*. We were informed that several security improvement projects are already in progress. One example is the undertaking of a complete infrastructure assessment by external cloud transformation, architecture and programme management specialists, the results of which will feed directly into the improvement plan. **See Matter Arising 2 in Appendix A**.

Conclusion:

2.13 Progress has been made to identify gaps in compliance and recommendations to improve current cyber security position. Whilst the DT&I team are awaiting feedback from the CRU prior to developing a formal improvement plan, appropriate measures for improvement have been identified and several projects have been initiated to improve the Health Board's cyber security position. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 4: there is monitoring and reporting of the progress of the improvement plan and gaps in compliance to an appropriate governance group.

2.14 Whilst a formal improvement plan has not been finalised as noted above, we reviewed the *Digital Transformation Programme Plan*, which includes cyber security improvement actions with timescales. We noted that the plan and wider ICT matters are overseen by the Digital Governance Board and updates against the plan are regularly provided to the Executive Committee and Delivery and Performance Committee via *Digital First* reports. The Executive Committee is the executive decision-making committee of the Health Board, chaired by the Chief Executive.

2.15 We observed that the Executive Committee was fully apprised of the NIS Directive via the *Digital First Cyber Security and Assurance Report* on 15 December 2021. Our review of Board papers noted that the report was referred to within the *Executive Committee's Chair's Assurance Report* presented during the January 2022 Board meeting.

2.16 Our review of a sample of *Digital First* reports presented to the Executive Committee and Delivery and Performance Committee noted that whilst there is discussion on cyber security, enhancements could be made to strengthen analysis and oversight by the inclusion of 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. **See Matter Arising 3 in Appendix A**.

2.17 Whilst there is a general risk on ICT included on the Corporate Risk Register, it has not been updated to include the NIS Regulations and does not relate to cyber security. We were informed by the Cyber Security Compliance Manager that an IT Risk Register is maintained by PCC, however, the DT&I team have limited visibility. **See Matter Arising 4 in Appendix A**.

Conclusion:

2.18 We noted that the Board has been apprised of the NIS Directive and whilst a formal cyber security improvement action plan has not been finalised due to the Health Board awaiting feedback on its self-assessment from the CRU, cyber security improvement actions are being progressed via the Digital Transformation Programme Plan. The plan is monitored by appropriate governance committees and whilst we noted reporting of cyber security matters, analysis and oversight could be enhanced. Consequently, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Supporting information retention (Operation)		**Impact**
Our review highlighted that records of discussions and supporting information provided to the CRU have not been captured and maintained throughout the self-assessment process.		Potential risk of: • poor or non-existent stewardship in relation to cyber security.
Recommendations		**Priority**
1.1 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Noted and agree, the Cyber Security and Assurance function is a newly developed team, and this action will be implemented going forward.	June 2022	The Cyber Security and Assurance Manager, accountable to the Assistant Director Digital Transformation & Informatics

Matter Arising 2: Improvement Action Plan (Design)		**Impact**
Whilst we were informed that a formal improvement action plan is not yet in place due to the Health Board awaiting the outcome of the CAF, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.
Recommendations		**Priority**
2.1 Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 The Cyber Security and Assurance function will formalise the existing Cyber Security improvement plan, and ensure any additional actions are captured following the outcome of the CAF assessment. This will be presented and available at Board level and performance measured in line with the overarching Digital Transformation Programme.	July 2022	The Cyber Security and Assurance Manager, accountable to the Assistant Director Digital Transformation & Informatics

Matter Arising 3: Cyber Security Reporting Metrics (Design)		**Impact**
Our review of a sample of *Digital First* reports presented to the Executive Committee and Delivery and Performance Committee noted that whilst there is discussion on cyber security, enhancements could be made to strengthen analysis and oversight by the inclusion of 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.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.
Recommendations		**Priority**
3.1 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.		Low
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 The Cyber Security and Assurance function will provide assurance against performance by the inclusion of both create critical success factors and key performance indicators. These will be developed within the Digital Strategic Framework and embedded within existing IT/Supplier Service SLA's.	September 2022	The Cyber Security and Assurance Manager, accountable to the Assistant Director Digital Transformation & Informatics

Matter Arising 4: Cyber Security Risk (Design)	**Impact**
Whilst there is a general risk on ICT included on the Corporate Risk Register, it has not been updated to include the NIS Regulations and does not relate to cyber security. We were informed by the Cyber Security Compliance Manager that an IT Risk Register is maintained by Powys County Council, however, the DT&I team have limited visibility.	Potential risk of: • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.

Recommendations	**Priority**
4.1 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.	Medium
4.2 Management should work with Powys County Council and within provisions of the existing section 33 agreement, to develop a collaborative IT Risk Register visible to both parties.	Medium

Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 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 risks identified from the self-assessment.	May 2022	The Cyber Security and Assurance Manager, accountable to the Assistant Director Digital Transformation & Informatics
4.2 The departmental risk register will be shared with PCC and collaboratively work together via S33 to ensure a single source of Risks logged is available to both organisations in relation to Health. The associated processes will be implemented as required to regularly review and update where necessary.	June 2022	The Cyber Security and Assurance Manager, accountable to the Assistant Director Digital Transformation & Informatics

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: April 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.

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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit, Risk & 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 2020-21 Charitable Funds Account	The audit of the 2020-21 financial statements has been finalised and the audit report is due for presentation to the Audit, Risk and Assurance Committee, Charitable Funds Committee, and the Board at the end of April. The financial statements will be signed by the Auditor General for Wales in May, subject to their approval by those charged with governance.
Audit of the 2021-22 Accountability Report and Financial Statements	Audit of the 2021-22 financial statements is due to commence from the 3rd May 2022.

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
Rollout of the COVID-19 vaccination programme in Wales	July 2021
Welsh Health Specialised Services Committee Governance Arrangements	June 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	Date of publication realigned with anticipated publication date of national planned care work July 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	looks to tackle the significant elective backlog challenges.	
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.	Feedback meeting arranged for early June 2022 July 2022
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. More detailed work will focus on specific aspects of the unscheduled care system including patient flow and discharge, and access to services.	Whole system commentary and data tool being published on 21 April Further work being scoped.

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
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:	Project brief due to be issued in May TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	• Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).	
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. We have not published any reports of relevance to the NHS since the last Audit, Risk and Assurance Committee.

7 In March 2022, the Auditor General published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through his national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. The closing date for responding to the consultation is 30 April 2022.

