Audit, Risk & Committee

18 May 2020, 10:30 to 13:30
Skype Meeting

Agenda

1
PRELMINARY MATTERS

ARA_Agenda_18May2020.pdf (3 pages)

1.1
Welcome and Apologies

Oral

Chair

1.2
Declarations of Interest

Oral

All

1.3
Minutes from the Previous Meeting held on 9 March 2020 (for approval)

Attached

Chair

ARA_Item_1.3_Unconfirmed_Minutes_9 March 2020.pdf (12 pages)

1.4
Matters Arising from Previous Minutes

Oral

Chair

1.5
Committee Action Log

Attached

Chair

ARA_Item_1.5_Action Log_18 May 2020.pdf (2 pages)

2
ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1
Application for Single Tender Waiver

Attached

Director of Finance & IT

2.2
Financial Control Procedure: COVID-19

Attached

Head of Local Counter Fraud

3
ITEMS FOR DISCUSSION

3.1
Head of Internal Audit Annual Report and Opinion for 2019-20

Attached

Head of Local Counter Fraud Services

ARA_Item_3.1_PTHB HoIA Opinion and Annual Report19-20. Final.pdf (37 pages)

3.2

Internal Audit Reports, 2019-20:

Attached

Board Secretary

3.2.1

Welsh Risk Pool Claims Management

ARA_Item_3.2a_PTHB_2019-01_Welsh Risk Pool Claims Management_Final Internal Audit Report_for health board issue.pdf (18 pages)

3.2.2

Capital Assurance Follow Up

ARA_Item_3.2b_Powys_Capital Assurance Follow Up_1920_Draft Report_v0.2.pdf (19 pages)

3.2.3

Outpatients - Planned Activity

ARA_Item_3.2c_PTHB_2019-21_Outpatients Planned Activity_Draft Internal Audit Report.pdf (36 pages)

3.2.4

Estates Assurance Follow Up

ARA_Item_3.2d_Powys_Estates Assurance Follow Up_1920_Draft Report_0.2.pdf (14 pages)

3.2.5

Financial Safeguarding: Estates Team Led Work

ARA_Item_3.2e_PTHB_Financial Safeguarding (Estates)_1920_Draft Report.pdf (28 pages)

3.2.6

Financial Safeguarding: Support Services Led Work

ARA_Item_3.2f_PTHB_Financial Safeguarding (Support Services)_1920_Draft Report.pdf (19 pages)

3.2.7

Risk Management and Board Assurance

ARA_Item_3.2g_PTHB_Risk Management and Board Assurance_Final Internal Audit Report_for health board issue.pdf (40 pages)

3.2.8

Welsh Language Standards Implementation

ARA_Item_3.2h_PTHB_1920_Welsh Language Standards Implementation_Draft Internal Audit Report_for client issue_v2.pdf (22 pages)

3.3

External Audit:

Attached

Head of Internal Audit

3.3.1

Letter from Auditor General

ARA_Item_3.3a_Audit Wales_COVID19 - Audit Plan Update Letter_Powys.pdf (4 pages)

3.3.2

Letter from Engagement Director

ARA_Item_3.3b_Audit Wales_Letter to Chief Executives.pdf (5 pages)

3.4

Approach to the Management of Audit Recommendations during COVID-19

Attached

Head of Internal Audit

ARA_Item_3.4_Management of Audit Recs During COVID.pdf (9 pages)

3.5

Approach to Risk Management during COVID-19

Attached

Head of Internal Audit

ARA_Item_3.5_Risk Management During COVID.pdf (5 pages)

3.6

Draft Financial Statements 2019-20

3.7

Draft Annual Accountability Report, 2019-20

Attached

External Audit

4

ITEMS FOR INFORMATION

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 the Next Meeting: 25 June 2020, 10.00 am, Board Room, Glasbury House

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
MONDAY 18 MAY 2020
10.30AM – 01.30PM
BOARDROOM, GLASBURY HOUSE, BRONLLYS HOSPITAL

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meetings on 9th March 2020	Attached	Chair
1.4	Matters Arising From Previous Meetings	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Application of Single Tender Waivers	Attached	Director of Finance & IT
2.2	Financial Control Procedure: COVID-19	Attached	Director of Finance & IT
3	**ITEMS FOR DISCUSSION**		
3.1	Head of Internal Audit Annual Report and Opinion for 2019-20	Attached	Head of Internal Audit
3.2	Internal Audit Reports, 2019-20: <u>Substantial Assurance Rating</u> a) Welsh Risk Pool Claims Management b) Capital Assurance Follow Up <u>Reasonable Assurance Rating</u> c) Outpatients – Planned Activity d) Estates Assurance Follow Up e) Financial Safeguarding: Estates Team Led Work f) Financial Safeguarding: Support Services Led Work	Attached	Head of Internal Audit Supported by Executive Director Leads

	Limited Assurance Rating g) Risk Management and Board Assurance h) Welsh Language Standards Implementation		
3.3	External Audit: a) Letter from Auditor General b) Letter from Engagement Director	Attached	External Audit
3.4	Approach to the Management of Audit Recommendations during COVID-19	Attached	Board Secretary
3.5	Approach to Risk Management during COVID-19	Attached	Board Secretary
3.6	Draft Financial Statements 2019-20	Attached	Director of Finance & IT
3.7	Draft Annual Accountability Report, 2019-20	Attached	Board Secretary
4	**ITEMS FOR INFORMATION**		
	There are no items for inclusion in this section		
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: • 25 June 2020, 10.00am, Boardroom, Glasbury House		

Key:

(green)	Governance & Assurance
(blue)	Internal & Capital Audit
(orange)	External Audit
(yellow)	Anti-Fraud Culture

MESSAGE TO THE PUBLIC:

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 by electronic / telephony means as opposed to in a physical location, for the foreseeable future. This will mean that members of the public will not be able attend in person or observe on-line.

The Board has taken this decision in the best interests of protecting the public, our staff and Board members. The Board will publish a summary of meetings held on our website within a week of the meeting to promote openness and transparency.

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED
MINUTES OF THE MEETING HELD ON
MONDAY 9 MARCH 2020
BOARD ROOM, GLASBURY HOUSE, BRONLLYS HOSPITAL

Present:

Tony Thomas	Independent Member – Finance (Committee Chair)
Mark Taylor	Independent Member – Capital and Estates
Ian Phillips	Independent Member – ICT

In Attendance:

Pete Hopgood	Director of Finance, Information and IT
Len Cozens	Head of Local Counter Fraud Services
Jackie Wilding	CHC Observer
Barrie Morris	External Audit (Grant Thornton)
Sarah Pritchard	Head of Financial Services
Elaine Matthews	External Audit (WAO)
Felicity Quance	Internal Audit
Osian Lloyd	Deputy Head of Internal Audit
Helen Higgs	Head of Internal Audit
Rani Mallison	Board Secretary
Jayne Lawrence	Assistant Director of Primary Care Services
Carol Shillabeer	Chief Executive
Dave Thomas	External Audit (WAO)
Jacqui Wilding	CHC Observer
Stuart Bourne	Director of Public Health (for item 3.1d)

Committee Support

Caroline Evans	Head of Risk and Assurance

Apologies for absence:

Mel Davies	Vice Chair
Matthew Dorrance	Independent Member – Local Authority
Carol Shillabeer	Chief Executive

ARA/19/103	**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/19/104	**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/19/105	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 14 January 2020 were RECEIVED and AGREED as being a true and accurate record.
ARA/19/106	**MATTERS ARISING FROM PREVIOUS MEETINGS** The Chair stated the pre-meeting held a discussion with the Head of Counter Fraud Services, and this had arised in a successful conclusion.
ARA/19/107	**COMMITTEE ACTION LOG** ARA/19/89: Rani Mallison confirmed that the Structured Assessment will be included in the Committee's workplan for next year. ARA/19/87: Pete Hopgood stated he has not received an update from procurement colleagues regarding the European Journal, and will follow this up. ARA/19/77: Rani Mallison stated that the CEO is unable to attend the Committee today in light of planning around Covid19, and requested that the ICF report is deferred to the next meeting. **Action: Board Secretary** ARA/19/68: Rani Mallison stated that work is ongoing in respect of the Serious Incidents Policy will be presented to the Experience, Quality and Safety Committee for approval in April.

ARA/19/108	**SINGLE TENDER WAIVERS (STWs)** Sarah Pritchard presented the STW request made between 1 January 2020 and 29 February 2020 and signed by the Chief Executive. Mark Taylor questioned if the STW is retrospective, not prospective. Sarah Pritchard stated that it is prospective, and that patients would not be sent for treatment until the STW is approved by the Committee. After discussion, the Committee RATIFIED the approval of the one STW (Dental Surgical Interventions for Children and Young Adults [£30,000]).
ARA/19/109	**COUNTER FRAUD POLICY & RESPONSE PLAN** The Committee Chair stated this is Len Cozens' last meeting as Len is moving onto another role, and thanked Len for all of the work that has been done, which has resulted in substantial improvements on previous arrangements. Len Cozens thanked the Committee for all of its support. Len Cozens presented the report, which provides a review and update of the Counter Fraud Policy & Response Plan. The Fraud, Bribery and Corruption Standards for NHS Bodies (Wales) produced by the NHS Counter Fraud Authority requires organisations to put in place a Counter Fraud, Bribery and Corruption Policy, which must be approved by the executive body or senior management team. The Committee APPROVED the Counter Fraud Policy & Response Plan.
ARA/19/110	**FCP 021: BUDGETARY CONTROL PROCEDURE** Pete Hopgood presented the Budgetary Control Procedure, which has been revised in line with Internal Audit recommendations, to ensure that the document remains relevant and reflects best practice. The key changes include: • Clarifying andtimescales on the publication of the annual letter of accountability to principle budget holders; • Any unallocated funds held in reserves will be reported within the Risks & Opportunities section of the Board Report; • New approach for scrutinising and approving all Business Cases and bids via the IBG process; • Clarification on the IMTP and Budget Setting process; • Revised process for recording and approving budget virements.

	Rani Mallison stated the policy will help address the recommendation from WAO within the Structured Assessment, in respect of budget letters. The Committee APPROVED the FCP 021: Budgetary Control Procedure.
ARA/19/111	**COUNTER FRAUD WORKPLAN 2020/21** Len Cozens presented the Local Counter Fraud Workplan 2020/21. The Fraud, Bribery and Corruption Standards for NHS Bodies (Wales) produced by the NHS Counter Fraud Authority require the nominated Local Counter Fraud Specialist (LCFS) and Director of Finance at each health body to agree, at the beginning of each financial year, a written work plan which outlines the LCFS' projected workload for that year. Len Cozens stated the plan will need to be revisited following completion of the self-review tool. In addition, the LCFS is currently on sick leave, so the plan may need to be adjusted in terms of available days. Any adjustments to the plan will be discussed with the Director of Finance, and will be brought to the next Audit, Risk & Assurance Committee. **Action: Head of Local Counter Fraud Services / Director of Finance** The Committee RECEIVED and NOTED the content of the report.
ARA/19/112	**AUDIT RECOMMENDATIONS TRACKING, JANUARY 2020** Rani Mallison presented the report, which provides an overview of the current position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit and External Audit (Wales Audit Office). Rani Mallison stated the team will shortly be working on development of the Annual Report, and it will be helpful to show the improvement on the implementation of audit recommendations within the Annual Report. Ian Phillips stated it would be helpful to have one overall appendix that states where the key issues are. Rani Mallison noted that this was included in the appendices but would look to make this more visible. The Committee RECEIVED and NOTED the content of the report.

ARA/19/113	**INTERNAL AUDIT PROGRESS REPORT** Helen Higgs presented the report, which informs the Committee of progress with the 2019/20 Internal Audit Plan as recorded at March 2020. Progress against the plan is as follows: - Helen Higgs informed the Committee the plan is on track to deliver. The Committee RECEIVED and NOTED the content of the report.
ARA/19/114	**INTERNAL AUDIT PLAN 2020/21** Helen Higgs presented the Internal Audit Plan 2020/21, which details the audits to be undertaken and an analysis of the correspeonding resources. The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk & Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. Helen Higgs stated that the plan has been developed in collaboration with Directors, sub-committees and the Board Secretatry. The plan has also been discussed with the Executive Committee. The Board Secretary stated that planning this year was really helpful, with IMs fully engaged. The Committee RECEIVED and NOTED the content of the report.
ARA/19/115	**INTERNAL AUDIT REVIEWS** **<u>Reasonable Assurance Rating</u>** **a) Primary Care Clusters** Osian Lloyd reported that the review identified one high, three medium and one low priority findings. Specifically, the audit focused on the following areas: • cluster plans, their format and content and compliance with the requirements of the Welsh Government framework guides;

	20
Number of audits issued at draft	2
Number of audits in progress	7
Number of audits not started	0
Year-end reporting	(2)
Total number of audits in 2019/20 plan	**29**

	• whether planning is two-way, particularly looking at how the health board inputs in cluster level plans, and how those plans are then reflected throughout the health board's IMTP; • the level of support given to the clusters by the health board in terms of Workforce and Finance resource; • the processes by which clusters provide assurance reporting to the Board; • whether oversight, leadership, performance monitoring and support is given to the PCCs through health board management and their supporting teams; and • whether mechanisms are in place to ensure that changes arising from the continuously improving cluster working are being communicated to the public and that the cluster model operating is delivering sustainable services. Ian Phillips stated that culture, maturity and ethos of cluster development is important, and questioned whether this will be considered as part of the reporting process. Rani Mallison stated the Director of Primary, Community and Mental Health Services is developing a Governance Framework, built on a national governance model for clusters. **b) Organisational Development Strategic Framework** Osian Lloyd reported that the review identified two medium priority findings. Specifically, the audit focused on the following areas: • the process by which the health board determined its key priorities required to deliver the new strategic framework; • engagement with key stakeholders on the proposed changes; • management of the implementation of the organisational development priorities, including clarity on roles and responsibilities; • the processes by which the Board receive assurance reporting of the implementation progress of the framework; and • management of risks and issues associated with the implementation of the framework. **c) Dental Services: Monitoring of the GDS Contract Follow-up**

	Osian Lloyd reported that the review identified two low priority findings. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan. Helen Higgs stated that the review focuses on progress of implementation of the recommendations from the previous review, as opposed to a full review based on the original audit scope. Ian Phillips stated he is pleased to see a tightening up of the contract monitoring and review, but has concerns around the unintended consequences of this, including access to GDP Services, as a result of disincentivising Dentists. Pete Hopgood stated the health board needs to ensure it sets the contract at the right level to enable reinvestment that can improve access elsewhere. Osian Lloyd stated that practices are expected to deliver 95% of their annual allocation. Rani Mallison stated that the Commissioning Assurance Framework in respect of GDS is presented to the Performance & Resources Committee. Ian Phillips asked how quickly are we receiving information in respect of underperformance, and are those performance arrangements timely and robust. Pete Hopgood stated there is regular monthly review of EDA performance. Osian Lloyd stated there is a mid-review stage. Ian Phillips asked if there is a level of variability that makes it difficult to see under or over performance. Pete Hopgood stated that historic data enables us to see patterns and triggers. Tony Thomas asked if there is discussion between health boards to avoid going out to the private sector in respect of Children's Services. Jayne Lawrence stated that the health board has recently been made aware of an alternative solution through a Cwm Taf Paediatric specialist, which provides a NHS pathway. The health board is now linking with Cwm Taf to obtain further detail. **d) Information Technology Service Management** Osian Lloyd reported that the review identified two medium and one low priority findings. The key objective areas of the review were as follows:

	• IT services are appropriately designed, provided and managed with reference to an appropriate framework (ITIL); • service desk provision is appropriate and appropriate request for service fulfilment management practices are followed; and • appropriate documented processes are in place for change, incident, event, problem, release and deployment management. Pete Hopgood confirmed that actions owned by non-PTHB employees due to the section 33 agreement have been signed off. Ian Phillips stated the user experience didn't feature in the audit, and that we might want to consider that going forward. Helen Higgs stated that there is a review scheduled for next year in respect of access to systems, which should encompass this query. **e) Machynlleth Hospital Primary & Community Care Project** Felicity Quance reported that the review identified one high, four medium and one low priority findings. The focus of the audit was directed to the following areas: Governance arrangements: • assurance that adequate governance arrangements were in place, including management ownership, defined roles and responsibilities, together with clear defined accountability and delegation arrangements; and • assurance that generally accepted project management techniques were appropriately applied and reported. Approvals: • assurance that appropriate internal/external approval mechanisms were applied as the project progressed through key junctures; and • assessment of the adequacy of the arrangements to develop the business case, including assurance that lessons learnt from previous projects were applied and that scrutiny comments were adequately addressed. Appointment and Contracting • assurance that appropriate contract documentation had been completed in accordance with the current phase of the project to protect the interests of the THB. This included any novation (where required) from the prior contractor and clarity of design liability. Cost monitoring and reporting • assurance that there was effective control and reporting of time and cost position; costs associated with the novation of design responsibility were clearly understood, challenged and reported; and the Project Board were effectively informed on any impact on the value for money assessment.

	Additional issues • identification and assessment of any additional key issues affecting the progression of the project. Mark Taylor stated that the management response in respect of the timeliness of signing of contract documentation is vague in terms of how we are evidencing the intention to the signatories. Rani Mallison stated this she would discuss this with the Director of Planning. **Action: Board Secretary** Mark Taylor noted the management response in respect of recommendation 6 (lessons learnt), but asked that the lessons learnt exercises be shared with the Committee. **Action: Board Secretary** Felicity Quance stated the Machynlleth Project is on next year's Internal Audit Plan, and the recommendations raised within this report will be followed up. Mark Taylor stated there is a gap in terms of the FBC being report through Board without going through a Committee initially. Rani Mallison stated that it should be reported through Performance and Resources prior to Board. Mark Taylor stated concern over clinical input signified by the attendance at meetings on page 27 of the report. Mark stated that if someone isn't going to attend they should be either not relevant or should nominate someone to attend on their behalf. Felicity Quance stated that a review of the ToR has been requested, questioning the appropriateness of the individuals named as nominated representatives, and challenging for non-attendance. The Committee RECEIVED the Internal Audit update.
	WALES AUDIT OFFICE REPORTS: **a) PRIMARY CARE SERVICES IN WALES** Jayne Lawrence joined the meeting via conference call. Jayne Lawrence presented the report to the Committee which detailed the progress of the Primary Casre Model for Wales. It was reported that many elements are in place across Powys however there is a lack on consistency, this is aligned with the recommendations made within the report. The report concluded that changes have been occurring across wales however at different paces.

It has been agreed with Welsh Government that the IMTP would be the mechanism for tracking rpgress against the recommendations within the report for Powys. It was noted that the IMTP includes 3 cluster specific IMTPs in Powys. The report also refereneced the additional £10m recurring funding for Wales (just over £400k for Powys) for clusters.

The Committee was assured that the Director of Primary, Community Care and Mental Health and the Assistant Director of Primary Care Servoces have been developing a revised cluster framework and Terms of Reference for Powys alongside the cluster leads to ensure appropriate representation. The strategic programme for Primary Care has 7 work streams and has been set up to increase the pace of the model.

It was noted that the workstream programme action plan has been approved by the National Primary Care Board and has been shared with CEO's across Wales.

The Committee RECEIVED the Structured Assessment.

EXTERNAL AUDIT: PROGRESS REPORT

Elaine Matthews presented the progress report, which provides an update on progress in relation to both financial and performance audit work, as well as information on the Auditor General's programme of NHS-related studies and publications as well as Good Practice Exchange events.
The following provides an update of work recently completed and/or underway:

Topic	Status	Executive lead	Committee report date
Follow up (2018): Orthopaedics	Fieldwork	Director of Planning and Performance	TBC
AGW review (2019): Review of the effectiveness of counter fraud arrangements	Fieldwork	Director of Finance	TBC
All Wales Thematic Review (2019): Quality governance arrangements	Scoping	TBC	TBC

The Committee RECEIVED the Audit Progress Report.

	EXTERNAL AUDIT PLAN 2020/21 Barrie Morris presented the External Audit Plan for 2020/21 to the Committee. It was noted that the Financial Audit has started with key risk identified as being: • Management override of Controls • Healthcare Commissioning Contracts Work is underway regarding the risks and update meetinsg have been held periodically thourghout the year with the Director of Finance and IT and the Head of Financial Services. Other areas for consideration included, ministerial in relation to implementation of a schemes pays initiative and IFRS 16 in respect of leases. Once the Audit has been completed there will be a full hand over with WAO in respect of next years audit. Mark Thomas queried if the lessons learned and ongoing work in Maternity Services across Wales will form part of the thematic performance or audit quality work. Elaine Matthews noted that HIW has done a lot of work on Maternity Services and Rani Mallsion raised that this item is reported to Experience, Quality and Safety Committee. The Committee NOTED that Anthony Veale will be taking over as financial lead for WAO following the handover from Grant Thornton.
	COMMITTEE RISK REGISTER Rani Mallison presented the Committee Risk Register to the Committee. It was noted that no updates have been made to the register since 14 January 2020 and that work is continues to develop the Directorate Risk registers and Directorate Assurance Mapping.
	COMMITTEE WORKPLAN 2019/20 Rani Mallison presented the workplan, which outlines planned pieces of work and any amendments made since the last meeting. It was noted that this will be the final version of the 2019/20 plan and planning for 2020/21 workplan will be undertaken. The Corporate Governance team will be in contact with the relevant teams for population over the coming weeks. The Committee RECEIVED and NOTED the content of the report.
	IMPLEMENTATION OF IFRS 16 – LEASES Sarah Pritchard provided an update to the Committee noting that as the National Lead for this work, meetings have been

	held monthly on a national basis. The full impact won't be within PTHB's accounts formally until 20/21 however an estimation will be included in 19/20 accounts. The core area of work has been assessing all of the Health Boards leases. One of the main difficulties is that peppercorn leases (buildings the Health Board occupy) have to be valued, these are due to be formally valued by the District Valuers office on 1st April 2020.
ARA/19/121	**ITEMS TO BE ROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Chair requested that continued satisfaction with the Audit Recommendation Tracking process and the 4 Resonable Assurance Audit Reports are shared with the Board.
ARA/19/122	**ANY OTHER URGENT BUSINESS** There was no other urgent business for discussion, and the Chair declared the meeting closed at 11.26 am.
ARA/19/123	**DATE OF NEXT MEETING** 27 April 2020, 01:30pm, Boardroom, Glasbury House, Bronllys

Key:

Completed
Not yet due
Due
Overdue
Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(May 2020)

Minute	Date	Action	Responsible	Progress	Status
ARA/19/87	14 January 2020	It will be queried with procurement colleagues whether the organisation will still be obliged to advertise in the European Journal post-Brexit	Director of Finance & IT		
ARA/19/77	11 November 2019	The Integrated Care Fund Report for RPB will be circulated to Committee members	Chief Executive	Attached: https://www.audit.wales/publication/integrated-care-fund-powys-regional-partnership-board	
ARA/19/68	11 November 2019	Health Board to hold a designated list of investigative officers in order to improve training and skills	Chief Executive	Serious Incidents Policy scheduled for Board, 27 May 2020.	

ARA/19/111	9 March 2020	The revised Local Counter Fraud Workplan 2020/21 will be brought to the next meeting of the Committee	Head of Local Counter Fraud Services / Director of Finance	Delayed due to COVID-19.	
ARA/19/115e	9 March 2020	The management response in respect of the timeliness of signing of contract documentation will be picked up with the Director of Planning & Performance.	Board Secretary	Delayed due to COVID-19.	
ARA/19/115e	9 March 2020	The Machynlleth Hospital Primary & Community Care Project recommendation 6 (lessons learnt) would be shared with the Committee, once available.	Board Secretary	Delayed due to COVID-19.	

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2019/20

May 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS

Report status: Final
Final report issued: xx May 2020
Author: Helen Higgs, Head of Internal Audit
Executive distribution: Carol Shillabeer, Chief Executive Officer
Rani Mallison, Board Secretary
Audit Committee: 18 May 2020

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved internal audit plan is biased towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion has been formed by summarising audit outcomes across eight key assurance domains. The overall opinion is then based upon these grouped findings. All domains carry equal weighting.

In my opinion 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. Several significant matters require management attention with moderate impact on residual risk exposure until resolved. Residual risk exposure in some areas (typically those areas with a 'limited' assurance rating) will be high until matters are resolved and these are detailed within this report.

1.3 Delivery of the Audit Plan

The internal audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit & Risk Assurance Committee. Regular audit progress reports have been submitted to the Audit & Risk Assurance Committee during the year.

As a result of the COVID-19 pandemic and the response to it from the health board, we have not been able to complete our audit programme in full. However, we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

We had anticipated, after adjustments to the original audit plan agreed with the Audit Committee, producing 29 outputs at the year end. However, due to the impact of COVID-19 the final position at Powys Teaching Health Board is: 21 Final reports and six Draft reports. There were no instances where insufficient work had been done to be used to support the opinion. No audits that are work in progress have been used to support the overall opinion.

For those audits that are at the Draft report stage, we will agree an appropriate approach to complete and finalise those reports with the health board for formal submission to the Audit Committee at a later date.

There are, as in previous years, additional audits undertaken at NWSSP, NWIS, WHSSC and EASC that support the overall opinion for NHS wales health bodies (see Section 3).

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2019/2020. We are now able to state that our service 'conforms to the Institute of Internal Audit's (IIA's) professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

The report summarises the outcomes from the internal audit plan undertaken in the year. The report also references assurances received through the internal audit of control systems operated by NWSSP for transaction processing on behalf of the Teaching Health Board.

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

In overall terms we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Strategic planning, performance management and reporting;
- Financial governance and management;
- Operational service and functional management;
- Workforce management; and
- Capital and estates management.

However, the significance of the matters identified in those areas where there are improvements to be made in governance, risk management and control impacts upon our overall audit assessment in the following assurance domains:

- Corporate governance, risk management and regulatory compliance;
- Clinical governance quality and safety; and

- Information governance and I.T. security

Management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where appropriate.

Please note that our assessment across each of the domains has also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (see also Sections 2.4.1 and 5.7).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key

organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Powys Teaching Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Wales Audit Office in the context of their external audit.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide the forming of the opinion for 2019/20.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix D**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the eight assurance domains that were used to frame the internal audit plan at its outset. The aggregation of audit results by these domains gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the assurance domain ratings and overall opinion are consistent with the underlying audit evidence and in accordance with the criteria for judgement at **Appendix E**.

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any *limited* or *no-assurance* reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the opinion, the Head of Internal Audit has applied both professional judgement and the Audit & Assurance '*Supporting criteria for the overall opinion*' guidance produced by the Director of Audit & Assurance and shared with key stakeholders, see **Appendix E**.