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

Audit Risk and Assurance Committee	**Date of Meeting: 26 April 2022**
Subject:	**Counter Fraud Annual Report 2021/22**
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 provide the Audit Risk & Assurance Committee with the Annual Report outlining counter fraud activity in 2021/22.
RECOMMENDATION(S):
It is recommended that the Audit Risk & Assurance Committee receive the report for discussion and information the content of this update report.

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	✓				

Powys Teaching Health Board

Counter Fraud Annual Report 2021/22

Matthew Evans

26 April 2022

Table of contents

1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2021/22 was approved by the Audit Committee in April 2021 and identified a total resource of 308 days for the year. The Counter Fraud Team delivered all 308 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £73,204.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2021/22 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud. Designed flexibility contained in the work plan allowed high risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The LCFS Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS

Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. From 2021/22 NHS Wales adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. Full compliance with the new Functional Standards is not expected until conclusion of 2022/23, in effect this represents a 2 year cycle to ensure compliance. A review of 2021/22 counter fraud work has resulted in uplift of ratings in relation to some Standards and maintenance of Green ratings in others. Standard 3, relating to fraud risk assessments, has maintained an Amber rating primarily due to the large operational requirements of undertaking such work, progress has been made with risk assessments undertaken in this area which is not captured in the RAG rating, continuance of this work in 2022/23 is anticipated to result in a Green rating at the conclusion of the year.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2022

The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Organisation Declaration

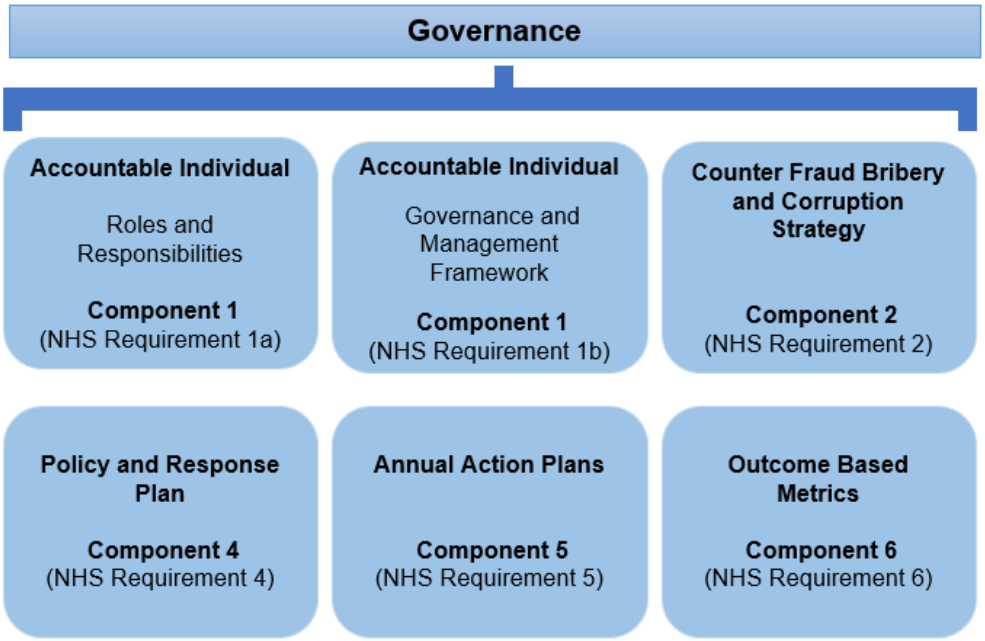
I declare that the counter fraud, bribery and corruption work carried out during 2021-22 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

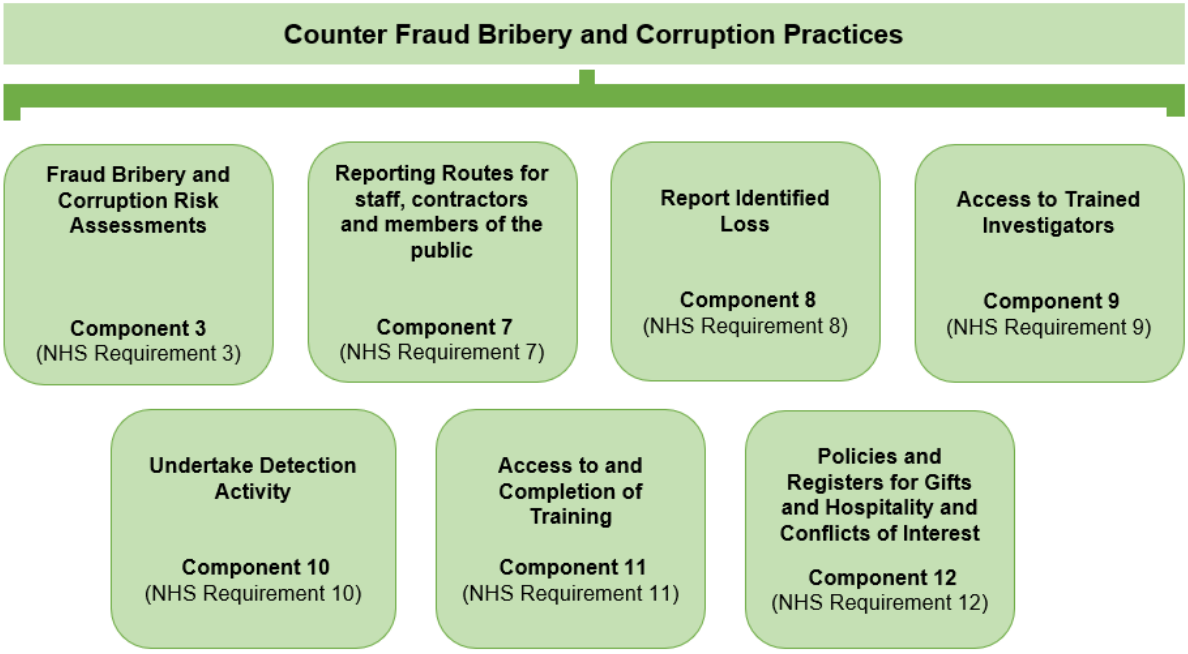
Organisation	
Accountable Board Member Signature	
Date	

4. Work carried out against the Functional Standard Requirements

In completing the annual report on the counter fraud, bribery and corruption work undertaken, the organisation should refer to the Functional Standard Requirements and the expected work needed to be compliant with each component.

The report should detail the work completed against each of the components relating to governance actives and counter fraud, bribery and corruption practices undertaken during the year, as set out below.





Governance

This section of the annual report outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
Component 1 **Accountable individual**	**NHS Requirement 1A**	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. I good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.	GREEN	GREEN	The Audit Committee is responsible for assessing the adequacy and effectiveness of counter fraud work. Regular reports have been received by the Committee throughout the year. The Health Board is still required to nominate a Fraud Champion, this is planned for 2022/23.
Component 2 **Counter fraud bribery and corruption strategy**	**NHS Requirement 2**	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
					attendance at Audit Committee.
Component 4 **Policy and response plan**	**NHS Requirement 4**	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current with a full formal review due in 2022. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy. Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2022.
Component 5 **Annual Action Plan**	**NHS Requirement 5**	This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.	GREEN	GREEN	An counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. A report outlining progress against each work plan action was

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
					brought to Audit Committee in February 2022 for assurance.
Component 6 **Outcome based metrics**	**NHS Requirement 6**	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	RED	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3, the new case management system, includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work. The system is now fully utilised by the Health Board resulting in rating improvement.

Counter Fraud Bribery and Corruption Practices

This section of the annual report should outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
Component 3 **Fraud bribery and corruption risk assessment**	**NHS Requirement 3**	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	AMBER	AMBER	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 120+ individual risk across the entirety of business areas the NHS engages in. These risks have been concatenated into 26 core risk areas for review locally. This is a wide ranging piece of work with initial risk assessments in these core areas leading to further development opportunities. Work will continue on this in 2022/23 to improve rating to Green.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
Component 7 **Reporting routes for staff, contractors and members of the public**	**NHS Requirement 7**	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 20 new investigations in 2021/22.
Component 8 **Report identified loss**	**NHS Requirement 8**	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	AMBER	GREEN	The Health Board now fully utilises the Clue case management system. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated using the information contained on the case management system which captures operational KPI information to inform and guide local counter fraud work. Full utilisation of these functions has resulted in increase in rating for 2022/23.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
Component 9 **Access to trained investigators**	**NHS Requirement 9**	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2021/22 was 1.2 FTE.
Component 10 **Undertake detection activity**	**NHS Requirement 10**	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	AMBER	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. Checks on payroll returns are undertaken following

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
					payroll runs. These include net pay increases and amendments to permanent data files. The HB also participates in the NFI process. As a result of this information and intelligence review process the Counter Fraud Team have registered 3 local proactive exercises on the case management system resulting in an increase in rating.
Component 11 **Access to and completion of training**	**NHS Requirement 11**	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts.

Function Standard Component	NHS Requirement		2021 Rating	2022 Rating	Current Position
Component 12 **Policies and registers for gifts and hospitality and Conflicts of Interest**	**NHS Requirement 12**	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in a survey issued in March 2022.

5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report should detail the total counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Area of activity	Days used
Proactive work	210
Reactive work	98
Total days used	308

Appendix 2 – Counter Fraud Costs

This section of the annual report should detail the total costs of the counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£49,912
Reactive costs	£23,292
Total costs	£73,204

Appendix 3 – Nominations Overview

This section of the annual report should detail the nominated officers at the organisation during the reporting period, including all supporting LCFS. If any of the nominations have changed during the year, the date of the change should be included.

The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B and 9.

Role	Name of Nominated Person
Accountable Board Member	Pete Hopgood
Audit Committee Chair	Tony Thomas
Fraud Champion	Vacant
Lead LCFS	Matthew Evans
Supporting LCFS	Kirsty James

Appendix 4 – Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

Investigation Information	Number
Investigations carried forward from 2020/21	6
Investigations Opened during the period	11
Investigations Closed during period	14
Investigations Ongoing	3

Appendix 5 – Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	24

Local Proactive Exercises	Number
Number of LPEs conducted during the year	3
Number of LPEs recorded on the NHS CFA Case management system as per component 8	3
Number of LPEs concluded during the year	2

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 6 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary	0
Civil	6
Criminal	1
Total Sanctions	7

Redress Imposed	Total Amount £
Fraud identified	£11,740
Fraud Prevented	£0
Fraud Recovered	£11,740

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.5

Audit, Risk and Assurance Committee	**DATE OF MEETING: 26 April 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, 6 April 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.

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. As the organisation transitions back into normal activity, timescales for the implementation of future audit recommendations have not been re-prioritised and remain as that determined by Internal Audit. This is in recognition that services will agree realistic timescales for implementation of recommendations, in light of current commitments and capacity.

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

The reporting period 2020/21 and 2021/22 is summarised by Internal Audit priority level (high, medium and low). 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	1	7	Medium	3	4		20
Priority 3	0	0	7	Low	6	4		17
Not Yet Prioritised	0	0	0					0
TOTAL	5	1	14		11	11		42

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

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	0	3
Priority 3	1	0	1	0	2
Not Yet Prioritised	0	0	3	2	5
TOTAL	3	0	5	2	10

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

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	2	2
TOTAL	2	2

Detail of local counter fraud recommendations can be found appended to this report as follows: -
Appendix H – Local Counter Fraud Audit Recommendations NOT YET DUE 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	2	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**	**33**	**28**	**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	5	0	0	1	0	0	1	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**	**69**	**32**	**0**	**1**	**0**	**0**	**1**	**0**	

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	3	0	0	3	0	0	0	3	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	0	0	0	1	0	0	1	0	×
TOTAL			**23**	**63**	**32**	**17**	**57**	**30**	**6**	**6**	**2**	**0**	**7**	**7**	**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	14	0	0	6	0	0	6				0	0	2	×
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	1	0				0	1	1	×
202116	Llandrindod Wells Project	Limited	0	5	1	0	5	1										✓
202117	Covid-19 Mass Vaccination Programme	Not Rated																✓
TOTAL			**5**	**26**	**25**	**3**	**22**	**16**	**2**	**3**	**6**	**0**	**0**	**0**	**0**	**1**	**3**	

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	0	0	0	1	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	2	1	2	1	0	×
212204	Midwifery – Safeguarding Supervision	Reasonable	0	2	0	0	2	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	0	0	×
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	1	0	0	0	0	1	3	1	×
TOTAL			**11**	**15**	**5**	**5**	**7**	**1**	**3**	**4**	**3**	**3**	**4**	**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	2	1	0	0	0	1		×
202152	Structured Assessment 2020	11	7	4	0	1	1	2	0	×
202153	Audit of Accounts	6	6							✓
TOTAL		**20**	**15**	**5**	**0**	**1**	**1**	**3**	**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	×
TOTAL		**3**	**1**	**2**	**0**	**0**	**0**	**2**	**0**	