The Head of Internal Audit has concluded 'reasonable' assurance can be reported for the Strategic Planning, Performance Management & Reporting; Financial Governance; Operational Service & Functional Management; Workforce Management and Capital & Estates domains. Only 'limited' assurance can be reported across the Corporate Governance, Risk & Regulatory Compliance; Clinical Governance, Quality & Safety; and Information Governance & I.T Security domains.

The audit work undertaken during 2019/20 and reported to the Audit Committee has been aggregated at **Appendix B**.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module; and
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

As stated above these detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed.

I have also considered residual risk exposure across those assignments where limited assurance was reported.

Where changes were made to the audit plan then the reasons were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review; I have considered the impact of changes made to the plan when forming my overall opinion.

Whilst we have been able to provide the health board with a reasonable overall opinion in 2019/20, the following should be noted.

Of the 27 reviews included in the 2019/20 Internal Audit Plan, 15 were rated as providing 'reasonable' assurance and two 'substantial'. Six reviews were rated as 'limited' assurance with a further one providing 'no' assurance. Ratings were not applicable to three reviews.

Audits of 'risk management & board assurance', 'Welsh Language Standards', 'care and nursing homes governance', DOLS best interest assessments', FoI requests' all received limited assurance. In addition, the follow up work on the 2017/18 'no' assurance report of 'podiatry' received a 'limited' assurance rating in 19/20.

The health board recognises that the effective management of risk is a key responsibility. It is therefore disappointing that for the second year running we have been able to deliver only a 'limited' assurance rating. We observed limited progress with implementing prior year recommendations, resulting in several of the findings from our 2018/19 limited assurance report being repeated. Whilst we noted slight improvement, the key finding from previous years remains –

there is an absence of directorate level risk registers and a lack of evidence of management oversight by directorate teams.

We gave a 'no assurance' rating to our review of the 'records management' where significant issues were highlighted. The overarching theme of our findings was the inadequacy of arrangements in place. The majority of the findings were consistent with those raised in previous audits, dating as far back as 2012, including a no assurance report in 2015/16. We raised six high priority recommendations.

Due to the Covid 19 outbreak and the impact on health board resource, we were unable to progress with two of the four remaining follow up reviews of 2018/19 limited assurance outcomes ('health & safety' and 'Section 33 governance arrangements'). The reviews of 'dental services – monitoring the GDS contract' and 'catering department' evidenced sufficient improvements to enable assurance ratings of 'reasonable'.

Both the Board and operational management have worked in partnership with Internal Audit throughout the year and formal feedback on our work demonstrates that Internal Audit is helping the health board to make continuous improvements.

A summary of the findings in each of the domains is set out below. Each domain heading has been colour coded to show the overall assurance for that domain.

Corporate Governance, Risk Management and Regulatory Compliance

We delivered four reviews within this domain, which is rated as limited assurance.

The 'risk management and board assurance' review was rated as providing limited assurance. We observed limited progress with implementing prior year recommendations, resulting in several of the findings from our 2018/19 limited assurance report being repeated. Whilst we noted slight improvement, the key finding from previous years remains – there is an absence of directorate level risk registers and a lack of evidence of management oversight by directorate teams.

'Welsh Language Standards implementation' was also rated as limited assurance. As of March 2020, the health board was behind its peers in assessing the impact of the Standards, there was no overarching implementation action plan in place and the majority of directorate action plans were still under development.

The review of 'assurance on implementation of audit recommendations' was rated as providing reasonable assurance, although one high priority finding was identified with regard to ensuring progress updates and revised deadlines are incorporated into the audit recommendation tracker.

Our review of 'Welsh Risk Pool Claims Management' received a substantial assurance rating.

Strategic Planning, Performance Management & Reporting

We delivered two reviews within this domain, which is rated as reasonable assurance.

Both reviews – 'primary care clusters' and 'Organisational Development Strategy' – were rated as providing reasonable assurance. One high priority recommendation was raised in the 'primary care clusters' report around the need to develop a Primary Care Cluster Governance Framework.

Financial Governance and Management

We delivered two reviews within this domain, which is rated as reasonable assurance.

Whilst the review of 'hosted bodies – governance arrangements' was not rated, we identified two high priority recommendations: that the health board clarifies the legal status of hosted bodies' staff and that it clarifies the accountability frameworks for hosted bodies.

The 'financial planning and budgetary control (commissioning)' review was rated as providing reasonable assurance.

Clinical Governance Quality & Safety

We delivered four reviews within this domain, which is rated limited assurance.

Our review of 'Deprivation of Liberty Safeguards ('DOLS') / Best Interest Assessments' was rated as providing limited assurance. We identified a number of areas of non-compliance with the DOLS Code of Practice arising from ineffective governance and oversight mechanisms within parts of the process. Additionally, further action was required to improve timeliness of DOLS authorisations.

'Care & nursing homes governance' was also rated as limited assurance. Key findings concerned improving the governance and reporting mechanisms for care homes and ensuring the authorisation of care home packages complies with the health board's Standing Orders.

The 'dental services – monitoring of the GDS contract – follow up' review was rated as providing reasonable assurance. Two of the four 2018/19 recommendations have been implemented in full and two implemented in part.

Our annual review of the health board's Annual Quality Statement ('AQS'), whilst not rated, raised one recommendation that the health board should ensure that the directorates and nominated officers provide and retain appropriate evidence to support their submissions for the AQS.

Information Governance & IT Security

We delivered three reviews within this domain, which is rated limited assurance.

The 'records management' review received a rating of no assurance, having identified significant issues with regard to the adequacy of arrangements in place. The majority of the findings were consistent with those raised in previous audits, dating as far back as 2012, including a no assurance report in 2015/16. We raised six high priority recommendations.

'Freedom of Information' ('FoI') was rated as providing limited assurance, with the key finding being poor performance against the Information Commissioners Office 20-day response target. Additional findings include limited FoI performance reporting to Board level and low staffing levels within the Information Governance team.

The 'service management – Information Technology Infrastructure Library' review was rated as reasonable assurance.

Operational Service and Functional Management

We delivered four reviews within this domain, which is rated reasonable assurance.

Our 'Podiatry Services – follow up' review received limited assurance. Whilst progress had been made against each of the eleven prior year recommendations, only one had been implemented in full. One of the seven prior year high priority recommendations – relating to the governance of the Podiatry Service – remained at high priority. In most cases, progress had been hampered by staffing levels, issues with recruitment and difficulties with operational and professional leadership.

The '111 Services' and 'outpatients – planned activity' reviews both received reasonable assurance ratings.

Two high priority recommendations were identified in the '111 Services' review: that the health board develops processes to enable the reporting requirements for the 111 Service to be met and that a suite of 111 Service metrics be agreed with WAST for regular performance reporting.

The 'outpatients – planned activity' review contained one high priority recommendation around working with health organisations in Wales and England to enhance the reporting of outpatients follow-up appointments waiting times.

Our follow up review of 'catering departmental review' also received reasonable assurance, with two of the 2018/19 recommendations having been implemented in full and the remaining five implemented in part.

Workforce Management

We delivered three reviews within this domain, which is rated reasonable assurance.

The 'disciplinary case management', 'safeguarding – appropriate employment arrangements' and 'staff wellbeing' reviews were all rated as reasonable assurance.

Capital & Estates Management

We delivered five reviews within this domain, which is reasonable assurance.

Reasonable assurance was determined at the 'estates assurance follow up' and 'Machynlleth Project' reviews. One high priority recommendation was identified in the 'Machynlleth Project' relating to retention of contract documentation and ensuring contract documentation is fully completed in a timely manner.

The 'capital systems' review was split into two reports covering projects/contracts led by the Estates Team and projects/contracts led by the Support Services Team – both reports received reasonable assurance.

The 'Capital assurance follow up' review was rated as providing substantial assurance.

A review (not delivering an assurance opinion) has also been completed in respect of Environmental Sustainability Reporting. Whilst not rated, this report raised two medium priority recommendations around ensuring timely completion, review and approval of the Annual Environmental Sustainability Report and ensuring a thorough quality review of the Annual Report is undertaken.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards and with the agreement of senior management and the Board Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances, which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and subject to the key financials and other mandated items being completed in-year the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the health board, audit work reported to draft stage has been included in the overall assessment. There is no work in progress as all reviews have been completed to at least draft stage. However, in light of Covid pressures, the follow up reviews of 'health and safety' and 'Section 33 – governance arrangements' have been deferred and will be undertaken in 2020/21.

The majority of audit reviews will relate to the systems and processes in operation during 2019/20 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews which remain relevant to the reporting of the Annual Report. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance work completed as part of this current year's plan albeit relating to the 2017/18 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2019/20 Annual Report and Quality Statement.

2.5 Required Work

There are a number of pieces of work that Welsh Government has required previously that Internal Audit should review each year, where applicable. These pieces cover aspects of:

- Health & Care Standards, including the Governance, Leadership and Accountability standard;
- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report; and
- Welsh Risk Pool.

Where appropriate, our work is reported in Section 5 – Risk based Audit Assignments and at **Appendix B**.

Please note that there are discussions on-going with Welsh Government as to whether this work will be required in future years.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms to all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Powys Teaching Health Board in conformance with the Public Sector Internal Audit Standards for 2019/20.

Our conformance statement for 2019/20 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2019/20 which will be reported formally in the Summer of 2020;
- the results of the work completed by Wales Audit Office; and
- the results of the External Quality Assessment undertaken by the IIA.

We have set out, in Appendix A, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2019/20 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;

- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office and Healthcare Inspectorate Wales.

2.7.1 Health & Care Standards (HCS)

The Annual Governance Statement last year noted that 'During 2018, HCS Steering Group members agreed that the implementation phase had been completed and the Standards had therefore become business as usual. We will continue to review progress through a self-assessment of our quality framework.'

The Clinical Quality Framework was approved by the Board during the year and sets out the health board's commitment to review the approach to the HCS. However, due to the impact of COVID-19, this has been delayed.

2.7.2 Governance and Accountability Board self-assessment

It is recognised that the arrangements for the Board to undertake its annual self-assessment of governance, leadership and accountability have been deferred due to the impact of COVID-19 pressures.

We will liaise with the Board Secretary during 2020/21 to consider the process undertaken and provide support where required.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. The Head of Internal Audit has had regard to these audits, which are listed below.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

- Accounts Payable - Reasonable
- Payroll – Reasonable (draft report)
- Primary Care Services – General Medical Services - Substantial
- Primary Care Services – General Pharmaceutical Services - Substantial
- Primary Care Services – General Dental Services – Substantial
- Primary Care Services – General Ophthalmic Services – Substantial
- Primary Care Services – Post Payment Verification - Substantial

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme.

The Head of Internal Audit Opinion for NWSSP has given an overall rating of Reasonable Assurance.

Six of the seven reports noted above (with the exclusion of the Post Payments Verification Audit) are also included in the table at Appendix B as they are undertaken annually to ensure coverage of the main financial systems and include transactions processed on behalf of the Health Board.

In addition, as part of the internal audit programme at Cwm Taf Morgannwg UHB a number of audits were undertaken in relation to both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialised Services Committee

- Cardiac review - Reasonable
- Information governance - Reasonable

Emergency Ambulance Services Committee

- Non-emergency patient transport service - N/A

NHS Wales Informatics Service (NWIS)

We have also undertaken six audits relating to the processes and operations of NWIS.

- Infrastructure / Network Management – Reasonable
- Service provision – Reasonable
- Supplier management – Limited (draft report)
- Follow up change control – Substantial
- GDPR – Limited (draft report)
- Pharmacy project – Reasonable (draft report)

While these audits do not form part of the annual plan for Powys Teaching Health Board, they are listed here for completeness as they do impact on the health board's activities, and the Head of Internal Audit does consider if any issues raised in the audits could impact on the content of our annual report.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report, along with the NWIS Audits; the WHSSC and EASC audits are detailed in the Cwm Taf Morgannwg UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits which remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2019/20 operational audit plan.

The assignment status summary is reported at section 5 and **Appendix B**.

In addition, throughout the year we have responded to requests for advice and/or assistance across a variety of business areas. This advisory work undertaken in addition to the assurance plan is permitted under the standards to assist management in improving governance, risk management and control. This activity has been reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. These have become part of the routine reporting to the Audit Committee during 2019/20. The key performance indicators are summarised in the **Appendix C**.

Post audit questionnaires are issued following the finalisation of all audit assignments. As at 30 April 2020, the response rate has been 32% (6 out of 19). The responses provided from management were positive in regards to the professionalism and the level of engagement and communication from the audit team. In addition, management agreed that the work was reported in a clear constructive way and had a beneficial impact. Words provided to describe the audit service received include professional, scrutiny, assurance, helpful, constructive, comprehensive, participatory, open to debate, supportive and focused. Where respondents have made specific comments these have been reviewed by the Head of Internal Audit for any necessary action.

Your feedback is important because it provides us with insight that we can use to improve our service and overall client experience.

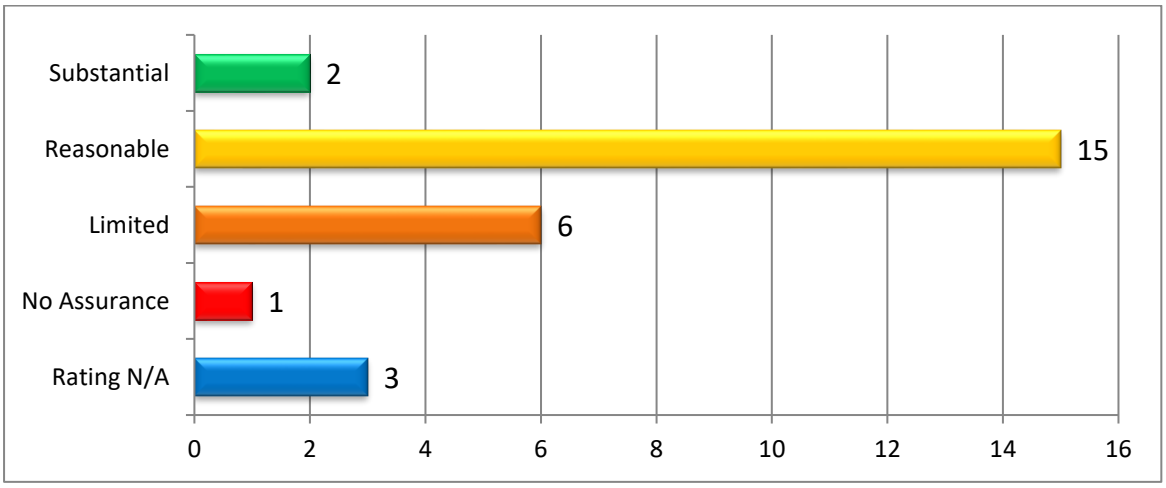
5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 27 audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



The assurance ratings and definitions used for reporting audit assignments are included in **Appendix D**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Follow up (Capital) DRAFT	To determine the status of previously agreed recommendations arising from the following capital assurance audits: • Capital Assurance: Follow Up [issued April 2019] ; • Llandrindod Wells Redevelopment Project: Follow Up [issued April 2019]; and • Capital Systems [issued March 2019].
Welsh Risk Pool Claims Management DRAFT	Assurance to the health board that the WRP Claims Management policies and procedures are effectively being discharged and the extent to which the associated management controls are being applied.

5.3 Reasonable Assurance

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Assurance on implementation of audit recommendations FINAL	An assessment of the health board's recommendation tracker process by following through a sample of recommendations noted as 'complete', in order to provide assurance to the health board that risks material to the achievement of the system's objectives are managed appropriately.
Financial planning and budgetary control	An assessment of the appropriateness of financial planning and budgetary control exercised by the

Review Title	Objective
(commissioning) FINAL	health board.
Disciplinary processes – case management FINAL	Assurance that operational procedures are compliant with key corporate policies and are being followed by staff.
Safeguarding – appropriate employment arrangements FINAL	Assurance that operational procedures were compliant with health board corporate and national policies.
Staff wellbeing FINAL	Consideration of the attendance management process with a focus on stress management and the response by the health board's Occupational Health Service
111 Services FINAL	A review of the effectiveness of the recently introduced 111 service and an assessment of the value added by its implementation.
Catering – departmental review follow up FINAL	Assurance over the progress against implementation of recommendations arising in our 2018/19 review.
Primary care clusters (PCC) FINAL	An assessment of how well equipped providers within Powys are to provide primary care services and focused on PCC development, the range of primary care services involved and how clusters needs for funds and resources are being reflected in the health board's 2020-23 draft IMTP. The audit excluded GP and dental practices being managed in-house by the health board which are outside of scope.
Organisational Development Strategy FINAL	Assurance as to how effective the health board is at managing change to support the longer-term strategy.
Dental Services – monitoring GDS contract – follow up FINAL	Assurance over the progress against implementation of recommendations arising in our 2018/19 review.

Review Title	Objective
Information Technology Infrastructure Library (ITIL) – service management FINAL	Assurance as to the extent to which ITIL controls are in place and in operation throughout the organisation but its main focus was the service desk operation.
Machynlleth Project FINAL	The processes, procedures and operational management of the health board were assessed in relation to the Machynlleth reconfiguration project.
Outpatients – planned activity DRAFT	Assurance over the health board's effectiveness in planning outpatient activity and that outpatients clinics are used to maximise productivity.
Follow up (Estates Assurance) DRAFT	To determine the current status of previously agreed recommendations arising from the following estates assurance audits: • Asbestos Management [issued October 2018]; • Water Management [issued April 2018]; • Fire Precautions [issued April 2017]; • Waste Management [issued October 2011]; and • Health and Safety [issued July 2011].
Capital Systems DRAFT	The capital systems (financial safeguarding) review sought to affirm that there are effective controls and systems operating to deter and safeguard against potential fraud within the THB's Estates and Support Services functions. This audit was split between projects/contracts led by the Estates Team and projects/contracts led by the Support Services Team. A separate report was provided for each area, both receiving reasonable assurance.

5.4 Limited Assurance

In the following review areas the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control,

within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Deprivation of Liberties / Best Interest Assessments FINAL	Assurance that operational procedures are compliant with the DoLS and are being followed by all staff.
Freedom of Information (FoI) FINAL	Assurance as to the extent to which FoI accountability, policies and procedures, performance measurement controls, and reporting mechanisms to monitor compliance are in place and in operation throughout the organisation.
Care and nursing homes governance FINAL	Assurance on the governance arrangements between the health board and care homes settings.
Podiatry Services follow up FINAL	Assurance over the progress against implementation of recommendations arising in our 2018/19 review.
Welsh Language Standards Implementation DRAFT	To evaluate and determine the adequacy of the systems and controls in place over the implementation of phase one of the Regulations and how lessons were learnt to inform the second phase due later in 2019/20.
Risk Management & Board Assurance FINAL	An assessment of how the BAF and Risk Management Framework was being implemented and if they were appropriately updated in line with the revised IMTP, and how the Board's responsibilities for risk management were effectively being discharged. It included focus on the integration of risk management and assurance process with the IMTP. Any areas of good practice are also highlighted. As part of this review, we followed up on the progress that the health board has made in implementing internal audit recommendations raised in the 2018/19 Risk Management Internal Audit report.

5.5 No Assurance

In the following review areas the Board has no assurance that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Action is required to address the whole control framework in these areas with high impact on residual risk exposure until resolved.

Review Title	Objective
Records management FINAL	Assurance that operational procedures and practices were compliant with the health board's strategies, policies and procedures for records management.

5.6 Assurance Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Review Title	Objective
Annual Quality Statement FINAL	Assurance that operational procedure is compliant with the requirements of the Welsh Health Circular: The Annual Quality Statement 2018/19 Guidance.
Environmental Sustainability FINAL	Assurance that operational procedure is compliant with Welsh Government minimum reporting requirements.

Review Title	Objective
Hosted bodies – governance arrangements FINAL	An assessment of whether the governance and financial framework arrangements associated with those functions hosted by the health board are operating as intended.

Additionally, the following audits were deferred or cancelled for reasons outlined below. The reason for deferment is outlined for each audit together with any impact on the Head of Internal Audit Opinion.

Review Title	Objective/reason for deferment/impact
Health visitors role in childhood immunisations	Assurance that Health Visitors understand their role in childhood immunisation and the Healthy Child Wales pathway i.e. immunisations are considered in routine contacts and follow-ups. As part of the review, we intended to include an assessment of the Child Health System and accuracy of data. The Executive Team assured that the risks originally raised no longer remained and that there were no issues of concern outstanding. Additional assurance from Internal Audit was not felt necessary at that stage. No impact.
Adult Psychology Service	Assurance that there is sufficient capacity and capability in the Service to ensure safe, quality care. Review postponed due to the independently commissioned baseline review of this Service against the Matrics Cymru guidance. We propose to revisit once we have been able to review the baseline assessment and resulting action plan. No impact.
Section 33 governance arrangements follow up	Assurance over the progress against implementation of recommendations arising in our 2018/19 review. Review postponed due to Covid-19. Some impact due to unknown continued risk,

Review Title	Objective/reason for deferment/impact
	taken into account in domain assurance rating.
Health & Safety follow up	To provide an assurance on progress with implementing recommendations made in the 2018/19 'limited' assurance report. Review deferred to 2020/21 due to Covid-19. Some impact due to unknown continued risk, taken into account in domain assurance rating.
Llandrindod Wells	To assess the delivery of the circa £6.6M multi phased project through to completion. Specific consideration will be given to the management of key issues affecting the delivery of the scheme to date, together with arrangements to ensure risks to project delivery are mitigated/managed appropriately and in accordance with defined contractual requirements. Review deferred to 2020/21 as it was considered that deferment would enable the sufficient progression of works on site to be incorporated within the scope of the audit. No impact.

6. ACKNOWLEDGEMENT

In closing, I would like to acknowledge the time and co-operation given by directors and staff of the health board to support delivery of the Internal Audit assignments undertaken within the 2019/20 plan.

Helen Higgs

Head of Internal Audit

Audit and Assurance Services

NHS Wales Shared Services Partnership

May 2020

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. WAO complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed

	for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with WAO, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
23000 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with

	implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN

Assurance domain	Audit Count	Overall rating	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
Corporate Governance, Risk and Regulatory Compliance	4				Risk Management & Board Assurance (Draft) Welsh Language Standards Implementation (Draft)	Assurance on implementation of audit recommendations	Welsh Risk Pool Claims Management (Draft)
Strategic Planning, Performance Management and Reporting	2					Primary care clusters Organisational Development Strategy	
Financial Governance and Management	2		Hosted bodies – governance arrangements			Financial planning & budgetary control (commissioning) NWSSP audits: * Accounts Payable * Payroll (Draft) * Reviews undertaken as part of the NWSSP audit programme	NWSSP audits in Primary Care Services: *General Medical Services *General Pharmaceutical Services *General Dental Services *General Ophthalmic Services
Clinical Governance, Quality and Safety	4		Annual Quality Statement		DOLS / Best Interest Assessments Care and nursing homes	Dental services – monitoring of the GDS contract – follow up	

Assurance domain	Audit Count	Overall rating	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
					governance		
Information Governance and Security	3			Records management	Freedom of Information	Service management - ITIL	
Operational Service and Functional Management	4				Podiatry Services – follow up	111 Services Catering – departmental review follow up Outpatients – planned activity (Draft)	
Workforce Management	3					Disciplinary case management Safeguarding – appropriate employment arrangements Staff wellbeing	
Capital and Estates Management	5		Environmental Sustainability			Machynlleth Project Follow up (Estates Assurance) (Draft) Capital Systems (Draft)	Follow up (Capital) (Draft)

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2019/20	G	March 2019	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2019/20	G	100%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	87%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	95%	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

Figures exclude the SSU performance that is reported separately to the NWSSP Audit Committee in aggregate form across organisations.
Figures for KPI2 & KPI3 reflect the position recorded as at 24th April 2020. It includes the 37 assignment reports expected within the first seven domains of the annual audit plan. The audit commentary on the AGS and Governance, Leadership & Accountability are not issued via reports, so excluded from the above.

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Overall opinion assessment matrix

Supporting criteria for the overall opinion

Criteria	Substantial Assurance	Reasonable Assurance	Limited assurance	No assurance
Audit results consideration				
Overall results				
Assurance domains rated green	≥5 green; and			
Assurance domains rated yellow	≤3 yellow; and	≥5 yellow; and		
Assurance domains rated amber	No amber; and	≤ 3 amber; and	≥5 amber; and	
Assurance domains rated red	No red	No red	≤3 red	≥4 red
Audit scope consideration				
Audit spread domain coverage	All domains must be rated	No more than 1 domain not rated	No more than 2 domains not rated	3 or more domains not rated

Note: The overall opinion (see section 2.4.2) is subject ultimately to professional judgement notwithstanding the criteria above.

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and

detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd

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Welsh Risk Pool Claims Management

Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	PTHB-1920-01
Report status:	Final
Fieldwork commencement:	10 March 2020
Fieldwork completion:	24 April 2020
Debrief meeting:	28 April 2020
Draft report issued:	27 April 2020
Management response received:	11 May 2020
Final report issued:	11 May 2020
Auditor/s:	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
Executive sign off	Alison Davies, Director of Nursing and Midwifery
Distribution	Wendy Morgan, Assistant Director of Quality and Safety Rebecca Membury, Senior Manager for Putting Things Right
Committee	Audit, Risk and Assurance Committee Experience, Quality and Safety 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.

1. Introduction and Background

The review of Welsh Risk Pool (WRP) Claims Management sought to provide assurance to Powys Teaching Health Board (the 'health board) that the WRP Claims Management policies and procedures are effectively being discharged and the extent to which the associated management controls are being applied.

It is a requirement of the WRP Claims Management Standard that a sample of claims made against the WRP is reviewed by Internal Audit each year. Specifically, the standard requires that Internal Audit review either 25 claims, or 25% of claims, whichever is the lower number.

2. Scope and Objectives

The review sought to provide assurance over the accuracy of reports and costs and the process for managing clinical negligence and personal injury claims.

Specifically the audit looked at the following control objectives:

- there is a well understood and clearly documented procedure for handling clinical negligence and personal injury claims;
- there is a system for learning lessons from failures identified;
- there is a claims database with information on all claims, which provides regular information to the Board or appropriate sub-committee;
- there are linkages between information on claims, risks, incidents and complaints;
- financial settlements are signed off in accordance with the scheme of delegation. Central approval by the Welsh Government is obtained for claims exceeding the limit of the delegated authority of £1M or for any claims which raise novel, contentious or repercussive features; and
- claims for reimbursement made on the Welsh Risk Pool are accurate and submitted in a timely manner.