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	1	2	0	×
TOTAL		**6**	**4**	**2**	**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: Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
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	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	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Apr-22		46	3	Mar-22	26/02/2019
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	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Apr-22		46	3	Mar-22	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. Going forward policies submitted to the Corporate Governance Department without the submission and approval form will be returned to the relevant Executive Director.	May-18	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	Support on policy development is being provided to the organisation as and when required	Apr-22		46	3	Mar-22	26/02/2019
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	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 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Apr-22		47	3	Mar-22	26/02/2019
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	Support on policy development is being provided to the organisation as and when required	Apr-22		46	3	Mar-22	26/02/2019
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	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	Overdue	2	Partially complete		A revised Records Management Framework is being developed.	Impact of COVID-19 on the IG team	IG advice and support is provided to the organisation when requested.	31-Dec-21		35	3	Mar-22	26/02/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R3	The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures should be developed, but aligned to the policies regarding records management and tracking. Practices should be consistent from one site to another. The health board should strengthen the current	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: • Review and update procedures and guidance to support effective tracking of records. • Ensure adequate Business Continuity Planning arrangements are in place relating to records	Mar-20	Dec-20	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. The Information Services Department lead on the rollout of Intelligence Tracking. Intelligence Tracking guidance exists, is updated in accordance with system changes and is regularly communicated to all users of WPAS. Training is provided to all new users	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed.	01-Apr-22		24	15	Mar-22	15/11/2019
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	Apr-20	Apr-22	Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the RM Improvement Plan. Detailed actions and lead officers have been identified. Options for on and off-site storage continue to be explored.	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		23	#NUM!	Mar-22	14/11/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records.	Apr-20	Apr-22	Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified.	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		23	#NUM!	Mar-22	14/11/2019
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Bord 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	(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. Follow up discussions will take place in line with organisational governance to review the current position in relation to Health Care Research Wales.	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		23	1466	Mar-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance and IT & Director of Primary, Community and Mental Health	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned	Dec-20	Sep-21	Overdue	2	Partially complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	Sep-21		15	6	Mar-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 incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	Apr-20	Jul-21	Overdue	2	Partially complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to	Jul-21		23	8	Mar-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	Mar-20	Apr-21	Overdue	2	Partially complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion,	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21		24	11	Mar-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.		This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		24	18	Mar-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	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Mar-22	Overdue	3	No progress		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.			Mar-22		12	0	Mar-22	26/09/2020
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and		R2	The health board should investigate options for the implementation of an electronic referral management system as a replacement for the	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	Overdue		Partially complete		Electronic Referrals is being covered with the 'All Wales' work being undertaken on the Welsh Admin Portal and the next Phase of clinical prioritisation	This is driven by the WCP programme led by DHCW				12	0	Mar-22	26/09/2020
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and	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	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	Mar-21	Mar-22	Overdue	3	Partially complete			COVID-19 delays		Mar-22		12	0	Mar-22	26/09/2020
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		12	2	Mar-22	26/09/2020
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		Management Plan being revised alongside refreshed Policy and Procedures approach	COVID-19 delays	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and	Feb-22		14	1	Mar-22	26/09/2020
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,	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	Mar-22	26/09/2020
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: • the roll of out awareness sessions, keeping records of attendance; • increasing the frequency and content of internal	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to record staff training.	Mar-21	Mar-22	Overdue	3	Partially complete		Work is ongoing. Covid-19 has disrupted implementation, particularly around staff training and developing a communication strategy. Virtual WL Awareness Sessions continue to be offered to staff which has been added to ESR in order	Lack of resources to fully implement the WL Standards. Additional funding requirements for translation costs.	Regular monitoring and reporting via the Executive Lead for WL. Additional resources requirement assessment	Implementation will be ongoing		12	0	Mar-22	26/09/2020
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.	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 ensuring signed agreements	Apr-21		Overdue	3	Partially complete		Reablement agreement reviewed. The review of the Overarching Agreement Deed of Variation has been delayed due to covid-19					11	11	Mar-22	26/09/2020
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	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.					6	0	Mar-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.					6	0	Mar-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,	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	Oct-21		Overdue		No progress							5		Mar-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							5		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 need to align between national (NWIS) and local as needed. A review of the existing policies to identify gaps will continue to ensure a full	Oct-21		Overdue		No progress							5		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 in Powys county council. This work	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21		Overdue		No progress							5		Mar-22	

202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		Overdue		No progress							5		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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. 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	Oct-21		Overdue		No progress							5		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 PCC re appropriate resource and support to be included in the S33. There is a need to manage various national development funding appropriately to	Oct-21		Overdue		No progress							5		Mar-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		No progress							3		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		Overdue		No progress							3		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		Overdue		No progress							3		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 established Digital Business Manager). There are numerous national funding streams that are available to help support developments in a number of areas	Oct-21		Overdue		No progress							5		Mar-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	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.	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	This cannot be implemented until the Board has agreed the timing of the strategic pathway change. It is not possible to set a		4		Mar-22	
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2	We concur with management and recommend the development of a documented framework that the health board can use in future collaborative change programmes to assist in the management of the programme and to ensure the use of a consistent and controlled approach.	This recommendation is accepted and a collaborative change programme framework will be developed and considered through the PTHB Executive Group for Strategic Planning and Commissioning.	Sep-21	Mar-22	Overdue		Partially complete		Standard PIDs have been agreed for the 9 Renewal Programmes including key stages in collaborative change such as identification of stakeholders, engagement and communication, consultation and formal written notice. This will be summarised in a Change Programme Framework and submitted to	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		6		Mar-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	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: - Key contacts when planning the change i.e. IG,	The recommendation will be actioned as part of the process of establishing the newly formed Digital Governance Board. Appropriate communication will be made to ensure that staff are clear on the process and route to access (clarity re process, governance and decision making). This will then be available on the	Sep-21	Dec-22	Deadline Revised		Partially complete		A Digital Governance process was established in April 2021, and has now been effective for 6 months with KPI reporting into the Digital Transformation Board. A paper for Execs on the process has been submitted to DoF and communications to staff and the process to be available on the Intranet by Dec 2021					6		Mar-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R2	a) The Digital Transformation Sub-Committee should be established and include oversight and monitoring of digital solutions implemented throughout the health board. b) Work to establish links and processes with the Innovation and Improvement Hub should be	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 Transformation Board This group monitors and has oversight of all digital solutions to be implemented in the Health Board.	Dec-21		Overdue		No progress							3		Mar-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	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	Mar-22		Overdue		Partially complete		Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines				Yes via meeting minutes & action logs	0		Mar-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 made we will look to introduce a process which provides more specific information in more appropriate timeframe.	Mar-22		Overdue		No progress							0	0	Mar-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		Overdue		No progress							0	0	Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R2	Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include: • Using item data from maintenance schedules to populate the e-Quip system, then forwarding e-	e-Quip implementation timeframes have been extended to December 2021, from September 2021. Action has been taken in the form of escalation to ensure services engage in the implementation, which is essential to meet the desired outcome. Challenges in terms of capacity are being met but additional	Dec-21		Overdue		No progress							3	3	Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads	R3	All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service governance leads in the form of self-audits. Governance leads will provide assurance to the Medical Devices Group through "At a Glance Reports."	Nov-21	Feb-22	Overdue		Partially complete		Meeting held with Governance Leads and Medical Device & Point of Care Testing Manager 06/12/21. Example of Idemnity Form shared with Governance Leads who will be undertaking focused work with services to ensure all areas use the indemnity forms and track medical devices loaned to patients	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.	Review of compliance to be undertaken at next Medical Devices Group in January 2022.		4	1	Mar-22	

212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Ward Manager – Graham Davies Ward / Governance Lead / Department	R4	1. Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. 2. A general reminder should be issued to all sites	1. Storage will be reviewed at Graham Davies Ward and all options explored. Feedback back on this review will be provided through Medical Device Group "At A Glance Report." 2. A Storage Audit Tool has been in use and was developed with input from Internal Audit following the	Mar-22		Overdue		No progress						0	0	Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Head of Clinical Education / Medical Device & POCT Manager	R5	1. The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 2. The manufacturer's instructions for all medical devices and equipment should be scanned and	1. Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group	Mar-22		Overdue		No progress						0	0	Mar-22	
212204	Midwifery – Safeguarding Supervision	Substantial	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding supervision /	R1	1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives 1c. Requirements to attend Safeguarding supervision	Dec-21		Overdue		No progress						3	3	Mar-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	To explore opportunities for a Clinical Director role for Planned Care (including Endoscopy and Theatres)	Mar-22		Overdue		No progress						0	0	Mar-22	Jan-22
212206	Theatres Utilisation	Reasonable	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							0	Mar-22	Jan-22
212206	Theatres Utilisation	Reasonable	Planning & 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							0	Mar-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			Mar-22			2	Mar-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Business Manager, Mental Health	R4	Management must ensure that the Performance measures are subject to appropriate independent review prior to submission.Good practice in data collection should be shared between the teams.	This process will be reviewed to ensure that Performance Measures are independently and rigorously tested prior to submission.The MHLD business manager will facilitate the sharing of good practice within data collection, including a common method to capturing and processing information.	Mar-22		Overdue		No progress						0	0	Mar-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, 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	When will implementation be achieved?					
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and monitored.	The Executive Directors will develop detailed objectives and actions that will enable the achievement of each of the key priority deliverables within the Organisational Development Framework. For each action there will be action owners or leads along with defined timescales which will ensure the ability to monitor	Mar-20	Sep-20	Complete	3	Complete		The Organisational Development Framework has been reviewed and refreshed. As part of this work, an action plan is being developed however, further discussion with the Executive team is required. This will be tabled		Given the Board is about to sign off the IMTP and key priorities identified	end of Qtr 2		22	16	Jan-22	
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 outpatient appointment into WPAS. This could be considered in alignment with the work being undertaken by the health board's newly created Health Records	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. Booking systems are automated and PTHB uses WPAS for booking. This action refers to some of the supporting systems, and	Mar-21	Mar-22	Complete		Complete		Electronic Referrals is being covered with the 'All Wales' work being undertaken on the Welsh Admin Portal and the next Phase of clinical prioritisation within the Welsh Clinical Portal. There is also ongoin work to add additional	This is driven by the WCP programme led by DHCW				12	0	Mar-22	26/09/2020
202102	Estates Assurance – Fire Safety	Limited	Director of Environment	Fire Safety Advisers	R5	Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed	The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	Jul-21	Jan-22	Complete	1	Complete		Over 400 Fire Incident Coordinators and Fire Wardens now trained: training includes use of local fire management folders.			Jan-22		8	2	Mar-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 needed.	Oct-21		Complete		Complete		Finance and Informatics have a local Risk Register which is held locally and follows appropriate governance and reporting 03/22 - Actions complete - Local risk register can be located where it is held showing review dates					5		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 need to align between national (NWIS) and local as needed. A review of the existing policies to identify gaps will continue to ensure a full suite is	Oct-21		Complete		Complete		03/22 - PTHB has been reliant on S33 for ICT support and shared policy. As Digital Transformation takes place all related Policies are reviewed and implemented if there are gaps. Recent new policies are IT User policy and Bring your					5		Mar-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		Complete		Complete		03/22 - Cyber Security and Assurance is now part of the Digital Transformation and informatics service. There is ongoing work nationally with the CAF framework which will					3		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		03/22 - the PTHB Cyber function has implemented a full Asset management solution to monitor and manage - it is called Snipe-IT					3		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 established Digital Business Manager). There are numerous national funding streams that are available to help support developments in a number of areas and any developments will include	Oct-21		Complete		Complete		The Digital Transformation team continues to strenghten to support the ambitious digital improvements required to meet the HB Digital First objectives. Programme and project management in place					5		Mar-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	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: - Key contacts when planning the change i.e. IG,	The recommendation will be actioned as part of the process of establishing the newly formed Digital Governance Board. Appropriate communication will be made to ensure that staff are clear on the process and route to access (clarity re	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 reporting into the Digital Transformation Board. A					6		Mar-22	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R2	a) The Digital Transformation Sub-Committee should be established and include oversight and monitoring of digital solutions implemented throughout the health board. b) Work to establish links and processes with the Innovation and Improvement Hub should be progressed to ensure opportunities for learning lessons	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 Transformation Board This group monitors and has oversight of all digital solutions to be	Dec-21		Complete		Complete							3		Mar-22	