3. Associated Risks

The risks considered in the review were as follows:

- the processes for managing clinical negligence and personal injury claims are not compliant with the latest guidance;

- lessons learned and corrective actions arising from clinical negligence and personal injury claims are not monitored regularly by an authorised sub-committee;
- the reporting mechanism in place does not provide sufficient and appropriate information to the Board;
- financial settlements are not signed off in accordance to the Scheme of Delegation; and
- claims for reimbursement from WRP are inaccurate and subject to late submission where penalties may apply.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Welsh Risk Pool Claims Management is **Substantial** Assurance.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Procedures				✓
2	Lessons learned				✓
3	Database management and reporting			✓	
4	Linkages between claims, risks and incidents				✓
5	Financial settlements				✓
6	Claims for reimbursement	N/A – no claims for reimbursement from WRP were submitted during 2019/20.			

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted **no** issues that are classified as weakness in the system control/design for the 'Welsh Risk Pool Claims Management' process.

Operation of System/Controls

The findings from the review have highlighted **one** issue that is classified as weakness in the operation of the designed system/control for the 'Welsh Risk Pool Claims Management' process.

6. Summary of Audit Findings

The All Wales guidance for the reimbursement of claims (*Welsh Risk Pool Services Case Reimbursement Procedures*) was revised during the year and the health board is in the process of updating its own *Management of Compensation of Claims Policy* to reflect. A key focus of the risk pooling

arrangements within NHS Wales is to share the lessons learned from errors which have caused harm and to reduce the risk of similar occurrences. To ensure that learning and improvement are commenced and implemented at the earliest possible stage, the WRP has made a change to its procedures to bring the scrutiny of learning much earlier in the lifecycle of a case.

The health board's claims profile is relatively small and whilst no claims for reimbursement from WRP were submitted by the health board during 2019/20, we understand that the health board is finalising the financial settlement in respect of two clinical negligence claims. We therefore extended our testing population to include claims with payments on them, focusing on those that are estimated to exceed the excess value set by WRP. The health board was able to demonstrate that financial payments are signed off in accordance with the health board's scheme of delegation and that learning is taking place across its claims profile.

Reports providing an overview of compensation claims including the claims profile, relevant themes and trends, learning and progress made with process improvements are presented regularly within the health board. However, we noted a small number of discrepancies between the claims included in these reports and the records captured within the Datix claims database.

Our audit identified one **low** priority issue that we consider requires management attention and provides scope for improvement to be made.

7. Detailed Audit Findings

Findings are set out by audit objective in the section below and where appropriate, repeated along with recommendations in the action plan in Appendix A that follows.

Objective 1 – there is a well understood and clearly documented procedure for handling clinical negligence and personal injury claims:

The All Wales guidance for the reimbursement of claims (*Welsh Risk Pool Services Case Reimbursement Procedures*) was reviewed in May 2019. The changes made to the previous version dated January 2019 included the inclusion of Redress Case Reimbursement arrangements, inclusion of Scheme for General Medical Practice Indemnity (GMPI), addition of earlier scrutiny of Learning from Events and review of forms and checklists associated with submissions for reimbursement. The procedure was updated again in September 2019 to further revise the forms and checklists following a pilot period.

The health board is in the process of updating its own *Management of Compensation of Claims Policy* to reflect the changes made to the All Wales guidance above. The policy covers the management of clinical negligence claims, redress claims, personal injury claims and property damages/losses and compensation claims. The new General Medical Practice Indemnity Scheme is described in a separate policy. The Policy was scheduled to be presented for approval in March 2020, however this was deferred due to Covid 19 pressures.

The health board's Putting Things Right department is a small team. It is led by the Assistant Director of Quality & Safety with support from the Senior Putting Things Right Manager, appointed in April 2019, and the Patient Experience/Concerns officer. In line with other health boards, the team is reliant on the support from NHS Wales Shared Services Partnership (NWSSP) Legal and Risk Services to keep appraised of developments and guidance. This includes attendance at the Claims Management Safety & Learning Network, intended to ensure that learning from cases is disseminated widely throughout organisations to improve best practice.

No issues raised.

Objective 2 – there is a system for learning lessons from failures identified:

A key focus of the risk pooling arrangements within NHS Wales is to share the lessons learned from errors which have caused harm and to reduce the risk of similar occurrences. The scrutiny of learning and improvement action plans is an important part of the approval process for reimbursement. To ensure that learning and improvement are commenced and implemented at the earliest possible stage, the WRP has made a change to its procedures to bring the scrutiny of learning much earlier in the lifecycle of a case. Health Board's are required to submit a Learning from Events Report within 60 working days from the decision to settle for scrutiny by the WRP Safety & Learning Team and consideration by the WRP Committee, where approval for reimbursement is only given once it is satisfied with the learning in a case. Whilst the health board's revised *Management of Compensation of Claims Policy* is yet to be approved, the impact of these changes have been communicated, including to the Experience, Quality and Safety Committee and the Executive Committee.

Whilst no claims for reimbursement from WRP were submitted by the health board during 2019/20, the health board was able to demonstrate that learning is taking place across its claims profile and that this is regularly reported. The '*Overview of Clinical Negligence and Personal Injury Claims'* paper presented at the Quality Governance Group (refer to objective 3 for further detail) includes detailed learning on a case by case

basis. The key broad learning themes identified by the health board impacting on its ability to defend claims remain effective communication with patients, the standard of documentation / record keeping and following health board and/or regulatory body policies and procedures.

No issues raised.

Objective 3 – there is a claims database with information on all claims, which provides regular information to the Board or appropriate sub-committee:

The health board uses the claims management module of the Datix incident reporting system as its database for clinical negligence and personal injury claims. These records are supplemented by more detailed electronic files, where a folder for each claim is maintained on the health board's shared drive. Whilst all members of the health board have access to the Datix incident reporting module, claims management is part of a separate Datix module, access to which is restricted to members of the Quality and Safety Department. The health board's claims profile is relatively small, a total of 19 open clinical negligence and personal injury claims were managed during 2019/20, some of which were ongoing claims initiated in previous years. Three of these claims were closed during the period and we understand that the health board is finalising the financial settlement in respect of two clinical negligence claims.

Reports providing an overview of compensation claims including the claims profile, relevant themes and trends, learning and progress made with process improvements are presented regularly within the health board. In line with the health board's Management of Compensation Claims Clinical Negligence & Personal Injury Policy, the Executive Committee, as the delegated committee on behalf of the Board, receives a six-monthly progress report on the management and status of claims against the health board (as required under Section 8 of the Putting Things Right guidance). The paper presented to the Executive Committee is supplemented with appendices which include a brief description of each claim and its status, the probability of loss, estimated date of settlement and estimated damages, defence costs and claimants' costs. The Quality Governance Group, a sub-group of the Executive Committee established in July 2019, is provided this report in the interim. The Group is chaired by the Chief Executive Officer and typically meets on a bi-monthly basis. As noted under objective 2 above, the '*Overview of Clinical Negligence and Personal Injury Claims*' paper presented at this Group includes more detail on the learning on a case by case basis.

The Experience Quality and Safety Committee also receives updates on the status of claims in line with its remit to monitor '*the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned'*. This includes receipt of the health board's *'Putting Things Right, Claims and Compensation Annual Report'*. Furthermore, the Patient Experience Steering Group, chaired by the Director of Nursing, receives a report regarding the learning from concerns and claims. We were informed there is an ongoing work programme under the new Clinical Quality Framework to review the reporting arrangements going forward. However, this work has been deferred until post Covid-19.

We performed a reconciliation between the claims captured within the Datix claims database to confirm they were included in the various reports presented to the forums mentioned above and noted a small number of discrepancies. *Refer to finding 1.*

Objective 4 – there are linkages between information on claims, risks, incidents and complaints;

As noted in the health board's Policy on 'Putting Things Right' and Management of Concerns: '*All patient concerns/incidents will be formally acknowledged and reported and recorded as soon as they are identified.*' Due to the nature of claims, most should have been reported to or by the health board at some point in the past as an incident. It is important to note that whilst the claims management module of Datix is separate from the incident reporting module, it is still the same system and therefore has the ability to link claims received through to earlier incidents. Once linked, these can be accessed from the claims module for an individual case via the 'incident' link function.

In order to confirm that claims have been linked to previously reported risks, incidents and complaints we checked whether a link was included for the four cases selected in our testing sample. However, our work identified that only one of the claims has been linked to a previous incident. Whilst this might suggest the under or untimely reporting of incidents, we were informed by management that there were no links associated to these cases due to them have all being raised as claims first.

No issues raised.

Objective 5 – financial settlements are signed off in accordance with the scheme of delegation. Central approval by the Welsh Government is obtained for claims exceeding the limit of the delegated authority of £1M or for any claims which raise novel, contentious or repercussive features;

Ordinarily, to fulfil WRP audit requirements, we would test 25 or 25% of claims submitted during the year, whichever is lower. Whilst no claims for reimbursement from WRP were submitted by the health board during 2019/20, we understand that the health board is finalising the financial settlement in respect of two clinical negligence claims. With a single claim, this would leave little coverage, therefore we extended our testing population to include claims with payments on them, for example where the health board has made payments on account for damages or paid a fee for an expert report, focusing on those that are estimated to exceed the excess value set by WRP.

Our testing of a sample of four claims confirmed that financial payments are signed off in accordance with the health board's scheme of delegation and were reflected in the losses and special payments register maintained separately by the Finance Department. There were no claims that required central approval by the Welsh Government.

No issues raised.

Objective 6 – claims for reimbursement made on the Welsh Risk Pool are accurate and submitted in a timely manner;

Each Health Board or NHS Wales Trust is responsible for the total cost of a claim made against them below the excess value set by the WRP. The value of the excess is currently set at £25,000. Where the total cost of a claim is greater than the excess value set by the WRP, a reclaim will be made for the reimbursement of those monies greater than the excess from WRP.

We were unable to test compliance with this process as no claims for reimbursement from WRP were submitted by the health board during 2019/20. We understand that the health board is finalising the financial settlement in respect of two clinical negligence claims, where a request for reimbursement should follow within four calendar months as required by the WRP procedure. However, submission of these has been deferred due to Covid 19 pressures.

Audit Recommendation Tracker

In line with our report on the implementation of the health board's Audit Recommendation Tracker (the Tracker), we have considered the implementation status of recommendations from the 2018/19 *'Welsh Risk Pool Claims Management'* report against the Tracker.

The March 2020 Tracker shows that health board management considers the prior year recommendation, in relation to the lack of reporting on the management and status of claims against the health board to the Executive Committee, as implemented. We concur with this view.

8. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	**-**	**-**	**1**	**1**

Finding 1 – Claims Reporting (Operation)	Risk
Reports providing an overview of compensation claims including the claims profile, relevant themes and trends, learning and progress made with process improvements are presented regularly within the health board. The Executive Committee, as the delegated committee on behalf of the Board, receives a six-monthly progress report on the management and status of claims against the health board (as required under Section 8 of the Putting Things Right guidance). The paper presented to the Executive Committee is supplemented with appendices which include a brief description of each claim and its status, the probability of loss, estimated date of settlement and estimated damages, defence costs and claimants' costs. The Quality Governance Group, a sub-group of the Executive Committee established in July 2019, is provided this report in the interim and includes more detail on the learning on a case by case basis. The Experience Quality and Safety Committee also receives updates on the status of claims in line with its remit. Furthermore, the Patient Experience Steering Group, receives a report on the learning from concerns and claims. We were informed there is an ongoing work programme under the new Clinical Quality Framework to review the reporting arrangements going forward. However, this work has been deferred until post Covid-19. We performed a reconciliation between the claims captured within the Datix claims database to confirm they were included in the various reports presented to the forums mentioned above and noted a small number of discrepancies.	The reporting mechanism in place does not provide sufficient and appropriate information to the Board.

Recommendation 1	Priority level
Management should consider reviewing the reporting mechanisms on compensation claims to ensure that all claims are captured. For example, the format could be enhanced to distinguish between new claims, ongoing claims and closed claims from one period to the next.	**Low**
Management Response 1	**Responsible Officer/ Deadline**
The recommendation is accepted. Future claims reports will distinguish between new claims, ongoing claims and closed claims from one period to the next.	**Lead Director: Director of Nursing and Midwifery** Assistant Director Quality & Safety The next scheduled report is due October 2020, where the change will be evident.

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The health board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Capital Assurance Follow Up

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Substantial Assurance
 - +
Prior year rating: Reasonable

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Review reference:	SSU_PTHB_1920_02
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Auditor:	NWSSP: Audit & Assurance - Specialist Services Unit
Executive sign off	Hayley Thomas, Director of Planning & Performance
Distribution	Wayne Tannahill, Assistant Director of Estates & Property Louise Morris, Head of Capital Sarah Pritchard, Head of Financial Services Helen Kendrick, Quality & Safety Advisor Rani Mallison, Board Secretary
Committee	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

An audit was undertaken to determine the status of previously agreed recommendations arising from the following capital assurance audits:

- Capital Assurance: Follow Up [issued April 2019]
- Llandrindod Wells Redevelopment Project: Follow Up [issued April 2019]
- Capital Systems [issued March 2019]

2. Scope and Objectives

This review encompassed an evaluation of the actions taken by Powys Teaching Health Board (the THB) to address previously agreed recommendations identified by audit for management actions from capital assurance reports.

This process was progressed through obtaining evidence in support of each recommendation. Results of the review were fed back to management to enable any errors or omissions to be corrected prior to the final issue of the report. The revised management action plan is attached in **Appendix B.**

3. Associated Risks

The potential risks considered in the review were as follows:

- The organisation fails to address known concerns exposing itself to unnecessary risk:
- Management control frameworks continue to exhibit weaknesses; and
- Management do not have processes in place to review and action agreed audit recommendations (and consequential risk mitigation).

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given to actions taken by management to address the previously agreed audit recommendations is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial assurance	 - +	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Summary of Audit Findings

The status of agreed management action can be summarised as follows:

Audit Report	Closed	Partially implemented	Outstanding	Total
Capital Assurance: Follow Up	2	-	-	**2**
Llandrindod Wells Redevelopment Project: Follow Up	3	1	-	**4**
Capital Systems	7	-	-	**7**
Total	**12**	**1**	**-**	**13**

Therefore of the 13 recommendations that were agreed by management, 12 recommendations were implemented (92%) with one recommendation partially implemented (8%).

The full audit findings are detailed in **Appendix A**.

6. Summary of Recommendations

A summary of the recommendations which remain to be addressed is outlined below by priority:

	H	M	L	Total
Llandrindod Wells Redevelopment Project: Follow Up	-	1	-	**1**
Total	**-**	**1**	**-**	**1**

The key issue for management is:

- Evidence to be retained to provide assurance that compensation events are approved in accordance with the THB's scheme of delegation. Such as a schedule maintained by the Capital team to reconcile with the change control tracker prepared by the Cost Advisor.

The updated recommendation is detailed in **Appendix B** together with the management action plan and implementation timetable.

Capital Assurance: Follow Up (April 2019)				
Ref	**Recommendation :@ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	The updated Capital Procedures should be ratified by the C&EIG and issued to staff as appropriate.	**Closed** The Capital Procedures have been finalised and ratified appropriately.	N/A	N/A
Low				
2	The scheme of delegation should be updated for approvals relevant to the Senior Capital Programme Manager.	**Closed** The Board Secretary advised that the disclosure of the limit from £25k upwards is consistent across all non-pay expenditure. Considered reasonable that no change is proposed.	N/A	N/A

Llandrindod Wells Redevelopment Project: Follow Up (April 2019)				
Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	Monthly assurance should be obtained to ensure the Welsh Government dashboard reports are reconciled to reflect amendments reported on risk contingency.	**Closed.** The risk register reviewed [November 2019] provided details of 14 open risks with an assigned value of £34.6k. The Welsh Government dashboard submitted at the same time period noted risk contingency as £55k – a variance of £20.4k to the risk register. However, the data in the dashboard report related to September 2019 and was supported by a Project Manager report and a Cost Advisor report of the same. These reports included a risk contingency of £0k. Whilst variations in the reported risk contingency sums continued to be observed, these arose due to time differences in the supporting documentation. All, however, were illustrating that the risk contingency was forecast to be used in full.	N/A	N/A
2	a) Management should provide assurance that the NEC terms of	**Closed.**	N/A	N/A

Llandrindod Wells Redevelopment Project: Follow Up (April 2019)				
Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
	contract have been approved and accepted for the role of Project Manager. b) Management should provide assurance that the consolidation of the Cost Advisor and Project Manager role has been evaluated as a reasonable way forward for the Llandrindod Wells Redevelopment Project.	a) A review of the contract documentation confirmed the scope of services were defined; setting out the obligations of the Project Manager as described within the NEC3 Engineering and Construction contract. b) Board acceptance to this approach was noted.		
3	Compensation events should be approved in accordance with the THB's scheme of delegation.	**Partially implemented** A sample of eight compensation events were reviewed to confirm approval in accordance with the THB's scheme of delegation. Refer to Appendix C for details of changes reviewed: • Evidence of appropriate approval was noted for one change; • Evidence of communication regarding the need for the change, but no evidence of appropriate approval of the value of the change was noted for two changes; and	Assistant Director of Estates & Property On-going	**Medium**

Llandrindod Wells Redevelopment Project: Follow Up (April 2019)				
Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
		• No evidence of appropriate THB approval for five changes, for which management advised the Project Manager used their ability under the contract to instruct. Review of the Project Manager Contract [Appendix A: Schedule of Services to be performed by the Project Manager: Section 1.9] states "The Project Manager will require written authority from the Project Director in relation to <u>any</u> instruction to Designers / Contractors involving a commitment to additional cost". Review of the Project Initiation Document further states that the Project Manager provides all information and the Employer takes a decision on how to proceed with the change. The above guidance was not consistently evidenced. For future changes / projects, it is recommended that a schedule is maintained by the Capital team of the changes received from the Project		

Llandrindod Wells Redevelopment Project: Follow Up (April 2019)				
Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
		Manager. This can be used as a reconciliation tool when receiving the change control tracker; with references to the date of agreement / officer authorising and link to the email communication [retained on a shared drive].		
4	The derogation process should be formally documented to ensure changes are evaluated and approved appropriately.	**Closed**. The Capital Control Group had approved the derogation procedure.	N/A	N/A

Capital Systems (March 2019)				
Ref	**Recommendation @ March 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	**Bidding Process** The procedure for bidding for non-medical equipment should be formally defined.	**Closed.** The procedure for bidding for non-medical equipment had not been updated. The same PRF form was used for both projects and non-medical equipment for consideration at the Capital Control Group (CCG). However, from the review of three bids presented to the CCG during the course of the financial year there have been no issues noted in respect of the accuracy and adequacy of the submitted bid for funding.	N/A	N/A
2	**Provision of financial information** All revenue and capital cost implications should be provided at bid submissions and the submitted forms will be reviewed for consistency and appropriateness.	**Closed** A revised EDOF form has been developed. The form now stipulates that all financial implications should be addressed upon submission i.e. source of funding and associated maintenance requirements, where applicable.	N/A	N/A

Capital Systems (March 2019)				
Ref	**Recommendation @ March 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
3	**Prioritisation evaluation forms** The data collated to assist the prioritisation process should be formally documented for transparency of decision making.	**Closed** The review of a sample of EDOF's that had been approved during 2019/20 confirmed documentation of a clear rationale through the prioritisation process.	N/A	N/A
4	**Communication with procurement [EDOF forms]** The notifications for successful medical equipment bids should be reviewed for clarity of the procurement process to ensue. Notifications to proceed should only be provided following approval at CCG.	**Closed** The review of the notification emails issued to the EDOF requestor confirmed clear communication of the chain of events leading to the procurement process.	N/A	N/A
5	**Budgeting for projects** Robust detailed design estimates should be required when presenting bids for consideration by the Capital Control Group.	**Closed** The review of CCG minutes noted there were only two projects [seven reported in the March 2019 report; value £288k] where variations to design estimates had been requested:	N/A	N/A

Capital Systems (March 2019)				
Ref	**Recommendation @ March 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
		1. £28.8k: additional costs following external advice following an oil leak incident at Ystradgynlais Hospital; and 2. £14k [maximum]: to cover the increased tender costs received for the lighting ventilation cabinet in Claerwen Ward, Llandrindod Wells Hospital. It was noted that due to insufficient resources, this project has since been postponed until a later date. Variations requested were significantly lower in number and value than in previous years.		
6	**Budgeting for projects** Project Managers should consider splitting projects/bids into tranches to best manage discretionary funding available (ensuring appropriate compliance with approval and letting requirements).	**Closed** The review of the CCG minutes noted that there had been no projects / bids requested to be split to manage the funding available.	N/A	N/A

Capital Systems (March 2019)				
Ref	**Recommendation @ March 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Low				
7	**Analysis of cost changes for equipment** The equipment tracker will be extended to demonstrate variances between the costs quoted and the costs obtained; and a suitable explanation provided to assist CCG in future decision making.	**Closed** The tracker had been updated accordingly.	N/A	N/A

Llandrindod Wells Redevelopment Project			
Ref	**Priority**	**Recommendation**	**Responsibility & Timescale**
3	**Medium**	Compensation events should be approved in accordance with the THB's scheme of delegation. For future changes / projects, a schedule should be maintained by the Capital team of the changes received from the PM. This should be used as a reconciliation tool when receiving the change control tracker; with references to the date of agreement / officer authorising and link to the email communication [retained on a shared drive].	Assistant Director of Estates & Property On-going

Ref	PMI	CE	Detail	Date	Value of change	Evidence reviewed
1	132		Outpatients: remove asbestos to service risers	30/05/2019	£37,148	No evidence of approval by the Project Director for this value of change. Management advised that the work was deemed essential to the completion of the project. The THB was informed of the requirement but the Project Manager used their ability under the contract to instruct the change.
2	139		Outpatients: Audiology upgrade	14/06/2019	£12,459	As above, no evidence of approval by the Project Director for the value of change. Management advised that the work was deemed as essential to ensure the Audiology facilities remained functional. The THB was informed of the requirement but the Project Manager used their ability under the contract to instruct the change.
3	154	173	Dental: dental boarding out	22/08/2019	£8,607	As Ref 1.
4	159	177	Dental: omission of dental hatch	26/09/2019	(£4,130)	Evidence of approval by the Project Director of this omission from the programme.

Ref	PMI	CE	Detail	Date	Value of change	Evidence reviewed
5	129	148	Birthing phase 2: floor replacement & support works	30/05/2019	£5,237	Minutes from client progress meeting [May 2019] were reviewed acknowledging the floor in one of the rooms was not suitable. However, there was no evidence of approval by the Project Director / Project Manager for this value of change [noting that neither were in attendance at the May meeting reviewed].
6	162	152	Birthing phase 2: maternity heating & additional fees for areas outside of scope	02/10/2019	£13,347	As Ref 1
7	150		Waiting: Rationalised waiting design	11/07/2019	(£14,500)	Email correspondence [June 2019] between the Project Director and the Contractor was reviewed, which provided approval to proceed with opportunities to reduce the programme for Waiting and Dental scope changes. This change was encapsulated within this approval but no specific Project Director approval evidenced for this value of change.
8	128		Reception: 2 week 3 day delay agreed	22/05/2019	£17,439	As Ref 1

Assurance & Risk Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management Action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Outpatients – Planned Activity

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Fieldwork commencement:	12 November 2019
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Final report issued:	XX
Auditor/s:	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Julian Creed, Principal Auditor
Executive sign off	Jamie Marchant, Executive Director of Primary, Community & Mental Health Service Hayley Thomas, Director of Planning and Performance
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	Simon McLellan, Lead Performance Information Analyst
Committee	Audit, Risk and Assurance Committee Performance and Resources 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.

1. Introduction and Background

The review of Outpatients – Planned Activity sought to provide Powys Teaching Health Board (the 'health board') with assurance over the health board's effectiveness in planning outpatient activity and that outpatients clinics are used to maximise productivity.

Outpatient services are complex and multi-faceted and perform a critical role in patient pathways. The performance of outpatient services has a major impact on the public's perception of the overall quality, responsiveness and efficiency of health boards.

The health board's Integrated Medium Term Plan (IMTP) for 2019-22 explains that the Planned Care Programme in Powys takes forward the National Programme, with a focus on care closer to home with the aim to achieve shorter waiting times, improved access and outcomes and high quality and sustainable services. This includes work to address service fragility and modernise appointments and pathways particularly where there have been challenges including diagnostics, therapies and outpatient follow ups. There are work streams in place for endoscopy, ophthalmology, orthopaedics, urology and Ear, Nose and Throat (ENT). This programme of work is critical to achieving the improvement trajectories.

A specific challenge to the health board is that Powys has some unique challenges in terms of demography and geography and the interrelationship between these factors. It is an entirely rural County with no major urban conurbations and no acute general hospitals. People in Powys have to travel outside the county for many services, including some aspects of healthcare. At the beginning of the 2019/20 financial year, reported statistics to the Welsh Government highlighted that 80% of outpatient appointments for the patients of the health board occurred outside of Powys borders. To address this, the IMTP announced the Transforming in Partnership program, an aspect of which has been designed to assist in improvement of coordinated and seamless pathways for outpatient treatments.

The Wales Audit Office reported on 'Review of Follow-up Outpatients' for the health board in April 2018, a follow-up audit of the original September 2015 All Wales review, concluded that the health board had made good progress in identifying clinical need and the risks associated with follow-up outpatient delays within its own services, but that greater attention was needed to strengthen commissioning assurance arrangements and prioritise alternative pathways for patients treated outside the health board area.

2. Scope and Objectives

The internal audit sought to assess the adequacy and effectiveness of internal controls in operation. Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The main areas reviewed were:

Health Board as a provider of services

- outpatient booking processes, including health board guidance and policies & procedures, are consistent with and comply with Welsh Government (WG) guidelines (in particular the All Wales Guide to Good Practice - Outpatients);
- communications between the health board, patients and service providers (such as GPs, dentists, optometrists) allow coordinated and seamless pathway for the timely completion of outpatient treatments;
- waiting times, the number of patients waiting and hospital or patient cancellations are reduced in order to maximize productivity of outpatient clinics;
- reporting of performance measures, such as waiting times, follow-up appointments and cancellations, and productivity of clinics is accurate and consistent at every level in the organisation up to and including the Board;

Commissioning arrangements with external organisations

- communications between the health board and external organisations allow coordinated and seamless pathway for the timely completion of outpatient treatments; and
- reporting of performance measures, such as waiting times, follow-up appointments and cancellations is accurate and consistent at every applicable level in the organisation up to and including the Board.