212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R2	1. Contractors should be periodically reminded of the THB's H&S requirements, via issue of the H&S Contract Rules & Guidance. 2. Contractor competencies and H&S practices should be periodically rechecked, with formal records maintained to confirm when checks were last made and are next due for review, ensuring compliance with HSE requirements. 3. The benefits of using a standard contractor	1. The PTHB Contractor Health and Safety Guidance Booklet will be circulated to all current Estates Maintenance Contractors and a database will be created to record issue dates and frequency of issue. 2. There is an ongoing emphasis, as noted in the audit comments, for a formal series of 3 to 5 year maintenance contract appointments to be rolled out. This	Dec-21		Complete		Complete		1. COMPLETE - Health and Safety Rules/Guidance booklet and pamphlet circulated to all current Estates and Capital Maintenance Contractors. 2. COMPLETE - KPI's are now formally included in all maintenance contracts along			01-Mar-22		3	1466	Mar-22	
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R6	The THB should apply their existing procedures to demonstrate compliance with HSE guidance in the following areas: a) Apply a consistent methodology for the monitoring of contractor working practices on site as defined in the Control of Contractors policy, and through retrospective compliance auditing, i.e. a percentage of jobs to be checked, the process for documentation of checks undertaken / observations made and recording of any follow up actions completed;	a. Real time monitoring of Contractor performance in Powys is a logistical challenge. Audit and monitoring by definition, would not occur in 100% of cases. Audit identified checks being undertaken on 15% of jobs which exceeds what would be considered as industry good practice at circa 5%. We will apply the 5% rule going forward.	Sep-21		Complete		Complete		a. Monitoring sheet in place and 5% check implemented on Estates jobs - COMPLETE b. KPI's written into 3-5 year maintenance contacts including any future contracts. COMPLETE c. Report taken to March 2022 Estates Compliance Group. COMPLETE			15-Feb-22		6	1466	Mar-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		Complete		Complete								1466	Mar-22	Jan-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 shared with the Finance Business Partner to monitor spend against the budget.	Ongoing		Complete		Complete		The Powys Living Well Service budget is reviewed monthly with colleagues from the Health Boards Finance Team. The Adferiad allocation of £217k has been allocated across pay and non-pay items and this is monitored through the fortnightly discussions with the DoTH and with regular feedback to the Health	The barriers to implementation have been the issues with regards to short term revenue funding being spent within the agreed timescale. These issues have been raised with Welsh Government as part of the application for funding for 22/23.	These issues have been raised with Welsh Governmen t as part of the application for funding for 22/23. A request has	On allocation of future funding.		#VALUE!	1466	Mar-22	Jan-22
212204	Midwifery – Safeguarding Supervision	Substantial	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguardin g	R1	1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives	Dec-21	Dec-21	Complete		Closed		1a. Internal audit report and required actions shared at Midwifery and Health Visiting meeting on 10th November 2021 and W&C Audit meeting 4th December 2021.- this action can be closed 1b Compliance for	Notable increase with Midwifery attendance / compliance to Safeguarding supervision - 76% Q3	W&C Internal audit evidence file in place if follow evidence is required			3	1466	Mar-22	
202102	Estates Assurance – Fire Safety	Limited	Director of Environment	Fire Safety Advisers	R5	Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed	The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	Jul-21	Jan-22	Complete	1	Complete		Over 400 Fire Incident Coordinators and Fire Wardens now trained: training includes use of local fire management folders.			Jan-22		8	2	Mar-22	
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R2	1. Contractors should be periodically reminded of the THB's H&S requirements, via issue of the H&S Contract Rules & Guidance. 2. Contractor competencies and H&S practices should be periodically rechecked, with formal records maintained to confirm when checks were last made and are next due for review, ensuring compliance with HSE requirements. 3. The benefits of using a standard contractor	1. The PTHB Contractor Health and Safety Guidance Booklet will be circulated to all current Estates Maintenance Contractors and a database will be created to record issue dates and frequency of issue. 2. There is an ongoing emphasis, as noted in the audit comments, for a formal series of 3 to 5 year maintenance contract appointments to be rolled out. This	Dec-21		Complete		Complete		1. COMPLETE - Health and Safety Rules/Guidance booklet and pamphlet circulated to all current Estates and Capital Maintenance Contractors. 2. COMPLETE - KPI's are now formally included in all maintenance contracts along			01-Mar-22		3	3	Mar-22	
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R6	The THB should apply their existing procedures to demonstrate compliance with HSE guidance in the following areas: a) Apply a consistent methodology for the monitoring of contractor working practices on site as defined in the Control of Contractors policy, and through retrospective compliance auditing, i.e. a percentage of jobs to be checked, the process for documentation of checks undertaken / observations made and recording of any follow up actions completed; b) Introduction of a formal contractor performance	a. Real time monitoring of Contractor performance in Powys is a logistical challenge. Audit and monitoring by definition, would not occur in 100% of cases. Audit identified checks being undertaken on 15% of jobs which exceeds what would be considered as industry good practice at circa 5%. We will apply the 5% rule going forward. b. The new contracts being let on 3-5 year basis have KPI monitoring and annual	Sep-21		Complete		Complete		a. Monitoring sheet in place and 5% check implemented on Estates jobs - COMPLETE b. KPI's written into 3-5 year maintenance contacts including any future contracts. COMPLETE c. Report taken to March 2022 Estates Compliance Group. COMPLETE			15-Feb-22		6	6	Mar-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?					
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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 PCC re appropriate resource and support to be included in the S33. There is a need to manage various national development funding	Apr-22		Not yet due		No progress							#NUM!		Mar-22	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		Not yet due		No progress							#NUM!		Mar-22	
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R3	3.1 As part of formalising the PFCU business cycles (see MA1), the health board should consider the key performance metrics for patient flow performance (including delayed transfers of care) to be used for reporting at each level within the health board and how frequently these should be reported. 3.2 The health board could refer to the 2017 Audit Wales report (Discharge Planning, Powys Teaching Health Board) in identifying metrics, recognising some of the metrics in that report are only relevant	3.1 KPI's and pathways are in situ but "paused" whilst DTOC reporting was stepped down. When recommenced a review of pathways will be held to ensure they are in line with any revised guidelines. KPI's for delays & repatriation times will be developed once the technology supports this – incoming with electronic flow system. 3.2 The HB will focus on national guidelines for step down & step up beds as a mechanism to support the identification and development of metrics - currently working with Hywel Dda University Health Board & the	May-22		Not yet due		Partially complete		Still awaiting direction from WG, which is expected November 2021. Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Will ensure KPI's are in line with national requirements when released.					#NUM!		Mar-22	
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R5	Given the impact of the Covid-19 pandemic and the ongoing development of patient flow initiatives, the health board should consider undertaking a formal demand and capacity review for staff resource for patient flow.	Seven-day working was stood up during the pandemic where a demand & capacity review was completed for weekend working. As a result, the HB established no demand for seven day working but has a plan to flip if required to seven days. Outside of this flow is managed & workload of CTC's is manageable There is	Jul-22		Not yet due		No progress							#NUM!		Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R1	1. A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. 2. The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or	1. Management will ensure a review of the purpose of the Preferred Equipment List is undertaken. How it is maintained and kept current will be part of this review. Both Procurement and Finance support will be required for this review. 2. There is currently a section within the EDOF stating	Nov-22		Not yet due		No progress							#NUM!	#NUM!	Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R6	The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (kpi's) and targets for each contract.	Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The renewal of the main maintenance contract (due 1st April 2022) provides an opportunity to significantly strengthen this area.	Apr-22		Not yet due		No progress							#NUM!	#NUM!	Mar-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads / Medical Device & POCT Manager	R7	1. Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care	1. Actions and improvements will be made through the POCT Group. Processes will be implemented for monitoring compliance and will be developed through the POCT Group in collaboration with service group Governance Leads. 2. The Management of POCT policy will be updated to	Dec-22		Not yet due		No progress							#NUM!	#NUM!	Mar-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 shared with the Finance Business Partner to monitor spend against the budget.	Ongoing		Not yet due		No progress							#VALUE!	#VALUE!	Mar-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!	Mar-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Assistant Director of Mental Health Services	R1	The operating environment within both teams needs further evaluation, to ensure clients have consistent access to services throughout the Health Board and good practice can be shared and embedded.	The configuration of the North Powys team to match the clinical specialism of the South will require additional funding, as well as any move to the South Team matching the North's 7- Day working practices. Elements of this funding will be considered as part of	Sep-22		Not yet due		No progress							#NUM!	#NUM!	Mar-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Operations Manager, Mental Health Services	R2	The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee.Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 – day basis we will require two flow charts demonstration patient flow and the method of referral.The SOP requires finalisation and until full expansion of the service will require two sections,	Apr-22		Not yet due		No progress							#NUM!	#NUM!	Mar-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	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	The review of performance measures will be undertaken as part of a wider MHLD service group's participation in Welsh Government's move to service user led outcomes and core data sets.Within the National move to service user led outcome and data sets, training for staff and managers on its collation	Sep-22		Not yet due		No progress							#NUM!	#NUM!	Mar-22	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	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							#NUM!	#NUM!	Mar-22	Jan-22