The review included testing within the endoscopy, diagnostics, SALT (Children's Speech and Language Therapy) and paediatrics services, where the health board is the provider. A review of follow-ups of outpatient appointments for both provider and commissioning services was included.

Scope limitations

The review did not address:

- accuracy and completeness of data held in individual patient records, as this is addressed in the health board's annual data

quality report presented at the Equality, Quality & Safety Committee in October 2019;
- reporting against performance of Service Level Agreements set up for commissioning arrangements with external organisations, as this was recently covered by the 2017/18 and 2018/19 internal audit Commissioning reviews.

3. Associated Risks

The potential risks considered in the review were as follows:

- the health board does not comply with WG outpatient guidance and standards, resulting in potential financial penalties and reputational loss;
- outpatient productivity adversely impacts on the health board's waiting list position; and,
- clinical risks of delayed treatment for outpatients, both for patients being seen within the health board and waiting for appointments with another provider.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls within the Performance Reporting process is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
Health Board as a Provider					
1	Compliance with strategies, policies and guidance			✓	
2	Internal and external communications			✓	
3	Clinic productivity / waiting list time reduction			✓	
4	Performance reporting			✓	
Commissioning arrangements with external organisations					
5	Internal and external communications			✓	
6	Performance reporting		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted four issues that are classified as weakness in the system control/design for the 'outpatients – planned activity' processes.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weakness in the operation of the designed system/control for the 'outpatients – planned activity' processes.

6. Summary of Audit Findings

Outpatient planned activity services are often the first point of contact that most elective care patients have with secondary care. Getting things right at this stage of the pathway can have significant benefits in terms of patient safety, quality and cost further downstream. The management and delivery of outpatient services is frequently complex, often requiring the co-ordinated delivery of parallel and/or sequential process steps by a range of clinical and non-clinical staff across many disciplines and departments. Delivery of planned activity is either performed within the health board's clinic locations ('provider services') or performed by other health boards and trusts in Wales and England ('commissioned services').

The health board's provider services include, but not limited to, the following core areas: Referral to Treatment (RTT); Diagnostics (including endoscopy, cardiology, non-obstetrics); Therapies (including SALT, radiology, podiatry); Follow-Up; and Eye Care. Provider services also includes in-reach services, whereby consultants from other health boards hold appointment sessions in Powys clinic locations.

To put the health board's intake into perspective, All Wales statistics as at September 2019 reported that the health board accounted for 7,916 outpatients on the provider services pathway waiting lists out of a national figure of 467,171. In addition, there were 10,838 Powys patients receiving commissioned services from other health boards and trusts in Wales and England, as reported in the National Outcomes Framework.

Of these 7,916 provider services outpatients, 4,157 relate specifically to RTT (including 4% patients who are not resident in Powys) and 407 follow-up appointments. RTT is the predominant area of the health board's provider services, with the clinic locations and their speciality services, together with the overall number of patients on the RTT waiting list as at September 2019 being:

Table 1

Locality	North				South & Mid			
PTHB Clinic Location / RTT speciality	Llanidloes Hospital	Machynlleth Hospital	Newtown Hospital	Welshpool Hospital	Brecon War Memorial	Llandrindod Wells Hospital	Ystradgynlais Hospital	Total patients on RTT waiting list - September 2019*
GENERAL SURGERY	X	X	X		X	X		448
UROLOGY		X	X		X	X	X	125
TRAUMA & ORTHOPAEDICS	X	X			X	X	X	516
ENT				X	X	X	X	1061
OPHTHALMOLOGY	X	X		X	X	X	X	640
ORAL SURGERY					X			253

ORTHODONTICS	X				X			39
CARDIOLOGY		X			X			149
DERMATOLOGY						X		109
RHEUMATOLOGY					X	X		127
PAEDIATRICS	X	X	X		X	X		30
GERIATRIC MEDICINE	X				X	X		72
GYNAECOLOGY	X	X	X	X	X	X	X	298
								3867

*This figure differs slightly from the 4,157 figure reported in the All Wales statistics above due to certain specialisms not being reportable, such as ear care and nursing services, and timing differences of report extraction.
Data source: 'SLA_Sessions Summary' – provided by the health board's Information Department extracted from national systems via the Intelligence Focussed Online Reporting (IFOR) system'.

The health board's Patient Services Department has two hubs for the co-ordination and management of outpatient booking services as a provider, Brecon War Memorial Hospital (South and Mid Localities) and Newtown Hospital (North Locality). Teams are managed by a Patient Service Manager at each hub, who report into the Senior Manager, Planned Care, Primary and Community Care. The Patient Services team in Brecon, with a staffing of 18 including three team leads, is the primary outpatient management hub, whilst the Newtown team has a staffing of four. Staff work across various locations within their locality. The teams are responsible for managing patient files, scheduling appointments and being the hub for communications between the health board, GP and third parties (clinics, consultants, patients etc.). Our audit fieldwork of the appointment procedures in place have focused on Brecon Patient Services, as the predominant hub.

The themes from our audit findings will be taken forward as part of the health board's work on the '*Planned Care Programme in Powys*' referred to in the introduction and background section above. In addition, the Wales Audit Office's (WAO) '*Review of follow-up outpatients – Assessment of progress – Powys'* (April 2018) concluded that the health board has made good progress in identifying clinical need and the risks associated with follow-up outpatient delays within its own services but greater attention is needed to strengthen commissioning assurance arrangements and prioritise alternative pathways for patients treated outside the health board area.

Welsh Government has given additional funding directly to health boards to improve waiting times. Whilst the health board is predominantly a commissioning organisation, since it is not affected by the pressures of unscheduled care facilities, there might be further potential for Powys to support other health boards with the provision of commissioning services and hence receive additional funding. However, since in-reach services are determined by the availability of consultants from other health boards, this potential could be impacted as consultants are often unavailable in order to address unscheduled care pressures in their home locations.

Our audit identified one **high priority** issue and three **medium priority** issues that we consider require management's attention and provide scope for improvement to be made:

Provider Services

Policies and guidance (Medium Priority)

We identified that the health board's Patient Access Policy is out of date. This is an overarching document that outlines the roles and responsibilities of outpatient services staff and the range of services provided by the health board for outpatient pathways, as well as interaction with services commissioned to other health boards and trusts. Currently, there are a limited number of health board employees with a full understanding of the structure and processes. Such a document would help to ensure that a reader is able understand how and which services are addressed by the health board in this service area, and how it relates to the various All Wales/National Rules for managing outpatient services.

Although a generic process flow is provided in the All Wales NHS Guide to Good Practice - Outpatients, it is not detailed sufficiently to support the health board's actual flows. No such local document exists that outlines the initial outpatient referral process, such as an easy to read flowchart.

Automated systems (Medium Priority)

The primary stage of the health board's outpatient booking system, from initial patient referral to the point that a patient is booked for a specific appointment into the national patient appointment system ('WPAS') is predominantly manual, onerous and time consuming. This can potentially lead to mistakes, errors in the recording and filing of patient documentation and patient appointments being delayed.

Some health boards across Wales have resolved this by implementation of Clinical Workstation System solutions. Moving to an automated system has the support of NHS Wales and the Welsh Government, as outlined in the draft three year strategy and action plan 2020-23: '*Transforming the way we deliver outpatients in Wales*'.

Additionally, an automated system would help with implementation of management actions from the Wales Audit Office's (WAO) '*Clinical coding follow-up review report'* (March 2019) and our '*Records Management internal audit report'* (November 2019) which identified the need to improve the management and quality of medical records across the health board.

Commissioning Services

Assurance over consistent treatment of Powys residents subject to Commissioned Services (Medium Priority)

The Delivery & Performance Committee highlight to the Executive Committee and Performance and Resources Committee any providers in 'special measures' or scored as a Level 3 and 4 under the health board's Commissioning Assurance Framework (CAF).

We were informed that patients are prioritised for treatment in line with their clinical condition and waiting times, and our analysis of performance data (refer to table 5 below) suggests that Powys residents are treated consistently as all other patients when referred to other health boards and trusts. We note that the CAF Escalation Report does not clearly define the context of the RTT figures presented, for example it does not show the comparable figures for the other health boards. Our analysis and review has identified that:

- there is variation in RTT performance by the different health boards and trusts, where Powys residents are commissioned to, across Wales and England. This applies to the performance measures for Powys outpatients waiting under 26 weeks for an appointment, over 36 weeks and over 52 weeks (refer to tables 6 and 7 below);
- the RTT waiting list performance measures for the health board as a provider are better than those of other health boards and trusts. Outpatients treated in the health board as a provider service have met the RTT waiting time target of 0 for both 36-51 weeks and over 52 weeks. However, reported data shows that a number of Powys residents treated at other health boards and trusts across Wales and England via commissioned services have waiting times of greater than 36 weeks. It is possible that the differences in the figures might be explained by clinical variations in the patient's condition and the type of treatment required;
- the report presents detailed tables and bar charts of the number of Powys-resident patients with RTT waiting list times greater than 36 weeks, per health board/trust and per speciality service. ; and,
- RTT data provided to the health board by the commissioned organisations is in line with the Long Term Agreements in place. Whilst Welsh health boards provide data to allow for timely monthly reporting, there is usually a 2-3 month delay in the provision of RTT data from English trusts and which were informed is outside the health board's control and influence.

Our review of the CAF Escalation Report highlighted that it does not clearly articulate the mechanisms that the health board has put in place to provide assurance that Powys residents subject to commissioned services are being treated as fairly and equitably as outpatients from other health boards. For example, we understand that there is active management of current waiting lists

through regular meetings with the other health boards and trusts in mitigation, although we have not seen documented evidence of this.

Commissioning Services: follow-up appointment data (High Priority)

The CAF Escalation Report provides overall data on waiting times for initial outpatient appointments relating to Powys residents receiving services from other health boards and trusts across Wales and England.

Welsh Government requires all health boards to report a set of outpatient follow-up performance measures each month. Internally, the measures are reported quarterly to the Board in the Integrated Performance Report. However, the comparable figures for Powys residents sent to these other organisations are not included in the CAF Escalation Report. This has been raised in the WAO's *'Review of Follow-Up Outpatients – PTHB report'* (April 2018) which stated that 'there is still insufficient focus on the clinical risks of delayed follow-up outpatients at Board and sub-committee level, for patients seen in the Health Board's localities and patients waiting for a follow-up appointment with another provider. The Health Board has limited information on follow-ups from commissioned services, partly due to a lack of engagement from those providers, and is therefore unable to gain a complete understanding of performance and risks relating to Powys follow-up outpatients.' This report is a follow-up of the WAO's September 2015 review that recommended to *'ensure that there is sufficient information on delayed follow-up outpatient appointments including clinical risks for all Powys patients regardless of where patients are treated, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.'* We understand that the health board is still working to address this.

7. Detailed Audit Findings

Findings are set out by audit objective in the section below and where appropriate, repeated along with recommendations in the action plan in Appendix A that follows.

Provider Services

Objective 1 – Compliance with strategies, policies and guidance

Unlike documentation that we have seen established at other NHS Wales organisations, the health board has no specific local policies and procedures relating to outpatient provider services relevant to the audit assignment **(see finding 1)**. In particular, we identified that the health board's Patient Access Policy is out of date. This is an overarching document that outlines the roles and responsibilities of outpatient services staff and the range of services provided by

the health board for outpatient pathways, as well as interaction with services commissioned to other health boards and trusts.

Instead, national guidance that should be followed includes:

- All Wales NHS Guide to Good Practice – Outpatients
- National Rules for Managing Referral To Treatment (RTT) Waiting Times (Outpatients)

There are separate national rules for specific diagnostic endoscopy procedures and therapy services, and planned cardiac and cancer care services (known as 'surveillance services') that are not covered by Appendix A of the All Wales Rules for Managing Referral to Treatment Times.

We note that the North Locality currently has a vacancy for the role of Outpatients Lead Nurse. This role is responsible and accountable for the management of North Locality outpatients, with 24 hour responsibility, reporting into the Director of Nursing. Such a role will be important with the planned implementation of the 'North Powys Well Being Programme', which includes an ambition to increase the number of outpatient treatment clinics and specialisms. The equivalent role in the South Locality is currently staffed.

Our walk-through of the outpatient booking procedures in place for the health board at the Brecon Patient Services hub compared actual operation against both All Wales Good Practice and National Rules. The National Rules for Managing RTT Waiting Times are varied and complex, depending on the specific treatment diagnosed, though the overall process is the same. Waiting time is monitored using the concept of the 'RTT Waiting Clock', which starts and stops according to the events and transactions that occur along the course of the patient pathway. The measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time.

The National Rules for Managing RTT Waiting Times describe certain exemptions that might result in a manual adjustment within WPAS of the '*RTT Waiting Clock*'. An example would include where a patient is made a '*reasonable offer*' and asked to travel to Llandrindod Wells for a referral instead of the more local clinic in Brecon, as there is a shorter waiting time. If the patient refuses and decides to remain at Brecon, their '*RTT Waiting Clock*' is adjusted to reflect the difference in appointment waiting times between Brecon and Llandrindod (i.e. a reduction in waiting time).'

The health board's outpatient appointment booking and scheduling process is predominantly manual, onerous and time consuming. Despite this, and the associated inherent risks, the health board's processes appear to be well managed and patient files well maintained. This is indicated by the fact that the health board's outpatient performance measures continue to be the best reported across All Wales (refer to tables 3 and 4 below) and the WAO's '*Clinical coding follow-up review report'* (March 2019) which stated: '*the Health Board's*

accuracy has improved over the last five years, albeit a minor deterioration in 2018-19 but performance is still better than the Welsh average.'

Whilst our audit fieldwork did not test adherence to the booking process, moving from a manual system to a more electronic system might assist the health board in addressing recommendations raised by the WAO's '*Clinical coding follow-up review report'* (March 2019) and our '*Records Management internal audit report'* (November 2019):

- the WAO report noted that more work is required to raise the profile and awareness of clinical coding across the health board, to ensure processes are in place to routinely validate and review the accuracy of coding and to improve the quality of medical records across the health board; and
- our audit report identified a number of areas where poor practices continued to be in operation including in respect of identification and tracking, storage and security of records.

Some health boards across Wales have resolved this by implementation of Clinical Workstation System solutions. NHS Wales and the Welsh Government have been supporting the implementation of new, innovative and ambitious approaches to service transformation. This is outlined in the draft three year strategy and action plan 2020-23: '*Transforming the way we deliver outpatients in Wales*'. NHS Wales will be supported to work with patients to develop and start using more automated systems to make getting specialist care easier and quicker **(see finding 2)**.

Objective 2 – Internal and external communications

The Planned Care Programme in Powys has a focus on care closer to home with an aim to have shorter waiting times, improved access and outcomes and high quality and sustainable services. This includes work to address service fragility and modernise appointments and pathways particularly where there have been challenges including diagnostics, therapies and outpatient follow ups. This programme of work is critical to achieving the improvement trajectories as a health board, in line with the national targets including those for Referral to Treatment.

The National Rules for Managing Referral to Treatment (RTT) Waiting Times (Outpatients) provide communications methodology, standard letter templates and target dates for communications between Health Boards, GPs, patients and consultants. The health board's Patient Services team acts as the communication hub between all parties. For example:

- appointment letters sent to patients are also copied to the GP who referred patient for consultation;
- patients are sent a reminder letter after 7, 14 and 21 days for them to call the hub to make an appointment;

- follow-up patient appointments are communicated to GPs.

Communications made are documented in Welsh Patient Appointment System (WPAS) and hard copies of letters are kept in individual patient files. We performed limited testing of this area, during a walk-through of the operational procedures, noting that both the RTT rules and good practice appear to be followed. We gain further assurance from the health board's strong RTT target performance to date. Also, with the health board's 'Planned Care Programme' being in place, suggests that the patient experience is a priority that is being considered and subject to continuous improvement. As highlighted in **objective 3** below, the health board's *'did not attend'* (DNA) rate, where patients have missed appointments, is below the national average, providing further assurance of good communications between all parties.

Furthermore, one of the key drivers for the draft three year strategy and action plan 2020-23: '*Transforming the way we deliver outpatients in Wales'* is to raise more awareness of outpatient services with patients, including information on the effect of missed or cancelled appointments. This is linked to a recent BBC Wales item in January 2020 which highlighted an article communicated by GPs in Wales on the topic of missed outpatient appointments. The article stated that nearly 1.5 million outpatient appointments were missed in the past five years, costing about £240m. This also means many patients need to go back to their GP for a new referral which takes up surgery appointments. The article explained that GP leaders are of the view that no-shows are not always deliberate and have called for patients who fail to turn up for hospital appointments to be given a second chance. In mitigation for Powys, our audit work in **objective 3** below shows that the health board has a missed/cancelled appointment rate of lower than the national average.

Objective 3 – Clinic productivity / waiting list time reductions

The All NHS Wales national outpatient waiting times appointment system (WPAS) is designed to model capacity versus demand on the basis of one consultant operating from one location only. However, for the health board, due to the geographical complexity of the county's health network, outpatient services operate on consultants working across multiple locations, including other Health Boards.

Our walk-through indicates that the health board lacks an automated technology to assist in addressing clinic productivity**.** In particular, a report by the Welsh Government entitled '*Endoscopy Services in Wales*', issued April 2019, cited a case study by a consultant nurse endoscopist at the health board: *'… we need to be using what we've got more efficiently. We need to be doing seven day a week endoscopy, we need to be using the suites for 12 hours at a time, we need to have people in them, not just the endoscopists—we need our nursing support as well to be well trained, and have enough of them.'*

The health board's response to the All Wales Outpatient Transformation Programme suggests that '*improvement work will help clinical teams understand how patients flow through their service and will support the identification of bottlenecks that can cause significant delays to patients. It is also expected to help to identify how the core activities and supporting processes add value to a patient's overall treatment. Opportunities to use technology to exploit new ways of using existing service capacity are to be followed, through the further development of virtual ways of working that can avoid the need for unnecessary appointments*'.

We note that the Welsh Government's NHS Wales Delivery Framework performance measures for outpatients do not include a target for clinic productivity (targets are typically based on patient appointment waiting list times). However, outpatient appointments and DNA figures are reported nationally. The national average DNA rate as at Q3 2019/20 was 8.8%.

The monthly statistics produced by the health board gives an indication of the level of clinic productivity, by clinic location, session, consultant and patient appointments/DNA. For the period April 2019-January 2020, the numbers were as follows:

Table 2

Number of cancelled sessions	391
Number of held sessions	3,207
New appointments	10,114
Follow-up appointments	14,368
DNA's	1,218
% rate DNA	**5%**

**Data extracted from: Document 'SLA_SessionsSummary'* – provided by the health board's Information Department extracted from national systems via the Intelligence Focussed Online Reporting (IFOR) system'.

The clinic productivity statistics are further consolidated for reporting to Delivery & Performance Committee, although the DNA % rate is not separately reported, since not considered an issue. Whilst there is no national performance measure related to consultant cancellations, the health board does report this specific figure in order to demonstrate the impact on in reach services provided. We are informed that consultant cancellations are usually due to either sickness absence or unavailability due to unscheduled care emergencies taking priority.

Furthermore, the 'green' reported waiting time targets for outpatient provider services by the health board provides some assurance that the above process is well-managed to attempt to maximise clinic productivity.

Objective 4 – Performance reporting as provider

Our overall comparison of internal waiting time presentations and reports indicate that consistent data and information was presented from operational management level through the various governance routes, including to the Delivery & Performance Committee and the Board, then onwards to the Welsh Government. For 2019/20 the set of performance measures that must be reported monthly by each health board are:

- The percentage of patients waiting less than 26 weeks for treatment
- The number of patients waiting more than 36 weeks for treatment
- The number of patients waiting more than 8 weeks for a specified diagnostic
- The number of patients waiting more than 14 weeks for a specified therapy
- The number of patients waiting for a follow-up outpatient appointment
- The number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%
- The follow up waiting list to be reduced by at least 15% by March 2020, a further 20% by March 2021 and a further 20% by March 2022

Outpatient waiting list time's performance is reported to the health board by the Planning Team, via the monthly Performance Dashboard supplied by NWIS. Prior to reporting, this data has been validated internally by the health board's Patient Services team, amendments made by Information Services and final approval provided by the Assistant Director, Community Services Group, Primary and Community Care.

Reported waiting list targets reported to Welsh Government for all pathways as at September 2019 provide positive figures for the health board as compared to other health boards in Wales:

Table 3

Welsh Providers	**September 2019**
Provider	**% of patients waiting <26 weeks for treatment (WG target: 95%)**
Powys Teaching Health Board	**97.7%**
Aneurin Bevan UHB	88.7%
Betsi Cadwaladr UHB	79.0%
Cardiff & Vale UHB	85.2%
Cwm Taf Morgannwg UHB	84.7%
Hywel Dda UHB	86.5%
Swansea Bay UHB	85.1%

Table 4

Welsh Providers	September 2019
Provider	**Over 36 weeks (WG target: 0)**
Powys Teaching Health Board	**0**
Aneurin Bevan UHB	1,313
Betsi Cadwaladr UHB	9,781
Cardiff & Vale UHB	682
Cwm Taf Morgannwg UHB	2,985
Hywel Dda UHB	452
Swansea Bay UHB	3,563

**Tables 3 and 4 data extracted from https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks*

Commissioning Services

Objective 5 – Commissioning services communications

Whilst the health board is predominantly a commissioning organisation, there has been progress in the health board's Transforming in Partnership program, partly designed to assist in improvement of coordinated and seamless pathways for outpatient treatments. The IMTP 2019-22 stated that 80% of RTT outpatient appointments for patients of the health board occur outside of Powys borders. The day-to-day management of commissioned services patients, i.e. communications, booking appointments and scheduling of sessions, is the responsibility of Patient Services at the health provider where the patient is referred.

Commissioning services provided by external organisations are managed by the health board through the Commissioning Assurance Framework ('CAF') Escalation Report. The health board's CAF helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients. It considers patient experience, quality, safety, access, activity, finance governance and strategic change. It is a continuous process, considering information from a broad range of sources including '*credible soft intelligence*'. The CAF also provides an update on referral to treatment times (RTT).

In compiling the CAF Escalation Report, the health board attempts to draw from providers' existing Board reports, plans, returns to Government and nationally

mandated information wherever possible. Additionally, formal inspection reports for the NHS organisations commissioned are available on the websites of Health Inspection Wales (HIW) and the Care Quality Commission (CQC). The health board's Internal Commissioning Assurance Meeting (ICAM) meets monthly to discuss the data in order to highlight providers in Special Measures or scored as Level 4 and 3 under the CAF. The Report is then presented to the Delivery and Performance Committee, to Executive Committee and then onwards to the Performance & Resources Committee for discussion, and escalation up to the Chief Executive Officer, as required.

Welsh Government has given additional funding directly to health boards in Wales to improve waiting times. This means PTHB has not received additional funding as a commissioner of those health boards. Organisational trajectories are being agreed with Welsh Government. PTHB is working to ensure it is not recharged for additional activity within Wales. As noted in the CAF Escalation Report presented to the Executive Committee in November 2019, waiting times for Powys patients remain a concern in Swansea Bay University Health Board in particular.

We have undertaken internal audit reviews of the CAF in recent years, the conclusion of our work provided reasonable assurance over the arrangements in place. In addition, the WAO's Structured Assessment Report for the health board, issued December 2019, concluded that *'there is a robust performance management framework for provided and commissioned services. Delivery of the IMTP priorities and outcome measures is largely on track against planned delivery although concerns continue for many commissioned services.'*

Objective 6 – Commissioning services performance reporting

As at November 2019, Powys-resident patients attend four health boards or trusts outside the Powys border that are all designated *'under special measures'*, one that has a *'Level 4'* category and ten with a *'Level 3'* category. The health board's Delivery & Performance Committee continues to discuss in detail and note the current status of each of these external health boards and trusts via the CAF Escalation Report as discussed in **objective 5** above.

We were informed that patients are prioritised for treatment in line with their clinical condition and waiting times, and our analysis of performance data (refer to table 5 below) suggests that Powys residents are treated consistently as all other patients when referred to other health boards and trusts. The CAF Escalation Report presents detailed tables and bar charts of the number of Powys-resident patients with RTT waiting list times, per health board and per speciality service. In particular, the November 2019 report presented the data in the first column of the following table. We note that the report format does not clearly define the context of the figures presented, for example it does not show the comparable figures for the other health boards and trusts as a provider

service which is publically available and shown in the second column of table 5 below:

Table 5

Data presented in the CAF Escalation Report (September 2019 figures)		Data extracted from the All Wales statistics*
Provider	**% of Powys patients waiting <26 weeks for treatment (WG target: 95%)**	**Overall % patients waiting <26 weeks for treatment at each health board**
Aneurin Bevan UHB	88.2%	88.7%
Betsi Cadwaladr UHB	71.7%	79.0%
Cardiff & Vale UHB	81.3%	85.2%
Cwm Taf Morgannwg UHB	77.4%	84.7%
Hywel Dda UHB	83.9%	86.5%
Swansea Bay UHB	81.3%	85.1%

**Data in the right hand column extracted from https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks*

Our analysis and comparison of the figures in columns two and three in the above table, and tables 6 and 7 below, shows that there is variation in RTT performance by the different health boards and trusts, where Powys residents are commissioned to, across Wales and England. Whilst the RTT waiting list performance measures for the health board as a provider are better than those of other Welsh health boards, it is possible that the differences in the figures might be explained by clinical variations in the patient's condition and the type of treatment required.

Table 6

Welsh Providers	**September 2019**	
Commissioning health board	**36 to 51 weeks (WG target: 0)**	**Over 52 weeks (WG target: 0)**
Aneurin Bevan UHB	26	0
Betsi Cadwaladr UHB	35	7
Cardiff & Vale UHB	5	2
Cwm Taf Morgannwg UHB	18	3
Hywel Dda UHB	2	0
Swansea Bay UHB	66	28

**Data extracted from PTHB CAF Escalation Report presented to Delivery and Performance Committee in November 2019*

Table 7

English Providers	July 2019		August 2019	
Provider	**36 to 51 weeks**	**52 weeks & Over**	**36 to 51 weeks**	**52 weeks & Over**
Robert Jones & Agnes Hunt	35	0	No available data	No available data
Shrewsbury & Telford NHS Trust	No available data	No available data	48	0
Wye Valley Trust	80	0	No available data	No available data

**Data extracted from PTHB CAF Escalation Report presented to Delivery and Performance Committee in November 2019*

In comparison, outpatients treated in the health board as a provider service have met the RTT waiting time target of 0 for both 36-51 weeks and over 52 weeks, as highlighted in table 4 above.

Our review of the CAF Escalation Report highlighted that it does not clearly articulate the mechanisms that the health board has put in place to provide assurance that Powys residents subject to commissioned services are being treated as fairly and equitably as outpatients from other health boards. For example, we understand that there is active management of current waiting lists through regular meetings with the other health boards and trusts in mitigation, although we have not seen documented evidence of this. However, the WAO's *'Review of Follow-Up Outpatients – PTHB report'* (April 2018) states *'the waiting list management group review fortnightly performance reports, which includes the number of SLA sessions delivered by specialty against the number required. They also review fortnightly Commissioning reports, with a section on 'referral to treatment' breaches and follow-up position by provider, although information they receive is limited to activity data, rather than the complete follow-up waiting list data'.*

Members often ask questions of the Board on whether Powys residents who are outpatients at commissioned organisations are treated any differently. Whilst we were informed that patients are prioritised for treatment in line with their clinical condition and waiting times, and our above analysis of performance data suggests that Powys residents are treated consistently as all other patients when referred to other health boards and trusts, we have not been able to fully confirm this directly from the CAF Escalation Report.

We also note that RTT data provided to the health board by the commissioned organisations in line with the Long Term Agreements in place. Whilst Welsh health boards provide data to allow for timely monthly reporting, there is usually a 2-3 month delay in the provision of RTT data from English trusts which we

were informed is outside the health board's control and influence **(see finding 3).**

The CAF Escalation Report provides overall data on waiting times for initial outpatient appointments relating to Powys residents commissioned to other health boards and trusts in Wales and England. Welsh Government requires all health boards to report a set of outpatient follow-up performance measures each month. Internally, the measures are reported quarterly to the Board in the Integrated Performance Report.

However, the comparable figures for Powys residents sent to these other organisations are not included in the CAF Escalation Report. This has been raised in the WAO's *'Review of Follow-Up Outpatients – PTHB report'* (April 2018) which stated that *'there is still insufficient focus on the clinical risks of delayed follow-up outpatients at Board and sub-committee level, for patients seen in the Health Board's localities and patients waiting for a follow-up appointment with another provider. The Health Board has limited information on follow-ups from commissioned services, partly due to a lack of engagement from those providers, and is therefore unable to gain a complete understanding of performance and risks relating to Powys follow-up outpatients.'* This report is a follow-up of the WAO's September 2015 review that recommended to *'ensure that there is sufficient information on delayed follow-up outpatient appointments including clinical risks for all Powys patients regardless of where patients are treated, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.'* We understand that the health board is still working to address this. **(see finding 4).**

8. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	**1**	**3**	**-**	**4**

Finding 1 – Policies and Guidance (Design)	Risk
We identified that the health board's Patient Access Policy is out of date. This is an overarching document that outlines the roles and responsibilities of health board staff involved in outpatient pathways and the range of services provided by the health board for outpatients, as well as interaction with services commissioned to other health boards and trusts. Currently, there are a limited number of health board employees with a full understanding of the structure and processes. Such a document would help to ensure that a reader is able understand how and which services are addressed by the health board in this service area, and how it relates to the various All Wales/National Rules for managing outpatient services. Although a generic process flow is provided in the All Wales NHS Guide to Good Practice, it is not detailed sufficiently to support the health board's actual flows. No such local health board document exists that outlines the initial outpatient referral process, such as an easy to read flowchart.	Lack of formalised documentation, team leadership can lead to mistakes, errors in the recording and filing of patient documentation, and patient appointments being delayed. The limited number of key staff and lack of detailed documented process notes limits resilience and continuity of service were any key staff not to be available for any considerable period of time.
Recommendation 1	**Priority level**
Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	**Medium**

Management Response 1	Responsible Officer/ Deadline

Finding 2 – Automated systems (Design)	Risk
The primary stage of the health board's outpatient booking system, from initial patient referral to the point that a patient is booked for a specific appointment into the national patient appointment system ('WPAS') is predominantly manual, onerous and time consuming. In particular: • GPs communicate initial outpatient referrals to the health board's Patient Services Department by letter or email, delaying the time that it takes for patient details to be entered into WPAS in order to initiate the outpatient appointment booking procedure; and, • Patient records are maintained manually. If documentation goes astray, this could lead to an outpatient appointment being delayed or cancelled by the officiating consultant. Some health boards across Wales have resolved this by implementation of Clinical Workstation System solutions. Moving to an automated system has the support of NHS Wales and the Welsh Government, as outlined in the draft three year strategy and action plan 2020-23: '*Transforming the way we deliver outpatients in Wales'*. Additionally, an automated system would help with implementation of management actions from the Wales Audit Office's ("WAO") '*Clinical coding follow-up review report*' (March 2019) and our 'Records Management internal audit report' (November 2019) which recommended improvement of the management and quality of medical records across the health board.	Reliance on manual systems can lead to mistakes, errors in the recording and filing of patient documentation, under-utilisation of clinics and patient appointments being delayed

Recommendation 2	Priority level
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 Management Group.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**

Finding 3 – Assurance over consistent treatment of Powys residents subject to Commissioned Services (Design)	Risk
Monthly, the Delivery & Performance Committee highlight to the Executive Committee Delivery and Performance Group any providers in Special Measures or scored as Level 3 and 4 under the health board's Commissioning Assurance Framework ('CAF'). We were informed that patients are prioritised for treatment in line with their clinical condition and waiting times, and our analysis of performance data (refer to table 5 above) suggests that Powys residents are treated consistently as all other patients when referred to other health boards and trusts. We note that the CAF Escalation Report does not clearly define the context of the RTT figures presented, for example it does not show the comparable figures for the other health boards. Our analysis and review has identified that: • there is variation in RTT performance by the different health boards and trusts, where Powys residents are commissioned to, across Wales and England. This applies to the performance measures for Powys outpatients waiting under 26 weeks for an appointment, over 36 weeks and over 52 weeks; • the RTT waiting list performance measures for the health board as a provider are better than those of other health boards and trusts. Outpatients treated in the health board as a provider service have met the RTT waiting time target of 0 for both 36-51 weeks and over 52 weeks. However, reported data shows that a number of Powys residents treated at other health boards and trusts across Wales and England via	Lack of detailed reporting, and comparison across health boards and trusts, of commissioning services RTT waiting list times may result in patient appointments being delayed. Clinic locations not being fully utilised, resulting in patients not provided with specialist services when required.

commissioned services have waiting times of greater than 36 weeks. It is possible that the differences in the figures might be explained by clinical variations in the patient's condition and the type of treatment required;

- the CAF Escalation Report presents detailed tables and bar charts of the number of Powys-resident patients with RTT waiting list times greater than 36 weeks, per health board and per speciality service; and,
- RTT data provided to the health board by the commissioned organisations in line with the Long Term Agreements in place. Whilst Welsh health boards provide data to allow for timely monthly reporting, there is usually a 2-3 month delay in the provision of RTT data from English trusts which we were informed is outside the health board's control and influence.

Our review of the CAF Escalation Report highlighted that it does not clearly articulate the mechanisms that the health board has put in place to provide assurance that Powys residents subject to commissioned services are being treated as fairly and equitably as outpatients from other health boards. For example, we understand that there is active management of current waiting lists through weekly meetings with the other health boards and trusts in mitigation, although we have not seen documented evidence of this. However, the WAO's *'Review of Follow-Up Outpatients – PTHB report'* (April 2018) states *'the waiting list management group review fortnightly performance reports, which includes the number of SLA sessions delivered by specialty against the number required. They also review fortnightly Commissioning reports, with a section on 'referral to treatment' breaches and follow-up position by provider, although information they receive is limited to activity data, rather than the complete follow-up waiting list data'.*

Members often ask questions of the Board on whether Powys residents who are outpatients at commissioned organisations are treated any differently. Whilst we were informed that patients are prioritised for treatment in line with their clinical condition and waiting times, and our analysis of performance data (refer to table 5 above) suggests that Powys residents are treated consistently as all other patients when referred to other health boards and trusts, we have not been able to fully confirm this directly from the CAF Escalation Report. Welsh Government has given additional funding directly to health boards in Wales to improve waiting times. Whilst the health board is predominantly a commissioning organisation, since it is not affected by the pressures of unscheduled care facilities, there might be further potential for Powys to support other health boards and trusts in Wales and England with the provision of commissioning services and hence receive additional funding. However, since in-reach services are determined by the availability of consultants from other health boards, this potential could be impacted as consultants are often unavailable in order to address unscheduled care pressures in their home locations.	
Recommendation 3	**Priority level**
The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This should include reference to anomalies that might be caused by potential variations in the types of clinical treatments, availability of certain specialist consultants (including, for example, the number of SLA sessions delivered by speciality against the number of sessions required).	**Medium**

Management Response 3	Responsible Officer/ Deadline

Finding 4 – Commissioning Services: follow-up appointment data (Design)	Risk
The Commissioning Escalation Report provides overall data on waiting times for initial outpatient appointments relating to Powys residents receiving services from other health boards and trusts across Wales and England. Welsh Government requires all health boards to report a set of outpatient follow-up performance measures each month. These figures are then reported monthly to the Chief Operating Officer of each health board. Internally, the measures are reported quarterly to the Board in the Integrated Performance Report. The follow-up measures relevant to this audit review are: • The number of patients waiting for a follow-up outpatient appointment; • The number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% of the time designated for their appointment date; and, • The follow up waiting list to be reduced by at least 15% by March 2020, a further 20% by March 2021 and a further 20% by March 2022. However, the comparable figures for Powys residents sent to these other organisations are not included in the CAF Escalation Report. This has been raised in the WAO's *'Review of Follow-Up Outpatients – PTHB report'* (April 2018) which stated that *'there is still insufficient focus on the clinical risks of delayed follow-up outpatients at Board and sub-committee level, for patients seen in the Health Board's localities and patients waiting for a follow-up appointment with another provider. The Health Board has limited information on follow-ups from commissioned services, partly due to a lack of engagement from those providers, and is therefore unable to gain a complete understanding of performance and*	Lack of detailed reporting, and comparison across health boards and trusts, of commissioning services RTT waiting list times may result in patient appointments being delayed. Clinic locations not being fully utilised, resulting in patients not provided with specialist services when required.

risks relating to Powys follow-up outpatients.' This report is a follow-up of the WAO's September 2015 review that recommended to *'ensure that there is sufficient information on delayed follow-up outpatient appointments including clinical risks for all Powys patients regardless of where patients are treated, and this is reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.'* We understand that the health board is still working to address this.	
Recommendation 4	**Priority level**
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.	**High**
Management Response 4	**Responsible Officer/ Deadline**

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Estates Assurance Follow Up

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Reasonable Assurance

Previous review rating **Reasonable Assurance**

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Andrew Cresswell, Assistant Director: Support Services & Facilities

Committee Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

The audit was undertaken to determine the current status of previously agreed recommendations arising from the following estates assurance audits:

- Asbestos Management [issued October 2018]
- Water Management [issued April 2018]
- Fire Precautions [issued April 2017]
- Waste Management [issued October 2011]
- Health and Safety [issued July 2011]

The status of the above was last reported in the 2018/19 Estates Assurance Follow Up report [issued April 2019].

It is noted that with effect from 1 April 2020, Executive responsibility for Fire Precautions / Fire Safety will change. It will be re-assigned from the Director of Planning & Performance to the Director of Workforce & Organisational Development.

2. Scope and Objectives

This review encompassed an evaluation of the actions taken by the teaching Health Board (tHB) to address previously agreed recommendations identified by audit for management actions arising from estates assurance reports.

This process was progressed through obtaining evidence in support of each recommendation. Results of the review were fed back to management to enable any errors or omissions to be corrected prior to the final issue of the report. The revised management action plan is attached in **Appendix B.**

3. Associated Risks

The potential risks considered in the review were as follows:

- The organisation fails to address known concerns exposing itself to unnecessary risk:
- Management control frameworks continue to exhibit weaknesses; and
- Management do not have processes in place to review and action agreed audit recommendations (and consequential risk mitigation).

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system

of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given to actions taken by management to address the previously agreed audit recommendations is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance	 - +	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Summary of Audit Findings

The status of agreed management action can be summarised as follows:

Audit Report	Closed	Partially implemented	Outstanding	Total
Asbestos Management	2	1	-	**3**
Water Management	2	-	-	**2**
Fire Precautions	1	1	1	**3**
Waste Management	1	-	-	**1**
Health & Safety	1	-	-	**1**
Total	**7**	**2**	**1**	**10**

Of the ten recommendations that were agreed by management, seven recommendations were implemented (70%) with two recommendations partially implemented (20%) and one outstanding (10%).

The full audit findings are detailed in **Appendix A**.

6. Summary of Recommendations

A summary of the recommendations remaining is outlined below by priority:

	H	M	L	Total
Asbestos Management	-	-	1	**1**
Fire Precautions	-	1*	1	**2**
Total	**-**	**1**	**2**	**3**

noting the lack of evidence to demonstrate compliance with the Fire Code for performance of fire drills, the priority has been increased from **low to **medium.***

Of the recommendations remaining, the key issues for management are:

- Asbestos Management– endorsement of the asbestos waste log and procedure for non-licensed waste for inclusion in the Asbestos Management Plan;
- Fire Precautions – review of the training needs assessment by the Fire Safety Group for implementation; and
- Fire Precautions – performance of site fire drills in accordance with the Fire Code.

The updated recommendations are detailed in **Appendix B** together with the management action plan and implementation timetable.

Asbestos Management – Reasonable Assurance (October 2018)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	The Asbestos register (database) should be updated during and following conclusion of the refurbishment surveys currently being undertaken.	**Closed** The Asbestos database was reviewed and the main dashboard indicated full compliance with the exception of one site. In this instance, a survey had yet to be undertaken as the THB had yet to take possession of the site.	N/A	N/A
Low				
2	A detailed review of the Asbestos Management Plan should be completed.	**Partially implemented** An asbestos waste log and procedure for non-licensed waste had been drafted at the date of this review. These procedures were shared with the Asbestos Sub Group for discussion on 18 February 2020. It is anticipated they will be formally endorsed for inclusion in the Asbestos Management Plan at the next meeting.	Asbestos Manager June 2020	**Low**
3	The updated Asbestos Policy should be formally ratified.	**Closed** The Asbestos Policy has been formally ratified by the THB.	N/A	N/A

Water Management – Limited Assurance (April 2018)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	A full audit trail should be maintained of the review of the central log books; and common noted issues should be included as agenda items for discussion by the Water Safety Group ensuring consistency in approach across the THB.	**Closed** There was an audit trail of the work that has been undertaken to date to review and update the log books. Llandrindod Wells Hospital has been used as the pilot for the update of the log book with a view for the remaining to be issued upon completion of site risk assessments [anticipated Summer 2020].	N/A	N/A
2	The role of the Deputy Responsible Officer should be addressed, subject to training and appointment.	**Closed** There has been a successful appointment to the role of Deputy Responsible Person (Water Safety).	N/A	N/A

Fire Precautions – Reasonable Assurance (April 2017)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	The fire safety management folders should be finalised for Newtown Hospital and Bronllys Hospital.	**Closed** The fire safety management folders were provided by management for the two sites, however: • Newtown – review date of April 2018 (two years overdue); and • Bronllys – no evidence of the effective date. It was noted that the content of the manuals will be subject to a full assessment as part of the Fire Safety audit which is scheduled for the 2020/21 Internal Audit plan.	N/A	N/A
2	The proposed fire training needs assessment (TNA) should be reviewed by the Fire Safety Group and implemented accordingly.	**Partially implemented** Whilst there was evidence of training having been discussed at the Fire Safety Group, and a training needs assessment developed, there was no evidence that it had been implemented accordingly.	Assistant Director: Facilities & Support Services June 2020	**Low**

Fire Precautions – Reasonable Assurance (April 2017)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
		It is noted that a full review of Fire Safety will be undertaken as part of the 2020/21 IA plan where the management of training will be assessed.		
Low				
3	Site fire drills should be performed on an, at least, annual basis.	**Outstanding** There was no evidence to confirm that site fire drills were being performed in an appropriate timely manner. Management advised this weakness was also raised through Fire Service inspections that had recently been undertaken [noting that the frequency of such had increased post Grenfell]. Noting the recommendation has remained outstanding since 2018, and the associated risk, the priority rating has been increased accordingly. It is noted that a full review of Fire Safety will be undertaken as part of the 2020/21 IA plan where the management of fire drills will be assessed.	Assistant Director: Facilities & Support Services June 2020	**Medium**

Waste Management – Reasonable Assurance (October 2011)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Low				
1	Action should be taken to address the remaining outstanding recommendations; and to demonstrate processes are embedded and working effectively in readiness for the Stage 2 audit (scheduled May 2019).	**Closed.** The THB received the ISO14001: 2015 certification in July 2019; which is valid for three years. The supporting report issued upon certification noted that the recommendations from the previous visit had been addressed appropriately by the THB. There were some areas noted with minor non-conformity but these did not have an impact on success of certification.	N/A	N/A

Health and Safety – Reasonable Assurance (July 2011)				
Prior Ref	**Recommendation @ April 2019**	**Action/Status @ March 2020**	**Updated responsibility and timescale**	**Current year priority rating**
Medium				
1	Formalisation of the role / group management of physical building and environment aspects of DDA compliance should be undertaken now that the link to the Equalities Manager has been made.	**Closed** Further to the issue of the original recommendation, management advised that the responsible officer for this area is the Service Improvement Manager (Welsh Language and Equality) rather than the Assistant Director of Estates & Property. Actions have been taken by the THB to address the physical building and environmental aspects of DDA compliance as well as the wider management of equality and diversity across the THB.	N/A	N/A

Asbestos Management			
Ref	**Priority**	**Recommendation**	**Responsibility & Timescale**
2	**Low**	The asbestos waste log and procedure for non-licensed waste, drafted following review of the Asbestos Management Plan (AMP) should be formally endorsed by the Asbestos Sub Group for inclusion in the AMP.	Asbestos Manager June 2020

Fire Precautions			
Ref	**Priority**	**Recommendation**	**Responsibility & Timescale**
2	**Low**	The proposed training needs assessment (TNA) should be reviewed by the Fire Safety Group and implemented accordingly.	Assistant Director: Support Services & Facilities June 2020
3	**Medium**	Site fire drills should be performed on an, at least, annual basis in accordance with the Fire Code.	Assistant Director: Support Services & Facilities June 2020

Assurance & Risk Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management Action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Financial Safeguarding: Estates Team Led Work

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


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Executive sign off	Hayley Thomas, Director of Planning & Performance
Distribution	Wayne Tannahill, Assistant Director of Estates & Property Pete Hopgood, Executive Director of Finance, Information and IT Services Steve Watkins, Estates Officer Engineering Specialist
Committee	Audit Committee

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

Please note:

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1. Introduction and Background

Fraud within the NHS Capital, Estates and Facilities functions has been more prevalent in recent years, with two recent examples being:

- a well-publicised incident within NHS Wales where three Estates officers were jailed in November 2018 after being found guilty of defrauding the NHS of £822,000; and
- another in Gloucestershire Hospitals NHS Foundation Trust where a senior Estates official was similarly sentenced abusing his position and defrauding the NHS of £870,490.

Therefore, in accordance with the agreed 2019/20 internal audit plan, the financial safeguarding review sought to affirm that there are effective controls and systems operating to deter and safeguard against potential fraud within Powys Teaching Health Board's ('the THB') Estates and Support Services functions.

This report focuses on projects / contracts led by the Estates team and should be read in conjunction with the separate report produced on the Support Services team.

2. Scope and Objectives

The audit was actioned under the operational internal audit plan agreed by the THB. The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the THB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The scope of the audit was limited to procurement exercises associated with pre-planned and reactive maintenance programmes. The audit did not cover major capital projects, discretionary capital projects or the purchase of medical devices.

Accordingly, the scope and remit of the audit included the following:

- **Declarations of interest –** assurance that:
  - Appropriate guidance and procedures exist for the declarations of interest and compliance was demonstrated in respect of the same;
  - Appropriate arrangements were in place to enable concerns and breaches to be raised; and
  - Appropriate training was afforded to all staff.
- **Quotation / Tender /Local Order processes** –assurance that:

- An appropriate governance framework was in place in respect of the procurement, tender, contract letting, local order processes (both manual and automated); and
- Compliance was demonstrated against the established internal control framework (and best practice) for selection and appointment.

- **Segregation of duties/delegated authority** – assurance that:
  - Appropriate guidance and procedures existed for the segregation of duties in the management and selection of quotes/tenders/local orders; and compliance was demonstrated in respect of the same; and
  - All approvals were appropriately sought and decision makers were appropriately authorised and adequately informed.
- **Verification of contractor/supplier arrangements** – assurance that:
  - Verification was undertaken prior to the appointment of contractors/suppliers including financial vetting, positions held by key directors; and
  - Assurance that information is produced on the award of contracts, fair rotation of contractors, analysis of key suppliers etc. - allowing analysis of tender/quotation returns and to identify any patterns of unusual behaviour.
- **Monitoring and reporting** – reporting and accountability lines were well defined, understood and applied.
- **Verification of works completed** – assurance that works were completed in accordance with the award criteria.
- **Stock control** – assurance that appropriate stock control systems were in place [including re-ordering, issue and return] to manage the materials utilised in delivery of pre-planned and reactive maintenance.
- **Other** – consideration of any other issues relevant to the general objectives above, which may arise during the review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Breach of mandatory regulations;
- Non-compliance with established internal controls impacting on the achievement of project objectives;

- Tender arrangements not compliant with local/national requirements and value for money not be demonstrated;
- Tender processes were not sufficiently robust to minimise / mitigate collusion and/or fraud;
- Personal interests, or interests that they owe to another body, influenced or affected the individual's decision-making.
- Poor risk identification and management, resulting in the THB being un-informed in relation to cost, time and quality performance.
- Failure to prioritise high risk areas in the estate.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

We evidenced a reasonable control framework in place via the THB's Standing Financial Instructions (SFI's) and Capital Procedures, where applicable. Robust segregation of duties, and application of delegated limits, were noted in the approval of work arrangements / contract entered into by the THB.

However, the audit identified the following control weaknesses:

- Whilst recognising the mitigating actions the THB put in place, there is a need to have formal contracts in place for all maintenance areas, which have followed the appropriate procurement route;
- The void of expertise needs to be addressed to assist in the development of quotation / tender specifications for the maintenance areas; and
- The requirement for completion of a declaration of non-collusion needs to be addressed at tendered contracts.

In addition, certain enhancements have been recommended in respect of:

- Review of cumulative value of work awarded to contractors and associated financial vetting requirements;
- Procurement activity reporting;
- Evaluation of contractor performance; and

- Implementation of a stores secure area procedure.

Against the context of the matters detailed above, the overall level of assurance has been assessed as **reasonable.**

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Declarations of interest				✓
2	Quotation / Tender processes			✓	
3	Segregation of duties / delegated authority				✓
4	Verification of contractor arrangements			✓	
5	Monitoring & Reporting				✓
6	Verification of works completed			✓	
7	Stock control			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the audit have highlighted **four** issues that are classified as weaknesses in the system control/design.

Operation of System/Controls

The findings from the audit have highlighted **three** issues that are classified as weaknesses in the operation of the designed system/control.

6. Summary of Audit Findings

The key findings are reported within the Management Action Plan (**Appendix A**).

To focus the audit testing on external contractual appointments made by the THB since April 2019, schedules were requested from the Estates departments to determine the number of contracts in place and total value. See below:

Area	Number	Approved allocation / value
Pre-planned maintenance	14[1]	Circa £70,000
Reactive maintenance [2]	Not defined	Circa £676,140

6.1 Declarations of interest

We sought assurance that appropriate guidance and procedures were available for declarations of interest, and compliance was demonstrated in respect of the same. We also sought assurance that appropriate arrangements were in place to enable concerns and breaches to be raised; and assurance that appropriate training is afforded to relevant staff.

A governance framework was in place for declarations of interest, namely the Standards of Behaviour Policy, which was available for all members of THB staff via the intranet.

Section 4.3 of the policy states "*arrangements are in place to prompt all employees … to complete a declaration of interests form on initial employment with the health board, and at periodic intervals thereafter*"

[1] There are a total of 26 pre-planned areas identified in the listing; noting that for some, contracts are in the process of being procured and/or interim measures are in place and consideration being given to procure the service through a contract. The number disclosed relates to the contractors on the listing who have a contracted value assigned.
[2] An aggregate listing of payments for all minor works was provided by Finance; data was filtered by subjective codes which were relevant to Estates work.

Section 4.7 of the policy states "*if an employee is requested to participate in the procurement process they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared"*

To confirm compliance, our review was limited to those named officers involved in the appointment process of the external contractors sampled during this audit.

Adherence to the policy for both general and the procurement related exercises was noted for Estates personnel. **Substantial assurance** has therefore been determined in this area.

Quotation / Tender/ Local Order Processes

We sought assurance that an appropriate governance framework was in place in respect of the procurement, tender, contract letting and local order processes (both manual and automated); and that compliance was demonstrated against an established internal control framework (and best practice) for selection and appointment.

Governance framework

Standing Financial Instructions and Standing Orders were readily available to provide guidance in respect of procurement processes. Additional guidance was also provided in the Capital Procedures which is accessible for all Estates staff.

Compliance with procedures

Details of the projects / contracts reviewed are set out within the report as follows:

- Appendix C: Pre-Planned Maintenance [Estates] (16 contracts)
- Appendix D: Reactive Maintenance [Estates] (6 contracts)

The procurement routes followed or, where applicable, proposed by the THB for appointment of the 22 contracts / jobs were as follows:

- Bravo platform: 11
- Framework: 4
- Multi Quote platform: 1
- Not competitively tendered (below 5k): 3
- Other [3]: 3

[3] Included in the 'other' classification are: renewal of existing arrangement; direct approach to one contractor for a value greater than the £5k threshold; and procurement following emergency incident.

It was acknowledged that for **all** procurement exercises above the £5k threshold, the THB instructs the services of NWSSP: Procurement to lead on their behalf.

Compliance with procedures was confirmed in the management of the number of contractors selected to tender / quotation and the evaluation process (prior to appointment). However, deviation from governance framework was noted:

- Only four of the 16 estates maintenance areas reviewed (25%) had live contracts **(recommendation 1);**
- For those areas where no live contract was in place, it was acknowledged that they were at varying stages of the procurement process including evaluation stage, tender submission stage and specification drafting stage – an area of expertise which management acknowledge is deficient at the THB **(recommendation 2).**

  It was, however, noted that in the absence of a formal contract, appropriate mitigating actions had been taken to ensure the pre-planned areas were not left unattended; and the relevant procurement route observed had been authorised in accordance with delegated authority.
- As cited in the Standing Financial Instructions competitive exercises are required for work above £5k. There is an expectation that tender / quotation documents should contain standard statements governing rules regarding bribery and corruption i.e. declaration of non-collusion. However, for the sampled competitive exercises, there was no evidence of a signed certificate of non-collusion from the relevant contractor **(recommendation 3)**

Whilst being cognisant of the lack of formal tender / quotation exercises that have been undertaken to manage the pre-planned maintenance areas, it is recognised that the THB has implemented reasonable controls to mitigate the risk of fraudulent activity. Therefore **reasonable assurance** has been determined.