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
												Progress of work underway	Barriers to implementation	How is the risk identified being mitigated pending	When will implementation be					
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	No progress		Reported intention to establish both stakeholder reference group and healthcare professionals forum at Board 30/03/22	Delayed in light of COVID-19	Clinical and Stakeholder engagement is undertaken via other means	30-Jun-22		29	12	Mar-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 delegated by the Board has been built into the Annual Governance Programme	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	30-Jun-22		29	3	Mar-22	
181951	Structured Assessment 2018	Board Secretary	R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21	Overdue	3	Partially complete		Report templates are being reviewed as part of establishment of committees for 2022-23 and the development of a number of reporting templates for cyclical reporting and assurance reports.	COVID-19 arrangements have taken priority over this work.		30-Jun-22		33	12	Mar-22	
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I1	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 work undertaken by	Mar-21	Mar-22	Overdue		Partially complete		12/4/21 The Counter Fraud Team now have a presence as part of the Health Board's Mandatory Induction Programme to deliver counter fraud awareness sessions. Delivery of training to groups of staff at	Congested mandatory and statutory learning schedule for staff may be barrier to full implementation for all staff.	Training has been or will be delivered to staff at higher irks of exposure to fraud.	Formalisation of Mandatory training for staff at higher risk of exposure to fraud will be explored in 2021/22.		12		Mar-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	No progress		See R2 above	See R2 above	See R2 above	See R2 above		0		Mar-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	•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.			0		Mar-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							0		Mar-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.	Mar-22		Overdue	3	Partially complete		The patient experience group continued to meet during the pandemic and patent experience has been routinely collected throughout as reported on in the annual patient experience report. A Task and finish group has been set up to write a	There are no dedicated staff to work on patient experience, it relies on the capacity of operational teams and the Quality Team. We	on track	Mar-22		0		Mar-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	Review and strengthen the induction arrangements for Independent Members to improve early understanding of corporate business. To include: •Background information on establishment of the health board •Good governance and structure of Committees •Board Assurance Framework •Cycle of meetings and Terms of Reference	Mar-22		Overdue	2	Partially complete		Work is in progress to be in place for the appointment of the new Independent Member (Third Sector).		Induction meetings with the Board Secretary, Executive Directors and other senior staff cover the items listed in the management response	30-Apr-22		0		Mar-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	No progress		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		0		Mar-22	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Audit, Risk and Assurance Committee	**Date of Meeting: 26 April 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, 6 April 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:

WHCs 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 March 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 15 Complete and 2 Partially Complete
- For those WHCs received in 2021 there are 20 Complete, 5 Partially Complete and 3 with No Progress

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 and 2020 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 March 2022 and the position reported in April 2021 and October 2021: -

	2018	2019	2020	2021		
	Position at 31/03/22	Position at 31/03/22	Position at 31/03/22	Position at 30/04/21	Position at 31/10/21	Position at 31/03/22
No Progress	0	0	0	0	0	3
Partially Complete	1	2	2	1	8	5
Complete	47	36	15	5	9	20
TOTAL NUMBER ISSUED	**48**	**38**	**17**	**6**	**17**	**28**

NEXT STEPS:

The Corporate Governance Team will continue to log and distributable Welsh Health Circulars to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported to the Audit, Risk and Assurance Committee on a quarterly basis, the next update report is due to be presented on 18th July 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 optometrist.	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	022- Sharing Patient Information - Royal College of
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery	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:	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	034 - Cancer - Policy - Single Cancer Pathway -
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Medical Director	Immediate	Partially Complete	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	003 - Value Based Health Care Programme - Data
2020-014	Ear Wax Management	29/09/2020	Determine and report on current service provision across Wales. Develop a national integrated pathway for the safe and effective management of ear wax to provide consistent patient outcomes across Wales and ensure: Equitable access; Efficient and effective use of NHS resources;	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:\ Services\Risk & As
2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to	Director of Primary, Community and Mental Health		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.	J:\ Services\Risk & As
2021-021	Introduction of Shingrix® for Immunocompromised Individuals (From September 2021)	27/08/2021	From 01 September 2021, general practices should offer the non-live shingles vaccine Shingrix® to all those who are eligible for shingles vaccination but are clinically contraindicated to receive the live vaccine	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	J:\ Services\Risk & As
2021-022	Publication of the Quality and Safety Framework	17/09/2021	Can you please share this Framework, link attached below, with all health and care staff within your organisations and continue to embed the ethos of good quality, safe care above all else.	Director of Nursing and Midwifery		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	J:\ Services\Risk & As
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Partially Complete	**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	J:\ Services\Risk & As
2022-007	Recording of Dementia READ codes	15/02/2022	Annex 1 sets out the READ codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their	Director of Primary, Community and Mental Health	01/04/2022	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.	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		WHC 2022 005 requirements for V WHC 2022 005 - requirements for T
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 routine and	Programme Director for Covid Vaccination	01/06/2022	Not Yet Due		WHC 2022 011 nt Testing Framewo
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 - bursable vaccines

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2021-002	Board Champion Roles	19/01/2021	Local Health Boards and NHS Trusts should undertake the following action: Identify the individuals currently fulfilling the Champion roles stated in this WHC as to be discontinued and advise them of this decision. Ensure the	Board Secretary		Complete	Board Champion role confirmed and approved at Board 30/3/22	J:\ Services\Risk & As
2021-008	Revised National Steroid Treatment Card	01/06/2021	Based on guidance from an expert working group,1 a steroid treatment card should be given to those patients receiving exogenous glucocorticoids at risk of adrenal insufficiency.	Director of Primary, Community and Mental Health	15/10/2021	Complete		J:\ Services\Risk & As
2021-026	OVERSEAS VISITORS' ELIGIBILITY TO RECEIVE FREE PRIMARY CARE	06/10/2021	LHB Chief Executives in conjunction with their Directors of Primary Care are asked to ensure copies of this circular are sent to all General Medical Services (GMS) contractors, Pharmacists, Dentists, Optometrists and	Director of Primary, Community and Mental Health	To be initially reviewed 12 months from issue of WHC	Complete	28.03.22 Circuated to all contractor professions and published on PTHB Intranet (Primary care page)	WHC 2021 026 - SEAS VISITORS' E
2021-027	NHS Wales Blood Health Plan	27/09/2021	It is essential that blood and blood components are used only when needed and where no other suitable alternative exists. The Plan therefore sets direction of optimising blood health and transfusion practice under	Medical Director	End November 2021	Complete	**March 2022** . The Blood Health Plan has been shared with Senior Nurse Clinical Leads within Planned Care. PTHB Planned Care do not undertake blood transfusions AS1 & AS2 low complex day case surgery only within PTHB. Pre-screening is general any issues	J:\ Services\Risk & As
2021-028	AMR & HCAI Improvement Goals For 2021-22	27/09/2021	Health boards should ensure IP&C measures and patient pathways of the COVID pandemic IP&C response are in place with plans for outbreak management and preparedness for Autumn and Winter 2021-22.	Medical Director		Complete	**March 2022** Chief Pharmacist leading the work on optimising the use of antimicrobials. WHC (2021) Number 28 optimising the use of antimicrobials improvement goals discussed during	J:\ Services\Risk & As
2021-032	Role and Provision of Dental Public Health in Wales	16/11/2021	Chief Executives of NHS organisations are requested to ensure dental public health consultants and other resources work for the whole system in Wales and that provision is consistent with this guidance.	Medical Director	Nov-24	Complete	**March 2022** This WHC is directed to PHW so there is no action for PTHB other than for information.	J:\ Services\Risk & As
2021-033	Role and Provision of Oral Surgery in Wales	14/12/2021	Chief Executives of NHS organisations are requested to ensure that those providing NHS oral surgery work for the whole system in Wales and that provision is consistent with	Director of Finance and IT	Immediate	Complete	recruited community and primary care based consultant oral surgeon for North Powys supported by DwES/Senior Dental Officers in oral surgery to provide tier 2 oral surgery procedures.	WHC 2021 033 - e and Provision of
2021-034	2022-23 Health Board revenue allocation	21/12/2021	Health Boards are expected to develop robust plans to deliver against the priorities for 2022-23 set out in the NHS Planning Framework from within this allocation. This is an initial allocation and additional funding for key	Director of Finance and IT	Immediate	Complete	Draft financial plan completed as part of the 2022/23 - 2024/25 IMTP with a focus on recovery and renewal from the pandemic whilst meeting its statutory duty to breakeven over the 3 year period. The financial plan has been developed based on the Welsh Government	WHC 2021 034 - 2022-23 HB Allocation.docx WHC 2021 034a - 2022-23 Health Board Allocation -

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	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Governance & Assurance:								
Approach to 2022-23 Annual Accounts	DF&IT							✓
Annual Accountability Report 2021-22	BS	✓	✓					
Annual Accounts 2021-22, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Losses and Special Payments Annual Report 2021-22	DF&IT		✓					
Losses and Special Payments Update report	DF&IT			✓			✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS			✓				
Review of Standing Orders	BS	✓						
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							✓
External Audit Progress Report 2022-23	EA	✓	✓	✓	✓	✓	✓	✓
External Audit Review Reports	EA	**In line with External Audit Plan 2022-23**						

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
External Audit Structured Assessment	EA					✓		
Anti-Fraud Culture:								
Bribery Policy	HoLCF			✓				
Counter Fraud Annual Report 2021-22	HoLCF	✓						
Counter Fraud Update	HoLCF			✓			✓	
Counter Fraud Workplan 2023-24	HoLCF							✓
Post Payment Verification Annual Report 2021-22	PPVO		✓					
Post Payment Verification Workplan 2023-24	PPVO							✓
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2021-22	BS				✓			
Development of Committee Annual Programme of Business	BS	✓						
Review of Committee Programme of Business	BS		✓	✓	✓	✓	✓	✓
Annual Self-assessment of Committee effectiveness 2022-23	BS						✓	
Committee Annual Report 2022-23	BS							✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓
Local Counter Fraud Team				✓			✓	

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
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