Segregation of Duties / Delegated Authority

We sought assurance that appropriate guidance and procedures were available for segregation of duties in the management and selection of quote/tenders/local orders and that compliance was demonstrated in respect of the same. We also sought assurance that approvals were appropriately sought and decisions were appropriately authorised and adequately informed.

For the pre-planned maintenance areas where formal contractual arrangements were in place, segregation was evident through the involvement of NWSSP: Procurement Services therefore reducing the reliance on the Estates department to manage a procurement exercise in

its entirety. This was applicable for both tenders and quotations [use of the Multi-Quote platform].

For those procurement exercises which fell within the discretionary threshold, segregation of duties remained apparent.

Application of the delegated limits for approval of work arrangements / contracts was evident in all instances.

Accordingly, **substantial assurance** has been determined in respect of this area.

Verification of Contractor Arrangements

We sought assurance that appropriate verification was undertaken prior to the appointment of contractors / suppliers, including adequate financial vetting and verification of positions held by key directors. We also sought assurance that information was produced on the award of contractors, analysis of key suppliers etc. – allowing analysis of tender/quotation returns and to identify any patterns of unusual behaviour.

Financial vetting

Section 5 of Schedule 1 to the Standing Financial Instructions states '*it is the responsibility of the Director of Finance, Planning & Performance to establish that all firms on the tender list are financially sound and professionally competent through a pre-qualification / financial vetting process undertaken by a suitably qualitied and experienced procurement officer'*

Of the 22 appointment processes reviewed:

- Three appointments were made from a Framework, for which vetting had been undertaken upon initial appointment;
- One appointment had evidence of financial vetting, as provided in the evaluation pack prepared by NWSSP: Procurement Services;
- At the date of fieldwork ten appointments had yet to reach the financial vetting stage of the procurement process (all pre-planned maintenance);
- There was no evidence for two of the pre-planned maintenance appointments; and
- There was no evidence for six of the reactive maintenance appointments (four of which were below the discretionary level).

Of the above appointments, 20[4] were below the implied £25k limit therefore would not be subject to a financial vetting exercise. However, the THB should not lose sight of the potential strategic importance of these lower value appointments, their cumulative value and integrity of the award process **(recommendation 4).**

Reporting on award of contractors

Schedule 1 (Section 7.25) to the Standing Financial Instructions states *'overall monitoring of the contracts awarded shall be the responsibility of the Director of Finance, who shall present a report annually to the Board detailing the number and value of all contracts placed during the previous financial year in excess of the tender limit'.*

The above implies that this is required only for tendering exercises entered into which are above the £25k threshold.

An annual procurement activity report is prepared for the THB by NWSSP: Procurement, setting out the various procurement categories and identifying any procedural compliance issues. At the date of fieldwork, the report for the financial year 2018/19 had yet to be received **(recommendation 5).** Management advised that assurances had been received from NWSSP: Procurement that the report would be issued in January 2020.

It is recognised that procedures / processes are in place for financial vetting and procurement activity reporting, albeit not applicable / not prepared at the date of fieldwork. Noting this, **reasonable assurance** has been determined.

Monitoring & Reporting

We sought assurance that reporting and accountability lines were well defined, understood and applied.

The Estates Compliance Group received monthly highlight reports, prepared by the Estates Officer (Engineering Specialist). Whilst not providing specific updates regarding procurement exercises, focus on the resource planning requirements to map pre-planned maintenance times and reactive maintenance information was evident.

The Estates Compliance Group fed into the Capital and Estates Improvement Group, which reported to the Performance & Resources Committee.

[4] It is noted that many of the appointment values provided were, in the absence of formal contracts, annual figures. It is the aim of the THB to introduce multi-year contracts for a number of maintenance areas, therefore the value of the contract will be higher and lend itself to the tender process.

Procurement exercises were subject to discussion at the monthly meetings held with NWSSP: Procurement. In attendance at the meetings were representatives from both Estates and Support Services [refer also to the *Verification of Contractor Arrangements* section].

Recognising the reporting and accountability lines, **substantial assurance** has been determined.

Verification of works completed

We sought assurance that works were completed in accordance with award criteria.

Where external contractors had been used to undertake pre-planned maintenance and reactive work, there was no evidence to confirm physical and actual completion other than payment of the invoice.

Whilst acknowledging arrangements for pre-planned maintenance are deemed ongoing for the contract duration, regular performance reviews should be embedded and evidenced as such **(recommendation 6).**

Whilst cognisant of minimal certificates of practical completion, the payment of the contractors invoice is taken as recognition of completion of work. As such, the level of assurance has been determined as **reasonable.**

Stock Control

We sought assurance that appropriate stock control systems were in place [including re-ordering, issue and return] to manage the materials utilised in the delivery of maintenance work.

Through discussions with management, it was acknowledged that areas of reactive maintenance can be addressed through either external appointment or use of in-house tradesmen. Therefore, we reviewed the arrangements in place to ensure appropriate records were maintained of the materials utilised in the delivery.

A review was undertaken of the processes followed at the storeroom located at Bronllys Hospital and Newtown [Mochdre Industrial Estate].

Typical procedure is the use of a 'just-in-time' approach whereby materials are only ordered and received as they are needed; therefore reducing the reliance on a stores / stock function within the THB. Management advised that a decision had been taken by the THB to reduce the overall level of stock held in a formal capacity, with regular recurring items being maintained by the relevant tradesmen or onsite.

There were no formal documented stock management procedures in place; reflecting the infrequent activity in the storerooms and the low value of

stock (circa £8k, across both sites reviewed). It was noted that ordered resources (used for reactive work: Bronllys) would use the site storeroom as temporary storage until collection for use. However, this area was observed to be not secure and a risk for potential misappropriation **(recommendation 7)**.

Noting the level of activity involved in the operational management of a storeroom and the value of stock maintained, **reasonable assurance** has been determined in this area.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Recommendations raised	-	6	1	**7**
Actioned since fieldwork	-	1	-	**1**
Recommendations to address	**-**	**5**	**1**	**6**

Finding 1: Tender / Quotation Processes – Maintenance Contract Setup	Risk
Pre-planned maintenance Only four of the sixteen sampled Estates maintenance areas were covered by a live contract at the time of the audit. These were either through the use of multi-year contracts through a tendering process managed by NWSSP: Procurement or external framework providers such as Eastern Shires Purchasing Organisation (ESPO). We were advised by management that a lack of physical resources available to the THB meant that they could not formalise tender/contract specifications etc., for all required areas. It was acknowledged that the Estates department were in the process of recruiting additional resource to manage these pre-planned maintenance contract issues. However, this process was still at a very early stage. For the maintenance areas where no formal contract arrangements were in place, the THB had sought to manage through rolling/extending existing supplier arrangements and using one-off orders. Reactive maintenance Four of the six reactive maintenance sampled items were below £5k in value, and therefore, as per the Standing Financial Instructions, contractors were appointed at the discretion of management rather than a formal procurement exercise. For the remaining two items, both were above the discretionary level: • Appointment required to address an emergency situation. This was undertaken in full consultation with Procurement, noting that formal	Maintenance areas are overlooked by the THB. THB unable to carry out work to full capacity. Risk to staff, patient and public safety.

tender/quotation processes were not adhered to. Procurement recorded this issue as a minor breach, and the Capital and Estates Compliance group were advised accordingly; • Appointment made as an interim arrangement via the pre-planned maintenance area.	
Recommendations 1 & 2	**Priority level**
1. The Estates department should ensure that pre-planned maintenance areas are covered by formalised contacts arrangements, and that there are formal interim measures in place until these contracts are finalised. **(O)**	**Medium**
2. The resource requirements to address the maintenance tender/contract expertise within the Estates function should be finalised. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. xx	Assistant Director: Estates & Property TBC
2. xx	Assistant Director: Estates & Property May 2020

Finding 2: Declaration of non-collusion	Risk
Schedule 1 (Procurement of Works, Goods & Services) of the THB Standing Financial Instructions (SFIs) states: *1.3 The main legal and governing principles guiding public procurement are:* • *Integrity: there should be no corruption or collusion with suppliers or others.* As part of a selective tendering process, tenderers should be required to complete a declaration on non-collusion. This is to assist in mitigating the risk of corruption in the tender process by requiring specific relevant declaration. The SFIs state that competitive procurement exercises are required for: • those within the £5k-£25k threshold (quotations); and • those in excess of the £25k threshold (tenders). Declarations of non-collusion were not evidenced at four of the sixteen sampled Estates maintenance areas (valued between £5k-£25k). Acknowledging that NWSSP Procurement Services lead all procurement exercises above the £5k threshold on behalf of the THB, the responsible officers advised that they do not require declarations on non-collusion below the £25k threshold.	Collusion of parties in preparation of tender / quotation. Non-compliance with policies and procedures.
Recommendation 3	**Priority level**
Management should ensure all competitive quotation and tender exercises utilise the standard declaration of non-collusion for return to the THB as part of the evaluation packs. **(O)**	**Medium**

Management Response	Responsible Officer/ Deadline

Finding 3: Cumulative value of work awarded	Risk
Whilst the value of the works sampled were mostly below the tender/quotation threshold, there were instances where the THB had appointed a single contractor, through a number of orders (below £5k), as part of an interim arrangement until a formal maintenance contract was established e.g. at period 7 of the 2019/20 financial year, one contractor had been awarded £21k worth of work. This approach places the THB and employees at undue risk of: • Non–compliance with SFI requirements [*"Any attempt to avoid these limits may expose the LHB to risk of legal challenge and result in disciplinary action against an individual[s]." (Schedule 1, Section 4.1, page 64)*] • Lack of openness and transparency in award processes; • Integrity of the procurement processes being challenged by suppliers, contractors, staff or general public; • Non demonstration of the efficiency of the procurement processes i.e. cost effectiveness and value for money; and • The accumulated amount of work allocated towards a single contactor requiring increased controls e.g. financial vetting.	THB's financial interests are not adequately protected. Financial risk in the event of contactor failure.
Recommendation 4	**Priority level**
a) Management should review all maintenance expenditure for the financial year and determine whether formal quotation/tendering exercises should have been undertaken based on the cumulative value of works awarded to individual contractors. The same should be reported to the Estates Compliance Group.	**Medium**

b) Management should have a standing agenda item at the procurement meetings detailing contractor/supplier orders placed e.g. cumulative number and value of all orders placed during the period/ financial year. The same would ensure openness, accountability, challenge and compliance with SFIs. c) Based on the outcome of (a) and (b), management should determine anticipated activity and service contract requirements for 2020/21 and future periods. **(D)**	
Management Response	**Responsible Officer/ Deadline**
	Assistant Director: Estates & Property Director of Finance TBC

Finding 4: Procurement Activity Reporting	Risk
In order to monitor and report period procurement activity, it was noted that NWSSP Procurement prepared financial year procurement activity reports, which detailed an overview of general procurement activity, details of all quotations and tender exercises throughout the financial year and any single quotation/tender waiver actions. At the date of the audit (January 2020) the activity report for 2018/19 had only just been issued in 'draft' by NWSSP Procurement. Whilst the monthly procurement meetings held between the THB and NWSSP Procurement are acknowledged, the activity report provides an effective summary of the procurement exercises entered into. The output of the report also helps define future decision making processes.	THB not being made aware of any issues in the Procurement process. Risk of THB not following correct procedures.
Recommendation 5	**Priority level**
Management, in consultation with NWSSP: Procurement, should define an appropriate and reasonable timeframe (following the end of a financial year) for the receipt of the Procurement Activity Report. **(D)**	**Low**
Management Response	**Responsible Officer/ Deadline**
	Assistant Director: Estates & Property TBC

Evans,Caroline
05/11/2020 15:54:16

Finding 5: Performance reviews	Risk
Where external contractors had been used to undertake pre-planned maintenance and reactive work, there was no evidence to confirm physical and actual completion other than payment of the invoice. However, as the THB progressively moves towards longer-term contract arrangements, performance reviews should be undertaken; allowing any corrective action required to be addressed in a timely manner. It is acknowledged that the reviews may be subject to a defined threshold according to the work arrangement / contract period.	The THB is uninformed in relation to cost, time and quality performance.
Recommendation 6	**Priority level**
The THB should develop key performance indicators against which external contractors will be evaluated; and the outcome reported to an appropriate forum. **(D)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
	Assistant Director: Estates & Property TBC

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Finding 6: Stock Procedures	Risk
The THB's SFIs (Section 16.2.3) specify that *"The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores and losses".* There were no documented procedures in place for the management of Estates stores. Management advised this was reflective of the infrequent activity in the storerooms and the low value of stock (circa £8k). Whilst it is acknowledged that the value of stock currently held by the THB is not material (circa £8k), an element of procedures and systems should be in place to comply with the SFIs. Furthermore, through discussions with key staff, it was identified that the Bronllys stores, upon receiving purchased resources, the delivered items would be held in the stores area in an open, unsecured area. We were informed by the THB that they were in the process of setting up a secure area for where resource deliveries can be stored.	Potential reduced control over stores management. Inconsistent procedures across Estates stores. Risk of potential stock misappropriation. Non-compliance with SFIs.
Recommendation 7	**Priority level**
The THB should implement the secure area procedure within stores, to ensure all procurement deliveries are safely and securely stored until use. **(D)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Actioned since fieldwork	N/A

Pre-Planned Maintenance [Estates]: summary of testing

Contract	Value per PPM listing	Duration of agreement	Procurement route	Number of contractors invited to tender	Financial vetting [5]	Segregation of duties	Authorised appropriately	Declarations of Interest [6]	Comments / Matters arising
PAT Testing & Microwave Testing	£6,179	1 year	ESPO Framework	24	✓	✓	✓	✓	Financial vetting undertaken as part of the Framework. Selection made from the options of contractors on the Framework on the basis of the lowest cost. Aim is for a 3-year agreement in the future.
Fire extinguisher maintenance	£6,562	1 year	ESPO Framework	7	✓	✓	✓	✓	Financial vetting undertaken as part of the Framework. Aim is for a 3-year agreement in the future.
Medical Gases quarterly maintenance	£3,385	1 year	Current arrangement on quotation	Specification for formal contract currently being developed in consultation with Procurement					Work being undertaken to develop specification for a 3+1+1 agreement. Contractor selected being used in the interim period.
Engineering Inspections	£6,405	-	CCS Framework RM3731 (Lot 1)	26	×	✓	-	✓	No financial vetting as was a renewal of contract. At date of fieldwork, procurement exercise had not been finalised.

[5] As implied by the Standing Financial Instructions, financial vetting relates to those contracts tendered competitively therefore > £25k
[6] Confirmation of declarations of interest relate to those officers approving the agreement / contract. The forms completed are general rather than specific to each agreement / contract reviewed.

Contract	Value per PPM listing	Duration of agreement	Procurement route	Number of contractors invited to tender	Financial vetting [5]	Segregation of duties	Authorised appropriately	Declarations of Interest [6]	Comments / Matters arising
Personal Attack Alarms on AMI, Bronllys	£3,498	1 year	Rolling historical agreement	-	✗	✓	✓	✓	Historical agreement – financial vetting undertaken at time of original agreement only.
Lift Servicing	£3,316	-	Framework	4	✓	✓	✓	✓	All Wales Framework – led by NWSSP Procurement
Annual test & inspection of lightning protection systems	£5,400	3+1+1	Tender	Open (5 returns)	✓	✓	✓	✓	Award of contract took place shortly after audit fieldwork had concluded.
Gas & Oil Boiler Annual Servicing	TBC	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders (reactive repairs only) being placed whilst formalise the procurement process
Fire Alarm Maintenance	£10k - £15k [estimated]	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders (reactive repairs only) being placed whilst formalise the procurement process
Critical Theatre ventilation for Llandrindod & Brecon	£3,129	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process
Legionella sampling, disinfections & tank cleaning	£50k	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Rolling forward previously agreed arrangements with named contractor.
Fire Alarm Monitoring	£2,304	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process
Gritting to all sites	£20,400	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process

Contract	Value per PPM listing	Duration of agreement	Procurement route	Number of contractors invited to tender	Financial vetting [5]	Segregation of duties	Authorised appropriately	Declarations of Interest [6]	Comments / Matters arising
Maintenance of Air Conditioning Units	£6,426	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process
Automatic Door Maintenance	£2,035	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process
Electrical Fixed wire testing	Unknown	Propose 3+1+1	Tender	No procurement exercise undertaken at date of audit					Individual orders being placed whilst formalise the procurement process

Reactive Maintenance [Estates]: summary of testing

Contract	Value per PPM listing	Procurement route	Financial vetting [7]	Segregation of duties	Authorised appropriately	Declarations of Interest [8]	Comments / Matters arising
Supply & fit suspension ropes & anchors]	£4,147	Direct approach to contractor	n/a	✓	✓	✓	Noted that a number of possible contractors were approached but due to the age of the lift, were limited as to those who would be able to undertake the work.
Replace Automatic Door Operator	£3,840	Multi-Quote	-	-	-	-	Unable to confirm as source documentation unavailable for review due to responsible officer no longer in post.
Oil spill from site storage tank	£6,605	Emergency	n/a	✓	✓	✓	Single tender waiver completed retrospective to the work [done in full consultation with Procurement]. Expectation is that all STW's are communicated at Audit Committee. No evidence of such, but evidence of endorsement of the work at CE&IG.
Welshpool Hospital (pseudomonas samples)	£5,905	Direct approach to contractor	x	✓	✓	✓	Historic agreement with the contractor. Previously agreed terms are being used until a new tender can be specified and let for water management.
AP Cover 01/10/18 to 31/03/19	£1,884	Direct approach to contractor	n/a	✓	✓	✓	-
Checking of assets 01/11/18 to 31/05/19	£4,522	Direct approach to contractor	n/a	✓	✓	✓	-

[7] As implied by the Standing Financial Instructions, financial vetting relates to those contracts tendered competitively therefore > £25k
[8] Confirmation of declarations of interest relate to those officers approving the agreement / contract. The forms completed are general rather than specific to each agreement / contract reviewed.

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Financial Safeguarding: Support Services Led Work

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


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Committee	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

Fraud within the NHS Capital, Estates and Facilities functions has been more prevalent in recent years, with two recent examples being:

- a well-publicised incident within NHS Wales where three Estates officers were jailed in November 2018 after being found guilty of defrauding the NHS of £822,000; and
- another in Gloucestershire Hospitals NHS Foundation Trust where a senior Estates official was similarly sentenced abusing his position and defrauding the NHS of £870,490.

Therefore, in accordance with the agreed 2019/20 internal audit plan, the financial safeguarding review sought to affirm that there are effective controls and systems operating to deter and safeguard against potential fraud within Powys Teaching Health Board's ('the THB') Estates and Support Services functions.

This review focuses on projects / contracts led by the Support Services team and should be read in conjunction with the separate report produced on the Estates team.

2. Scope and Objectives

The audit was actioned under the operational internal audit plan agreed by the THB. The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the THB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The scope of the audit was limited to procurement exercises led by Support Services associated with addressing health & safety, statutory and regulatory requirements through routine service delivery. The audit did not cover general support services such as catering.

Accordingly, the scope and remit of the audit included the following:

- **Declarations of interest –** assurance that:
    - Appropriate guidance and procedures exist for the declarations of interest and compliance was demonstrated in respect of the same;
    - Appropriate arrangements were in place to enable concerns and breaches to be raised; and
    - Appropriate training was afforded to all staff.
- **Quotation / Tender /Local Order processes** –assurance that:

- An appropriate governance framework was in place in respect of the procurement, tender, contract letting, local order processes (both manual and automated); and
- Compliance was demonstrated against the established internal control framework (and best practice) for selection and appointment.

- **Segregation of duties/delegated authority** – assurance that:
  - Appropriate guidance and procedures existed for the segregation of duties in the management and selection of quotes/tenders/local orders; and compliance was demonstrated in respect of the same; and
  - All approvals were appropriately sought and decision makers were appropriately authorised and adequately informed.
- **Verification of contractor/supplier arrangements** – assurance that:
  - Verification was undertaken prior to the appointment of contractors/suppliers including financial vetting, positions held by key directors; and
  - Assurance that information is produced on the award of contracts, fair rotation of contractors, analysis of key suppliers etc. - allowing analysis of tender/quotation returns and to identify any patterns of unusual behaviour.
- **Monitoring and reporting** – reporting and accountability lines were well defined, understood and applied.
- **Verification of works completed** – assurance that works were completed in accordance with the award criteria.
- **Stock control** – assurance that appropriate stock control systems were in place [including re-ordering, issue and return] to manage the materials utilised in delivery of pre-planned and reactive maintenance.
- **Other** – consideration of any other issues relevant to the general objectives above, which may arise during the review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Breach of mandatory regulations;
- Non-compliance with established internal controls impacting on the achievement of project objectives;

- Tender arrangements not compliant with local/national requirements and value for money not be demonstrated;
- Tender processes were not sufficiently robust to minimise / mitigate collusion and/or fraud;
- Personal interests, or interests that they owe to another body, influenced or affected the individual's decision-making.
- Poor risk identification and management, resulting in the THB being un-informed in relation to cost, time and quality performance.
- Failure to prioritise high risk areas in the estate.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

We evidenced a reasonable control framework in place via the THB's Standing Financial Instructions (SFI's). Robust segregation of duties, and application of delegated limits, were noted in the approval of work arrangements / contract entered into by the THB.

However, the audit identified the following control weaknesses:

- The arrangements for completion of declarations of interest need improving;
- Whilst recognising the mitigating actions the THB put in place, there is a need to have formal contracts in place for all service delivery areas, which have followed the appropriate procurement route; and
- The requirement for completion of a declaration of non-collusion needs to be addressed at tendered contracts.

Against the context of the matters detailed above, the overall level of assurance has been assessed as **reasonable.**

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Declarations of interest			✓	
2	Quotation / Tender processes			✓	
3	Segregation of duties / delegated authority				✓
4	Verification of contractor arrangements				✓
5	Monitoring & Reporting				✓
6	Verification of works completed				✓
7	Stock control	Not applicable			

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the audit have highlighted **no** issues that are classified as weaknesses in the system control/design.

Operation of System/Controls

The findings from the audit have highlighted **three** issues that are classified as weaknesses in the operation of the designed system/control.

6. Summary of Audit Findings

The key findings are reported within the Management Action Plan (**Appendix A**).

To focus the audit testing on external contractual appointments made by the THB since April 2019, a schedule was requested from Support Services to determine the number and total value of 'routine' service agreements/contracts in place to manage the health & safety, statutory and regulatory requirements within this THB function.

Details of seven contracts[1] were provided with a value of circa £200k

6.1 Declarations of interest

We sought assurance that appropriate guidance and procedures were available for declarations of interest, and compliance was demonstrated in respect of the same. We also sought assurance that appropriate arrangements were in place to enable concerns and breaches to be raised; and assurance that appropriate training is afforded to relevant staff.

A governance framework was in place for declarations of interest, namely the Standards of Behaviour Policy, which was available for all members of THB staff via the intranet.

Section 4.3 of the policy states "*arrangements are in place to prompt all employees … to complete a declaration of interests form on initial employment with the health board, and at periodic intervals thereafter"*

Section 4.7 of the policy states "*if an employee is requested to participate in the procurement process they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared"*

To confirm compliance, our review was limited to those named officers involved in the appointment process of the external contractors sampled during this audit.

Whilst there was evidence of completion of declarations for Support Services staff at respective procurement stages, there was no evidence of

[1] Included in this total is one contract covering five areas [waste] and one contract covering four areas [bulk skip items]

the expected annual returns by all members of the Support Services team **(recommendation 1)**

Noting the evidence of compliance during the respective procurement processes, **reasonable assurance** has been determined in this area**.**

6.2 Quotation / Tender/ Local Order Processes

We sought assurance that an appropriate governance framework was in place in respect of the procurement, tender, contract letting and local order processes (both manual and automated); and that compliance was demonstrated against an established internal control framework (and best practice) for selection and appointment.

Governance framework

Standing Financial Instructions and Standing Orders were readily available to provide guidance in respect of procurement processes.

Compliance with procedures

Details of the agreements / contracts reviewed are set out within Appendix B to this report.

The procurement routes followed by the THB for appointment of the seven agreements / contracts were as follows:

- Bravo platform: 4
- Framework: 2
- Single Tender: 1

It was acknowledged that for **all** procurement exercises above the £5k threshold, the THB instructs the services of NWSSP: Procurement to lead on their behalf.

Compliance with procedures was confirmed in the management of the number of contractors selected to tender / quotation and the evaluation process (prior to appointment). However, deviation from governance framework was noted:

- Four of the seven Facilities maintenance areas (57%) had live contracts **(recommendation 2);**
- For those areas where no live contract was in place, it was acknowledged that they were at varying stages of the procurement process including tender submission stage and specification drafting stage, tender submission stage and completion of formal award [as at date of audit]**.**

It was, however, noted that in the absence of a formal contract, appropriate mitigating actions had been taken to ensure the service areas were not left unattended; and the relevant procurement route

observed had been authorised in accordance with delegated authority.

- As cited in the Standing Financial Instructions competitive exercises are required for work above £5k. There is an expectation that tender / quotation documents should contain standard statements governing rules regarding bribery and corruption i.e. declaration of non-collusion. However, for the sampled competitive exercises, there was no evidence of a signed certificate of non-collusion from the relevant contractor **(recommendation 3)**

Whilst being cognisant of the lack of formal tender / quotation exercises that have been undertaken to manage the 'routine' service delivery areas, it is recognised that the THB has implemented reasonable controls to mitigate the risk of fraudulent activity. Therefore **reasonable assurance** has been determined.

6.3 Segregation of Duties / Delegated Authority

We sought assurance that appropriate guidance and procedures were available for segregation of duties in the management and selection of quote/tenders/local orders and that compliance was demonstrated in respect of the same. We also sought assurance that approvals were appropriately sought and decisions were appropriately authorised and adequately informed.

For the 'routine' service delivery areas where formal contractual arrangements were in place, segregation was evident through the involvement of NWSSP: Procurement Services therefore reducing the reliance on the Support Services function to manage a procurement exercise in its entirety.

Application of the delegated limits for approval of work arrangements / contracts was evident in all instances.

Accordingly, **substantial assurance** has been determined in respect of this area.

6.4 Verification of Contractor Arrangements

We sought assurance that appropriate verification was undertaken prior to the appointment of contractors / suppliers, including adequate financial vetting and verification of positions held by key directors. We also sought assurance that information was produced on the award of contractors, analysis of key suppliers etc. – allowing analysis of tender/quotation returns and to identify any patterns of unusual behaviour.

Financial vetting

Section 5 of Schedule 1 to the Standing Financial Instructions states '*it is the responsibility of the Director of Finance, Planning & Performance to*

establish that all firms on the tender list are financially sound and professionally competent through a pre-qualification / financial vetting process undertaken by a suitably qualitied and experienced procurement officer'

Of the seven appointment processes reviewed:

- Two appointments were made from a Framework, for which vetting had been undertaken upon initial appointment;
- Two appointments had evidence of financial vetting, as provided in the evaluation pack prepared by NWSSP: Procurement Services; and
- At the date of fieldwork two appointments had yet to reach the financial vetting stage of the procurement process.

Reporting on award of contractors

Schedule 1 (Section 7.25) to the Standing Financial Instructions states *'overall monitoring of the contracts awarded shall be the responsibility of the Director of Finance, who shall present a report annually to the Board detailing the number and value of all contracts placed during the previous financial year in excess of the tender limit'.*

The above implies that this is required only for tendering exercises entered into which are above the £25k threshold.

The detail of the Support Services contractual arrangements were reported to the Executive Team; which reported into the Performance & Resources Committee.

It is recognised that procedures / processes are in place for financial vetting and procurement activity reporting. Noting this, **substantial assurance** has been determined.

6.5 Monitoring & Reporting

We sought assurance that reporting and accountability lines were well defined, understood and applied.

As referenced in 6.4, Support Services reporting was to the Executive Team which reported to the Performance & Resources Committee.

Procurement exercises were subject to discussion at the monthly meetings held with NWSSP: Procurement. At the date of the audit, in attendance at the meetings were representatives from both Support Services and Estates. However, management advised this will be reviewed in the new financial year.

Recognising the reporting and accountability lines, **substantial assurance** has been determined.

Verification of works completed

We sought assurance that works were completed in accordance with award criteria.

Where external contractors had been used to deliver 'routine' service delivery, management advised that regular meetings were held with the contractors to manage performance. Furthermore, due to the nature of the service i.e. waste, if the contracted service is not undertaken it is quite apparent. Invoices will only be paid with assurances that the work has been undertaken.

Being cognisant of physical nature applied to confirm performance of the service agreement, the payment of the contractors invoice is taken as recognition of completion of work. As such, the level of assurance has been determined as **substantial.**

Stock Control — Not applicable

We sought assurance that appropriate stock control systems were in place [including re-ordering, issue and return] to manage the materials utilised in the delivery of maintenance work.

It was evident from the sample of Support Services agreements / contracts reviewed that the THB stores were not accessed to deliver the service. Accordingly, no opinion is given on this objective at this report.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Recommendations raised	-	3	-	**3**

Finding 1: Declarations of interest	Risk
The THB Standards of Behaviour policy states *"The Board Secretary has delegated responsibility for ensuring arrangements are in place to prompt all employees and Independent Members to complete a Declarations of Interest Form on initial employment with the health board, and at periodic intervals thereafter" (page 11)* Declarations of interest are completed by staff to ensure that they have made the THB aware of any potential conflicts which could influence or impair their way of working. Audit testing confirmed that Support Services members of staff only filed declarations of interest forms on procurement activities as a part of NWSSP: Procurement's management of procurement exercises.	Non-compliance with policies and procedures. Support Services staff have conflict of interest. Risk of fraud.
Recommendation 1	**Priority level**
Support Services staff should complete declaration of interest form in accordance with the Standards of Behaviour policy. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
	Assistant Director: Facilities & Support Services April 2020

Evans Caroline
05/11/2020 15:54:16

Finding 2: Tender / Quotation Processes –Contract Setup	Risk
Three of the seven (43%) sampled Support Services areas were covered by a live contract at the time of the audit. These were either through the use of multi-year contracts through a tendering process managed by NWSSP: Procurement, external framework providers or by a single tender waiver. We were advised by management that actions were being taken to address the shortfall in the formal tender arrangements. However, this process was at an early stage to address all areas defined as needing a contract. For those areas where no formal contract arrangements were in place, the THB had sought to manage through rolling/extending existing supplier arrangements and using one-off orders.	Maintenance areas are overlooked by the THB. THB unable to carry out work to full capacity. Risk to staff, patient and public safety.
Recommendation 2	**Priority level**
The Support Services function should ensure that pre-planned maintenance areas are covered by formalised contacts arrangements, and that there are formal interim measures in place until these contracts are finalised. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
	Assistant Director: Facilities & Support Services TBC

Finding 3: Declaration of non-collusion	Risk
Schedule 1 (Procurement of Works, Goods & Services) of the THB Standing Financial Instructions (SFIs) states: *1.3 The main legal and governing principles guiding public procurement are:* • *Integrity: there should be no corruption or collusion with suppliers or others.* As part of a selective tendering process, tenderers should be required to complete a declaration on non-collusion. This is to assist in mitigating the risk of corruption in the tender process by requiring specific relevant declaration. The SFIs state that competitive procurement exercises are required for: • those within the £5k-£25k threshold (quotations); and • those in excess of the £25k threshold (tenders). Declarations on non-collusion were not evidenced at any of the sampled Support Services maintenance areas (three of which were above the £25k tender threshold).	Collusion of parties in preparation of tender / quotation. Non-compliance with policies and procedures.
Recommendation 3	**Priority level**
Management should ensure all competitive quotation and tender exercises utilise the standard declaration of non-collusion for return to the THB as part of the evaluation packs. **(O)**	**Medium**

Management Response	Responsible Officer/ Deadline
	Assistant Director: Facilities & Support Services TBC

Service Agreements / Contracts: summary of testing

Contract	Value per PPM listing	Duration of agreement	Procurement route	Number of contractors invited to tender	Financial vetting [2]	Segregation of duties	Authorised appropriately	Declarations of Interest [3]	Comments / Matters arising
Clinical Waste for all sites	£55k - £60k per annum	5-year contract [wef 01/04/2017]	Tender	4	✓	✓	✓	✓	All Wales Contract – managed by NWSSP Procurement
Confidential Waste for all sites	£30k per annum	Not defined – process ongoing	Tender	Not defined – process ongoing				✓	BCUHB led procurement exercise
Waste collection for all sites	£70k - £75k per annum	Annual	Single tender	n/a	✓	✓	✓	✓	STW completed to address the fact that no formal agreement was in place despite having used the same provider to undertake the work in previous years. More formal contract arrangements are required.
Waste collection (bulk skip)	£10k per annum	Expectation is will be 3+1+1 agreement	Tender	7	Not defined – process ongoing			✓	One-off orders being placed whilst the procurement exercise is ongoing.
High level kitchen duct cleans	£8k per annum	Rolling contract	Framework	n/a	✓	✓	✓	✓	Framework agreement – managed by NWSSP Procurement. Current work being undertaken as part of a rolling contract. No evidence of VFM being assured.

[2] As implied by the Standing Financial Instructions, financial vetting relates to those contracts tendered competitively therefore > £25k
[3] Confirmation of declarations of interest relate to those officers approving the agreement / contract. The forms completed are general rather than specific to each agreement / contract reviewed.

Contract	Value per PPM listing	Duration of agreement	Procurement route	Number of contractors invited to tender	Financial vetting [2]	Segregation of duties	Authorised appropriately	Declarations of Interest [3]	Comments / Matters arising
Water Dispenser Maintenance	£8k per annum	3 years	Tender	4	✓	✓	✓	✓	At date of the audit, awaiting commencement of the formal contract.
Window Cleaning	£10k per annum	-	Framework	7	✓	✓	✓	✓	ESPO Framework – led by NWSSP Procurement. Requested for 7 suppliers from the Framework to provide costing for the work required. Only one response was received.

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Risk Management and Board Assurance

Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Distribution	Rani Mallison, Board Secretary Caroline Evans, Head of Risk and Assurance
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.

Please note:
This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.
Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

This review was an assessment of the effectiveness of Powys Teaching Health Board's ('the health board') risk management and Board assurance systems, to establish whether the process is in line with the Risk Management Framework and Board Assurance Framework (BAF). The BAF is designed to provide a structure and process that enables the Board to focus on those risks that might compromise achieving its most important (principal) objectives as set out in the Integrated Medium Term Plan (IMTP). In its 2018 Structured Assessment report for the health board, the Wales Audit Office stated; '*The Board approved the Board assurance framework and risk management framework in January 2017. While it was reported to Board that the Board assurance framework would be updated after approval of the IMTP in March 2018 to reflect the move to eight well-being objectives, this has not yet been completed although it is anticipated that the assurance framework will be updated before the start of 2019-20. The assurance framework improvement and deployment plan was agreed in July 2018 and work is underway to ensure by the end of March 2019 this has been completed at an organisational level.*'

Risk management within the health board underwent development in 2017/18 and the implementation of structures designed, then continued in 2018/19. A Risk Management Improvement and Deployment Plan was approved by the Executive Committee in May 2018 and discussed at the July 2018 Audit and Assurance Committee. Oversight capacity and support was increased in quarter 4 of 2018/19 with the formation of a multi-directorate / discipline Risk and Assurance Group, which is constituted by Assistant Directors and senior managers and held its inaugural meeting in January 2019. The health board also appointed into two key senior posts: Head of Risk and Assurance and the Head of Corporate Governance. The impact of these is expected to materialise by strengthening the current risk management arrangements during 2019/20. Our review of Risk Management at the end of 2018-19 highlighted that the Risk Management Improvement and Deployment plan did not appear to have been implemented. The audit also identified a continued absence of Directorate level risk registers, a lack of evidence of management oversight by the directorate teams and further training needs still persisting. This resulted in a 'Limited Assurance' opinion being issued.

A revised Corporate Risk Register and latest draft Board Assurance Framework were endorsed by the Board in March 2019. The Board noted that:

- *'Time was being taken to ensure that Committee Work Programmes for 2019/20 would be aligned to the BAF and priorities in the Corporate Risk Register, and that the content of the Integrated Performance Report would be updated for 2019/20 to reflect the BAF and the priorities set out in the Integrated Medium Term Performance Plan; and,*
- *the Corporate Risk Register is now subject to routine review by the Risk & Assurance Group, where ongoing work includes a review of operational risk registers and a process of 'moderation' of risk rating.'*

The Annual Governance Programme for 2019/20 was approved by the Board at the meeting in March 2019 in readiness for implementation. This includes a focus on embedding a risk and assurance culture. In addition, a revised Risk Management Framework was approved by the Board in September 2019 following a series of consultation and review processes.

2. Scope and Objectives

The review sought to assess how the BAF and Risk Management Framework was being implemented and if they were appropriately updated in line with the revised IMTP, and how the Board's responsibilities for risk management were effectively being discharged. It included focus on the integration of risk management and assurance process with the IMTP. Any areas of good practice are also highlighted.

As part of this review, we followed up on the progress that the health board has made in implementing internal audit recommendations raised in the 2018/19 Risk Management Internal Audit report. This assessment is incorporated within the objectives set out below:

Risk Management Framework

- we will continue to assess awareness and understanding of the health board's Risk Management Framework with the staff we speak with on this review, to assess the extent it is embedded throughout its structure;

Risk Management

- risk registers are maintained at the different departments / areas throughout the health board and the risks identified are 'real' risks posed to the health board;
- mitigating measures are identified to address risks and prompt action is taken to reduce threats identified;
- significant risks are escalated from local registers through to departmental, directorate and corporate risk registers as appropriate;

- responsibilities relating to clinical, operational and financial risk management have been delegated to appropriate sub-committees of the Board and are subject to regular review;
- regular risk review and monitoring takes place across the health board, with appropriate reporting right up through to Board level; and

Board Assurance Framework

- Board Assurance Frameworks are maintained at the different directorates / departments / areas throughout the health board which contain the essential components (objectives, risks, controls, assurance, gaps in control, sources of assurance and remedial action);
- there is a clear link between directorates / departments assurance frameworks and risk registers;
- risks, systems, processes and assurances are assessed against the controls currently in place;
- sources of assurance and gaps in assurance are identified;
- significant issues arising from assurance frameworks are escalated appropriately exception reports are produced identifying deviations from agreed acceptable risks; and,
- arrangements are monitored throughout the year so that early decisions and action is taken on risk and control issues to address gaps in control or gaps on assurance.

3. Associated Risks

The principal risk was that the absence of functioning Risk Management Framework and BAF left the Board unable to anticipate risks that will jeopardise its ability to deliver Health and Care Standards and the targets set out in the IMTP.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Risk Management and Board Assurance is **Limited** Assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Risk Management Framework			✓	
2	Risk Management		✓		
3	Board Assurance Framework			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted **two** issues that are classified as weakness in the system control/design for the 'risk management and board assurance' processes.

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the operation of the designed system/control for the 'risk management and board assurance' processes.

6. Summary of Audit Findings

Risk Management Framework

Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities. The aim of risk management is not to remove risk altogether but to manage risk to an acceptable level, taking into account the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

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

1. Risk identification
2. Assessment and scoring
3. Treatment and recording
4. Monitoring and review

The health board's Risk Management Framework (RMF) identifies those individuals with responsibilities for the management of risk, and sets out the health board's key risk management structures and processes. The RMF defines three levels of risk: strategic risks, operational risks and project risks.

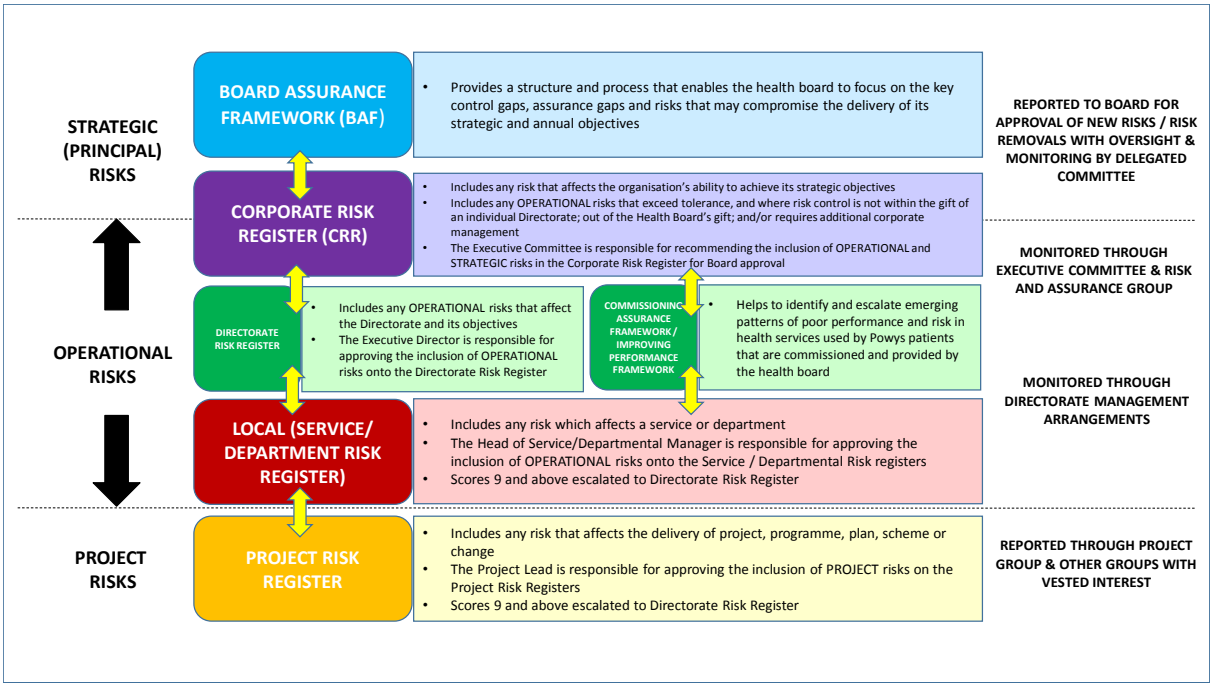
The health board is predominantly a commissioning organisation, buying services on behalf of the population from a wide range of providers, including from primary care contractors, independent sector care homes, ambulance services, district general hospitals and other specialist hospitals. The health board's Commissioning Assurance Framework ('CAF') therefore helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients. We reviewed the CAF in our 2016/17 and 2017/18 '*Commissioning*' internal audit reports, as well as touching on elements of the CAF in our 2019/20 '*Outpatients – planned*

activity' report, all of which have provided the health board with reasonable assurance over its management of arrangements.

Furthermore, it was noted in the September 2019 Board meeting that clinical and other risk managed through the Board's Joint Committees and Partnership Boards would be addressed in the Partnership Governance Framework which is under development. We have not looked at this area since a review will be undertaken in the '*Partnership governance – programme interface'* assignment included in the 2020/21 internal audit plan.

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

Diagram 1
Source: Risk Management Framework (September 2019)



A revised RMF was approved by the Board in September 2019 following a series of consultation and review processes, although we note that the previous version is still on the health board's intranet page. In addition, although the RMF methodology is 'live', the RMF Toolkit, a mechanism to assist with the training of all staff in risk management processes remains under development and the Risk Management training plan has yet to be rolled out.

Our review has observed that the Corporate Risk Register ('CRR') is well established and reviewed regularly. However, whilst noting improvement in the structure, wording and scoring of the CRR in recent months, in some

instances our audit work has not identified supporting Board and Committee meeting minutes or papers to evidence the validity and accuracy of amendments to CRR. In addition, and as noted in our prior year audit report, there appears to be a lack of documented scrutiny around the achievement of the specific deadlines relating to the mitigating actions included on the CRR, or whether the actions are still in line with the Annual Plan/IMTP.

Furthermore, the majority of Directorate risk registers remain absent, although each Directorate were asked by the Head of Risk and Assurance in an email dated 27 February 2020 to finalise these and were also required to present their top risks at the January 2020 RAG meeting. In lieu of local departmental or service risk registers, we were advised that risks are discussed at regular directorate and departmental meetings, although these are not formally documented. Following the recent restructure, Sub-board committees were introduced to the CRR and their respective Committee. In the absence of Directorate risk registers, the Committee Risk Registers still only include the CRR risk for which the relevant Committee has been delegated responsibility to provide oversight and monitoring.

The Risk and Assurance Group (RAG) has continued to meet, holding five meetings since its inaugural meeting in January 2019. It is a management group of the Executive Committee and advises the Committee on any risk management issues, including all significant risks arising from activities within the organisation. The 23 member group comprises the Chief Executive Officer (chair), Board Secretary, Head of Risk & Assurance and Assistant Directors from each of the health board's Directorates. The primary responsibility of the group, as defined in the RMF, is for leading the implementation of the risk, control and assurance processes established within the organisation. RAG will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

However, despite the establishment of the risk management hierarchy, there is still no Group oversight of a complete list of risk registers for the health board, at project/local departmental and service/directorate level. In addition, without reference to the individual DRR risk scoring, the discussion indicates a lack of understanding of how the risk escalation process should operate between DRR and CRR. In particular, a lack of fully completed DRRs might impact on effective operation of the RAG and their ability to consider and moderate appropriate risks for recommendation to the Executive Committee. Thus, it is even more important for DRRs to be in place for discussion and review.

The RMF requires that the Executive Committee *'has responsibility for ensuring implementation of the risk management process and has responsibility for agreeing the risks on the CRR and the BAF, prior to consideration and approval by the Board'*. We acknowledge that there have been a number of changes to members of the Executive Committee during the 2019/20 year and thus it may take time for new members to get acquainted with the RMF process.

Board Assurance Framework

The health board's Assurance Principles Document ('Principles'), issued January 2016, set out the principles and purpose of the Board Assurance Framework (BAF). The BAF provides a structure and process that will enable the health board to focus on the risks that may compromise the delivery of its strategic and annual objectives. It ensures that the assurance mechanisms operating within the health board are fully aligned to support the Chief Executive, as the Accountable Officer, and the Board to deliver the organisations objectives and meet their corporate governance obligations. To be successful the BAF must be aligned to the annual objectives that will support the delivery of the strategies that the health board has put in place for delivering its overall purpose.

The Principles require that the health board's directorates are expected to undertake an assurance mapping exercise against the objectives that are set out in their Annual Delivery Plans. They should work with the services, departments and wards that they manage, commission or contract to ensure that the assurance mechanisms in place at these levels are also mapped. All directorates are expected to have a robust Local Assurance Framework in place; although not in place currently, these will inform and feed into the BAF.

The RMF states that a role of RAG is to lead the ongoing development of the BAF, reviewing the key risks to delivery; scrutinising the detailed mapping assurances; consider the adequacy of assurance arrangements; and identify gaps in control for action. However, the most recently updated BAF (Q3 2019/20 update) was presented to the January 2020 RAG meeting for information only. The minutes stated that '*it was noted that the BAF is a complex tool which is due for review in April 2020, in line with the annual plan'.* Due to the BAF being a comprehensive document, its complexity has also been acknowledged by the WAO in their most recent Structured Assessment report where it is suggested that a more methodical approach should be adopted.

Our review of the BAF has identified that the content of the document and methodology currently adopted is in line with that of other NHS organisations. We have observed that the approach to quarterly

presentation to the Board for endorsement of the review and update of the BAF is still maturing. The Board receives a brief summary paper and the most recently updated BAF. In addition, although not specifically noted in the Principles, each sub-board committee has documented a Committee Assurance Framework, which is included within the committee's work programme. Whilst still in its infancy, the aim of the framework is to underpin the Committee's programme of business which should improve with time to embed.

Our audit identified two **high** priority issues and three **medium** priority issues that we consider requires management attention and provides scope for improvement to be made. As noted above, several of our findings are a repeat of our 2018/19 *'Risk Management'* audit report, since we have observed limited progress with previous recommendations made (refer to 'Audit Recommendations Tracker' section below.)

7. Detailed Audit Findings

Findings are set out by audit objective in the section below and where appropriate, repeated along with recommendations in the action plan in Appendix A that follows.

Objective 1 – Risk Management Framework

The health board's Risk Management Framework (RMF) identifies those individuals with responsibilities for the management of risk, and sets out the health board's key risk management structures and processes. To some extent the RMF is applicable to all employees of the health board and related third party organisations.

The Board approved its initial RMF in January 2017. Following our review of Risk Management arrangements in the health board in 2018/19, the RMF was revised and updated to take into consideration the recommendations contained within our report. A revised RMF was approved by the Board in September 2019 following a series of consultation and review processes.

The Risk and Assurance Group (RAG) was consulted in the development of the RMF, and feedback from the Group has been taken into consideration in the final version of the document. In addition, a Risk Management Toolkit is currently in development, under the leadership of the Head of Risk and Assurance. Once finalised and approved (still under development at the time of our audit fieldwork), the Toolkit will be included as an appendix to the RMF, and will provide guidance and templates to support services to actively manage their risks. The Toolkit is especially important for the rollout of risk management training to appropriate health board staff.

The revised RMF and supporting Toolkit are designed to support a robust risk management culture across the health board. We note that the revised RMF is a more substantial document than its predecessor. There have been improvements to:

- Risk Appetite Statement;
- Risk Review and Escalation; and,
- setting out a dynamic and integrated approach to risk identification and risk management across all levels of the health board.

The RMF states that '*it applies to Board members, all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts and other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of services'*. During our review we have assessed the processes for communication of the RMF and observe that:

- two versions of the RMF can be located on the intranet, being the January 2017 document and the 'draft for approval' presented at the September 2019 Board meeting. Whilst the RMF was approved at that meeting, no final version of the RMF has been posted to the intranet (i.e. it is missing hyperlinks to some supporting documents; for example the RMF Toolkit, since this document is still under development);
- although the RMF methodology is 'live', the RMF Toolkit, a mechanism to assist with the training of all staff in risk management processes, is still under development as at end March 2020; and,
- a Risk Management training plan is still under development and yet to be rolled out; as such, training currently delivered is reactive to requested demand. We note that this comment was raised in the previous year's internal audit '*Risk Management'* report.

Objective 2 – Risk Management

The health board's risk management hierarchy is outlined in diagram 1 of section 6 above. To summarise from the Risk Management Framework (refer to **Objective 1**), the building blocks of the hierarchy should be the Board Assurance Framework (refer to **Objective 3**), Corporate Risk Register, Committee Risk Registers, Directorate Risk Registers, Local Service/Departmental Risk Registers and Project Risk Registers. However, there is still no Risk and Assurance Group oversight of a complete list of expected risk registers for the health board, at project/local departmental

and service/directorate level as raised in the previous year's audit report. Our review has observed that despite the Corporate Risk Register being well established, there is currently an absence of other risk registers in place, and we are unable to determine whether all real risks to the health board have been identified and thus considered appropriately and mitigating actions taken.

Corporate Risk Register

The Corporate Risk Register (CRR) is presented to the Board for review and update at their bi-monthly meetings. Prior to Board review, in line with the RMF, the Executive Committee meets separately in advance of Board presentation to review the CRR and provide comments. The Audit, Risk and Assurance Committee may make recommendations to the Executive Committee, to take to the Board who may endorse recommendations where applicable.

In September 2019, the Board endorsed a decision that each risk in the CRR would be allocated to a sub-board committee for detailed scrutiny of revised risk rating and narrative, and to assess the robustness of assurance that could be taken from progress against planned mitigation. We note the work performed by RAG to improve structure, wording and risk scoring in the CRR over recent months.

We reviewed the CRR throughout the period April 2019 to March 2020 to establish what updates were made, identifying that there have been:

- a total of 14 corporate risks throughout the period, of which 12 are still active in the CRR as at March 2020;
- two additions, namely CRR013 (ability to achieve National Outcome Framework measures) and CRR014 (Covid-19);
- two deletions, namely CRR003 (breach of Information Governance Standards') and CRR011 ('no-deal Brexit);
- eight occurrences of the level of risk reducing; and,
- four occurrences of the level of risk increasing.

The Board summary papers to support the latest presented CRR provide a list of additions, deletions and changes to risks. However, in some instances, the level of detail to provide rationale for changes documented in the Board papers does not sufficiently support validity and accuracy of these amendments to the CRR.

For each risk, the CRR template incorporates a 'Mitigating actions (what should we do more?)' section. Mitigating actions should assist in the

reduction of the risk. This section lists the actions to be taken, the lead responsible for each action and the timing deadline for completion of the action. Our review of the January 2020 CRR identified 49 mitigating actions to be taken, and we have summarised the number of completion deadlines as:

- 'in line with Annual Plan 2019-20' or 'in line with IMTP/ICP – 41;
- no date or in progress' – 4;
- due date stated (including one for Nov 2019 and 2 for March 2020) – 3; and,
- completed – 1.

As noted in our prior year audit report, there appears to be a lack of documented scrutiny in the Board or sub-board committee meeting minutes around achievement of these specific deadlines, or whether the actions are still in line with the Annual Plan/IMTP.

Committee Risk Register

The concept of Committee Risk Registers is still evolving. At the January 2020 RAG meeting it was noted that *'Committee Risk Registers are now being presented to each Committee for consideration. Currently these include only CRR risks* (for which the relevant Committee has been delegated responsibility to provide oversight and monitoring), *but in future will also include Directorate Risk Register risks'*.

The CRR documents the lead committee responsible for oversight and monitoring for each corporate risk. We acknowledge that this notation helps to ensure that focus on strategic risks is undertaken by the appropriate group of the Board.

Each sub-board committee was presented with the latest CRR and their respective Committee Risk Registers at their November 2019 meetings. Subsequently, the Performance & Resources Committee reviewed their Committee Risk Register in January 2020 at which the risk scoring for one risk was challenged.

Thus, challenge and scrutiny of CRR risks by the appropriate committee is in its infancy and will take time to fully embed. This is also reflected in the WAO's '*Structured Assessment* 2019' report that noted '*arrangements for the effective conduct of business are maturing and supported by a comprehensive annual governance programme. The Committee restructure looks appropriate although the new arrangements are taking time to embed'*.

Directorate Risk Register

The RMF states '*each Directorate will maintain a comprehensive Directorate Risk Register (DRR) which will be informed by relevant local Risk Registers, and formally reviewed at an appropriate Directorate meeting'*.

In recent years, we have raised the lack of completed directorate risk registers or service risk registers as an issue across many departments of the health board. Our audit has established that to date 5 of the 9 Directorates of the health board currently maintain a documented DRR. This represents a slight increase on our previous year's findings:

Table 1

Directorate with a DRR	Latest update	2018/19
Finance, Information and IT	October 2019	N/A
Medicine	TBD – Audit has no sight of this	N/A
Nursing	January 2019	January 2019
Public Health	February 2020	March 2019
Therapies and Health Science	August 2019	N/A

With the absence of a complete set of DRRs' there remains a possibility that the Board and sub-board committees may be unsighted on certain operational risks. This could lead to a lack of support for departments and service areas to manage their risks. In addition, the health board may not be sighted on the risks it faces at the appropriate level in the organisation.

To manage this, the Board Secretary Directorate has instructed all Directorates to document their DRR by 31 March 2020, and to present them at the RAG meeting that is scheduled for late April 2020 (refer to ***'Risk and Assurance Group Meetings'* below**).

The prior year audit reported a series of recurring weaknesses in the format and content of risk registers that were tested and recommended these be addressed. Good risk management practice advocates providing all risk entries in registers with clear descriptions, dates, ownership, actions, status markers and links to strategic objectives.

We reviewed the risk registers in place at 2 of the 5 directorates from table 1 above, namely the Directorate of Public Health and the Directorate of Finance, Information & IT. We assessed their effectiveness and the extent and level of detail they contain and whether good risk management practices recommended in our previous year's '*Risk Management'* audit report have been introduced and identified a number of issues (refer to **finding 3**).

Risk and Assurance Group Meetings

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

This tone was set at the October 2019 RAG meeting, where the group was asked to note that it is presently difficult to provide an analysis of improvement or deterioration in the number of risks due to a larger volumes of risk registers being received compared to previous RAG meetings. Furthermore, the October 2019 meeting raised a number of key factors to be taken into consideration when reviewing risks:

- the need to achieve better alignment between the CRR and DRR;
- refining risk descriptions to avoid confusion around the true nature of the risk;
- possibility that further training may be required around Risk Assessment and the variations in Risk Assessments in different teams due to the high number of high scoring risks;
- the above in turn causes difficulty identifying the critical risks and highlights the importance of the moderation exercise that should undertaken at this group;
- if risks are static a mitigation plan needs to be implemented, if this is not possible risk appetite needs to be adjusted; and
- risks should not be escalated or held at a high risk rating in an attempt to secure additional funding or resources etc.

Following on from the October 2019 RAG meeting, and with an absence of a full set of documented DRRs, Assistant Directors of each Directorate were asked to present their top 2-3 risks at the January 2020 RAG meeting in order to identify whether the CRR adequately represents the DRRs. Our review of the meeting minutes identified:

- variations in the detail provided on risks presented and that no risk score had been allocated to the risks discussed;
- Planning and Performance Directorate presented 'IMTP' and 'strategic change' as their top 2 risks, which are already escalated in the CRR;
- Mental Health Service presented 7 risks, yet there is no commentary in the meeting minutes re discussion of them; and,

- Public Health Directorate presented 'no-deal Brexit' and 'seasonal flu viruses' as their top 2 risks, which are already escalated in the CRR.

RAG did not recommend any DRR risks discussed at the January 2020 meeting to be further escalated to the Executive Committee, as top risks presented by the Directorates being already in the CRR.

In the absence of the majority of DRR's, and without consideration and documentation of risk recommendations for escalation or de-escalation or changes in individual DRR risk scoring at RAG meetings, the discussion might indicate a lack of understanding of how the risk escalation process should operate between DRR and CRR. In particular, a lack of fully completed DRR's might impact on effective operation of the RAG and their ability to consider and moderate appropriate risks for recommendation to the Executive Committee.

As recommended in our previous year's 'Risk Management' audit report, subsequent to each RAG meeting, the Group presents a summary paper to the Executive Committee that highlights appropriate risks for recommendation ahead of Board meetings, with the purpose to provide:

- an update of the adequacy of the assurance arrangements that are in place to aid the delivery of the health board's strategic objectives and priorities; and,
- the latest version of the Corporate Risk Register for review.

However, our review of the summary papers and comparison to RAG, Executive Committee and Board meeting minutes have highlighted some differences between risks recommended for consideration for amendment in the CRR and insufficient detail of rationale provided for changes (refer to **finding 4**).

Project Risk Register

The Project Risk Register (PRR) is specific to each project, where deemed relevant and sits in the Risk Management Hierarchy below the local departmental/service risk registers (refer to diagram 1).

The PRR is reported through its Project Group and it includes any risk that affects the delivery of project, programme, plan, scheme or change. The Project Lead is responsible for approving the inclusion of project risks on the Project Risk Registers. Risk rated scores of 9 and above should be escalated to Directorate Risk Register.

We reviewed the PRR for the health board's Records Management Project, a project instigated as a result of Internal Audit's '*Records Management*'

audit report. We have reviewed the PRR and associated Action Log and note that the risks identified in the '*Records Management'* audit report have been duly incorporated. The PRR has been presented and discussed at the P&R Committee (Dec2019) and corporate risk CR007 has been updated in the CRR.

Objective 3 – Board Assurance Framework

The Risk Management Framework (RMF) references to the Assurance Principles Document (Principles) as the source of a detailed explanation of the health board's Assurance Framework. However, the Principles were last updated and issued, in draft, in January 2016.

The Principles state that '*it is essential that the health board has an effective and efficient Board Assurance Framework (BAF) in place so that sufficient, continuous and reliable assurance on the management of the major risks to the delivery of its strategic objectives and most importantly the delivery of quality, patient centred services (provided and commissioned) is provided'.*

The BAF is structured to provide reliable evidence to underpin the assessment of its risk and control environment. It describes how risk and assurance arrangements are directed to meet the delivery and accountability needs of the Chief Executive and Board, providing evidence-based assurances on the management of risks that threaten the successful achievement of strategic objectives.

With input from Executive Directors and members of the Risk and Assurance Group (RAG), a new version of the BAF was developed to reflect the IMTP's four core and four enabling wellbeing objectives. This newly updated BAF was endorsed by the Board in March 2019. Our review of the BAF has identified that the content of the document and methodology currently adopted is in line with that of other NHS organisations.

In line with the health board's Risk Management Framework, the BAF should be reviewed and updated quarterly. The quarter 2 2019/20 update was presented at the November 2019 Board meeting and the quarter 3 2019/20 update in January 2020. We have observed that the approach to quarterly presentation to the Board for potential endorsement of the review and update of the BAF is still in its infancy. The Board receives a brief summary paper and the most recently updated BAF. Although discussions are held around suggested changes to risks & risk ratings, it would be more appropriate for a detailed BAF report to be presented that explains why BAF risks have been amended.

We note that a quarterly review of the BAF and the Annual Governance Programme is undertaken by the Executive Committee. Our comparison between the CRR and each of these updated BAFs has confirmed alignment of the corporate risks. Furthermore, the Integrated Performance Report, which is presented to both the Board and the Performance & Resources Committee, includes the Board Assurance Framework RAG rating.

The purpose of the sub-board committees are to provide advice and assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales. The scope of each committee extends to the full range of PTHB responsibilities. This encompasses the delivery and performance management of all directly provided and commissioned services. Committees will also focus on the alignment of the health board's resources, including financial and workforce, to ensure achievement of the Board's aims and objectives. Committee Work Plans for 2019/20, comprising their annual programme of business, have been developed as a result.

Although not specifically noted in the BAF's Principles, each sub-board committee has documented a Committee Assurance Framework included within the committee's work programme. Based on the individual Committee's remit, the framework underpins the Committee's programme of business. This assessment is provided to support the Committee in focussing its attention on key areas of risk and assurance need. For the areas of the Committee's delegated powers and authority, the framework documents:

- Low rated assurance arrangements from the BAF
- Risks from the Corporate Risk Register
- Internal and external audit reports and their overall assurance ratings

Whilst the BAF's Principles refer to each directorate requiring a Local Assurance Framework, we have no evidence of such frameworks being in place. Neither are they referred in the risk management hierarchy.

Our review of the latest Committee Assurance Frameworks for each committee has confirmed that the frameworks are currently documented as a brief summary. Moving forward, there needs to be further refinement of the frameworks to allow members to review them in conjunction with the BAF and CRR in order to then appropriately scrutinise and challenge any identified gaps in controls and/or assurance, how they are being actioned and monitoring progress implementing those actions.

The RMF states that a role of the Risk and Assurance Group is to lead the ongoing development of the BAF and Corporate Risk Register, reviewing the

key risks to delivery; scrutinising the detailed mapping assurances; consider the adequacy of assurance arrangements; and identify gaps in control for action. The most recently updated BAF was presented to the January 2020 Risk and Assurance Group meeting for information (not discussion) by the Board Secretary. The minutes stated that '*it was noted that the BAF is a complex tool which is due for review in April 2020, in line with the annual plan. The Board Secretary reported that this will be an opportunity for reflection and possible improvements to the BAF. It was raised that Wales Audit Office has suggested that it could be more methodical, and it was noted that it is not an easy tool to follow if it is not being used regularly. The Board Secretary recognised that it is a high level and broad overview that can lose sight of the day-today issues, this will be something that is addressed in the review'.*

Complexity of the BAF is further compounded by the comment raised in the WAO's '*Structured Assessment 2019'* report that said '*Together the BAF and corporate risk register provide good coverage of controls and assurances. However, they are complex documents which may benefit from a more methodical organisation of the controls and sources of assurance'*.

Audit Recommendation Tracker

In line with our report on the implementation of the health board's Audit Recommendation Tracker (the Tracker), we have considered the implementation status of recommendations from the 2018/19 *'Risk Management'* report against the Tracker.

The March 2020 Tracker shows that health board management considers one recommendation to be implemented, the recommendation on the format and content of risk registers is overdue (extension approved from 30 September 2019 to 31 March 2020) and the recommendation regarding the risk management toolkit and training is not yet due (extension approved from 31 March 2020 to 31 May 2020). Our view is that all three recommendations remain partially implemented. Management suggested that the management and oversight of risk finding was complete as the Risk and Assurance Group has been established and meeting regularly. However, our follow up review identified that further work is required in order to fully address our recommendation.

8. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	**2**	**3**	**-**	**5**

Finding 1 – Risk Management Framework (Design)	Risk
The Risk Management Framework (RMF) states that '*it applies to Board members, all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts and other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of services'*. During our review we have assessed the processes for communication of the RMF and observe that: • two versions of the RMF can be located on the intranet, being the January 2017 document and the 'draft for approval' presented at the September 2019 Board meeting. Whilst the RMF was approved at that meeting, no final version of the RMF has been posted to the intranet); • although the RMF methodology is 'live', the RMF Toolkit, a mechanism to assist with the training of all staff in risk management processes, is still under development as at end March 2020; and, • a Risk Management training plan is still under development and yet to be rolled out; as such, training currently delivered is reactive to requested demand. We note that this comment was raised in the previous year's internal audit '*Risk Management'* report.	Areas of the Health Board do not have full knowledge or understanding of the organisation's adopted risk management model.
Recommendation 1	**Priority level**

a. Finalise the current version of the RMF and ensure placed on the health board's intranet in a location that is easy for all employees to locate. b. Finalise the RMF Toolkit and append to the RMF. c. Finalise the Risk Management training plan and rollout to individuals of the health board in line with the training programme timetable proposed in the RMF. Ensure training materials are available on the intranet.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Agreed.	**Executive Lead: Board Secretary** a. Head of Risk & Assurance 30 June 2020 b. Head of Risk & Assurance 30 June 2020 c. Head of Risk & Assurance 30 September 2020

Finding 2 – Review and scrutiny of risk register mitigating actions (Operation)	Risk
Corporate Risk Register Throughout the period April 2019 to March 2020, a total of 14 corporate risks have been documented in the Corporate Risk Register (CRR), of which 12 are still active in the CRR as at March 2020. We reviewed the CRR to establish what updates were made, identifying that there have been: • two additions, namely CRR013 (ability to achieve National Outcome Framework measures) and CRR014 (Covid-19); • two deletions, namely CRR003 (breach of Information Governance Standards) and CRR011 (no-deal Brexit); • eight occurrences of the level of risk reducing; and, • four occurrences of the level of risk increasing. The Board summary papers to support the latest presented CRR provide a list of additions, deletions and changes to risks. However, in some instances, the level of detail to provide rationale for changes documented in the Board papers does not sufficiently support validity and accuracy of these amendments to the CRR: • CRR010 (prioritised resourcing) shows no change in risk during the period. The November 2019 CRR was presented at the January 2020 RAG meeting where the minutes state '*that although CRR010 is currently on the CRR it is anticipated that the risk level for this item will increase. The Board*	The Health Board may over / under assess risks to the achievement of their objectives. Board / Sub-Committees of the Board may be unsighted on risks Lack of support for departments / service areas to manage their risks. The Health Board may not assess the significant risks it faces at the appropriate level in the organisation.

Secretary assured members that the CRR will be reviewed at Board on 29th January 2020'. We not seen evidence of this review; • no clear rationale stated for the addition of CRR013 (sustainability of services); and, • whilst the CRR shows the level of risk trend increasing or reducing for CRR001 (sustainability of commissioned services), CRR002 (statutory breakeven position) and CRR006 (staff recruitment and retention), the actual risk score or target from one CRR update to another has not changed. For each risk, the CRR requires a 'Mitigating actions (what should we do more?)' section to be documented. This lists the actions to be taken, the lead responsible for each action and the timing deadline for completion of the action. Mitigating actions should assist in the reduction of the risk. We identified that 49 mitigating actions were documented in the January 2020 CRR providing a variety of deadlines: • "in line with Annual Plan 2019-20" or "in line with IMTP/ICP" (41); • no date or "in progress" (4); • due date of November 2019 and March 2020 (3); and, • completed (1). There appears to be a lack of documented scrutiny in the Board or sub-board committee meeting minutes around achievement of these specific deadlines, or whether the actions are still in line with the Annual Plan/IMTP.	

Committee Risk Register Each sub-board committee was presented with the latest CRR and their respective Committee Risk Registers at their November 2019 meetings. Currently the Committee Risk Registers only include CRR risks (for which the relevant Committee has been delegated responsibility to provide oversight and monitoring). Subsequently, directorate level risks will be escalated into these registers (refer to **finding 3**). Thus, challenge and scrutiny of CRR risks by the appropriate committee is in its infancy and will take time to fully embed. This is also reflected in the WAO's '*Structured Assessment* 2019' report that noted '*arrangements for the effective conduct of business are maturing and supported by a comprehensive annual governance programme. The Committee restructure looks appropriate although the new arrangements are taking time to embed'*.	
Recommendation 2	**Priority level**
a. Improve the level of documented scrutiny in the Board and sub-board committee meeting minutes around rationale for making changes in risk scores for individual risks in the CRR, the achievement of deadlines for completion of mitigating actions. b. Ensure the on-going improvement of Committee Risk Registers so that they incorporate directorate level risks, where applicable, in due course.	**Medium**

Management Response 2	Responsible Officer/ Deadline
Agreed.	a. Board Secretary 31 December 2020 b. Head of Risk & Assurance 31 December 2020

Finding 3 – Directorate Risk Register (Operation)	Risk
In recent years, we have raised the lack of completed Directorate Risk Registers (DRR) or service risk registers as an issue across many departments of the health board. Our audit has established that to date 5 of the 9 Directorates of the health board currently maintain a documented DRR. This represents a slight increase on our previous year's findings:	With the absence of a complete set of DRRs' there remains a possibility that the Board and sub-board committees may be unsighted on certain operational risks. This could lead to a lack of support for departments and service areas to manage their risks. In addition, the health board may not assess the significant risks it faces at the appropriate level in the organisation.

Directorate with a DRR	Latest update	2018/19
Finance, Information and IT	October 2019	N/A
Medicine	TBD – Audit has no sight of this	N/A
Nursing	January 2019	January 2019
Public Health	February 2020	March 2019
Therapies and Health Science	August 2019	N/A

We reviewed the risk registers in place at 2 of the 5 directorates from table 1 above, namely the Directorate of Public Health (PH DRR) and the Directorate of Finance, Information & IT (FIT DRR). We assessed their effectiveness and the extent and level of detail they contain and whether good risk management practices recommended in our previous year's '*Risk Management'* audit report have been introduced. We note:

- the DRRs that are documented are not all maintained in the format of the template register provided in the RMF;

• in lieu of local departmental or service risk registers, risks are typically discussed at monthly directorate and weekly departmental meetings, although these meetings are not formally documented; • we found risk entries that do not give any information about the date the risks were entered on the register meaning it is not possible to assess when the threat recorded had been identified and therefore gauge whether it remained current or potentially had expired, nor to be able to assess the impact of lengthy risk exposure to the health board and whether alternative mitigating actions should be required; • although there is a field in the risk register to record whether there is a need for escalation to the CRR, it is not always populated; • the PH DRR shows that risks are actively managed, being added or deleted from the DRR as necessary; • both DRRs cross reference between the risk entries in the DRR and CRR, and record by whom and by when the mitigating actions they feature will be delivered and the next review date; and • within the FIT Directorate, the finance team holds a detailed Risk & Opportunities log (R&O). The R&O lists every risk and opportunity that the team is managing and/or aware of that may potentially have an impact on the financial position during the financial year (This is related to CRR002 'failure to achieve breakeven'). The R&O is summarised monthly and presented to the P&R Committee.	

Recommendation 3	Priority level
Ensure that the Directorate Risk Register template, as documented in the RMF Toolkit (and appended to the Risk Management Framework) is adopted by all Directorates and fully populated for discussion at Risk and Assurance Group meetings going forward.	**High**
Management Response 3	**Responsible Officer/ Deadline**
Agreed. This work is ongoing, with an original deadline of 31st March 2020 assigned. This deadline has been extended in light of current arrangements in response to COVID-19.	**Executive Lead: Board Secretary** Head of Risk & Assurance 31 December 2020

Finding 4 – Risk and Assurance Group meetings (Operation)	
With an absence of a full set of documented Directorate Risk Registers (DRRs, Assistant Directors of each Directorate were asked to present their top 2-3 risks at the January 2020 Risk and Assurance Group (RAG meeting in order to identify whether the Corporate Risk Register (CRR) adequately represents the DRRs. Our review of the meeting minutes identified: • variations in the detail provided on risks presented and that no risk score had been allocated to the risks discussed; • Planning and Performance Directorate presented 'IMTP' and 'strategic change' as their top 2 risks, which are already escalated in the CRR; • Mental Health Service presented 7 risks, yet there is no commentary in the meeting minutes re discussion of them; and, • Public Health Directorate presented 'no-deal Brexit' and 'seasonal flu viruses' as their top 2 risks, which are already escalated in the CRR. RAG did not recommend any DRR risks discussed at the January 2020 meeting to be further escalated to the Executive Committee, as top risks presented by the Directorates being already in the CRR. In the absence of the majority of DRR's (refer to **finding 3**), and without consideration and documentation of risk recommendations for either escalation or de-escalation or changes in individual DRR risk scoring at RAG meetings, the	The Health Board may over / under assess risks to the achievement of their objectives. Board / Sub-Committees of the Board may be unsighted on risks Lack of support for departments / service areas to manage their risks. The Health Board may not assess the significant risks it faces at the appropriate level in the organisation. A lack of fully completed DRR's might impact on effective operation of the RAG and their ability to consider and moderate appropriate risks for recommendation to the Executive Committee.

discussion might indicate a lack of understanding of how the risk escalation process should operate between DRR and CRR. As recommended in our previous year's '*Risk Management'* audit report, subsequent to each RAG meeting, the Group presents a summary paper to the Executive Committee that highlights appropriate risks for recommendation ahead of Board meetings, with the purpose to provide: • an update of the adequacy of the assurance arrangements that are in place to aid the delivery of the health board's strategic objectives and priorities; and, • the latest version of the Corporate Risk Register for review. However, our review of the summary papers and comparison to RAG, Executive Committee and Board meeting minutes have highlighted some differences between risks recommended for consideration for amendment in the CRR and insufficient detail of rationale provided for changes: • CRR011 (no-deal Brexit) presented for de-escalation to the Executive Committee January 2020 meeting was approved at the subsequent Board meeting. However, neither RAG nor Executive Committee meeting minutes of January 2020 make reference to this de-escalation; • several changes to risk scores or targets are presented with a generic rationale of 'amended in line with risk appetite'. There is no documentation of risk scores or targets in related RAG or Executive Committee meeting minutes to evidence this;	

• CRR013 (sustainability of services) was presented for de-escalation to the Executive Committee July 2020 meeting, but with no clear rationale provided. In addition, a number of changes to the risk score/target for other risks and the deletion of CRR003 (breach of Information Governance Standards) were presented for consideration. However, the related RAG meeting minutes do not reflect any of these recommended changes.	
Recommendation 4	**Priority level**
a. Ensure that going forward, reviews of the Directorate Risk Registers at Risk and Assurance Group meetings are appropriate to the task required, i.e. to discuss risk scores and consider risks for recommendation to the Executive Committee to be escalated to the Corporate Risk Register. b. Ensure that summary papers presented by RAG to the Executive Committee accurately reflect discussions and decisions made and documented.	**High**
Management Response 4	**Responsible Officer/ Deadline**
Agreed	a. Board Secretary 31 December 2020 b. Head of Risk & Assurance 31 December 2020

Finding 5 – Board Assurance Framework (Design)	Risk
A newly formatted and updated Board Assurance Framework (BAF) was endorsed by the Board in March 2019. The quarter 2 2019/20 BAF update was presented at the November 2019 Board meeting and the quarter 3 2019/20 BAF update in January 2020 for review and approval. We have observed that the approach to quarterly presentation to the Board for potential endorsement of the review and update of the BAF is still in its infancy, although we note that the document and methodology currently adopted is in line with that of other NHS organisations. The Board receives a brief summary paper and the most recently updated BAF. Although discussions are held around suggested changes to risks & risk ratings, it would be more appropriate for a detailed BAF report to be presented that explains why BAF risks have been amended. Although not specifically noted in the BAF's Principles, each sub-board committee have documented a Committee Assurance Framework included within the committee's work programme. Based on the individual Committee's remit, the framework underpins the Committee's programme of business. Whilst the BAF's Principles refer to each directorate requiring a Local Assurance Framework, we have no evidence of such frameworks being in place. Neither are they referred in the risk management hierarchy.	The Health Board may over / under assess risks to the achievement of their objectives. Board / Sub-Committees of the Board may be unsighted on risks.

Recommendation 5	Priority level
a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and, • the relevant committees have regular oversight of the strategic objectives and risks assigned. b. Consider enhancement of the Board Assurance Framework review process by implementing and presenting a detailed BAF report at Board meetings. c. Establish the concept of Local assurance frameworks into the risk management hierarchy and then introduce them as a process documentation and discussion at directorate level.	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
Agreed	Board Secretary / Head of Risk & Assurance a. 31 December 2020 b. 31 December 2020 c. 31 March 2021

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Welsh Language Standards Implementation

Draft Internal Audit Report

2019/20

Powys Teaching Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Claire Madsen, Executive Director of Therapies & Health Science
Distribution:	Kathryn Cobley, Service Manager Welsh Language & Equality
Committee:	Audit, Risk and Assurance Committee Experience, Quality and Safety 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.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

On 20th of March 2018, Assembly Members voted in favour of the Welsh Language Standards [No7.] Regulations 2018. The two key principles that underpin the Regulations are:

- in Wales, the Welsh Language should be treated no less favorably than the English Language; and
- persons in Wales should be able to live their lives through the medium of Welsh language if they choose to do so.

The financial penalty for non-compliance with the Standards could be a civil penalty of up to £5,000 per breach.

In July 2018, the Welsh Language Commissioner (the 'Commissioner') issued a draft compliance notice to all Welsh health organisations. After a twelve-week consultation period, responses on the reasonableness and proportionality of implementing each standard were submitted to the Commissioner by all Welsh health organisations. Final compliance notices were issued in November 2018.

Powys Teaching Health Board's (the 'health board') final Compliance notice required compliance with 124 standards (116 standards plus eight additional reliant standards); out of which 98 standards required compliance within 6 months, 22 standards required compliance within one year and four within two years. The health board formally challenged 22 of the standards due for compliance; 16 standards were challenged in May 2019 and a further six standards were challenged more recently. The Commissioner has accepted a variance to three standards as valid but has not agreed the other challenges and has given the health board until the end of April to appeal the remaining five standards from the most recent challenge.

The health board has approached the Regulations in two phases, with phase one being the impact assessment, response to the draft compliance notice and development of implementation action plans. Phase two represents the implementation of those action plans.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place over the implementation of phase one of the Regulations and how lessons were learnt to inform the second phase due later in 2019/20.

In order to provide assurance, we considered the systems and controls in place over:

- how the health board has assessed the impact of the Regulations on the organisation;
- the process for creating implementation actions to achieve compliance with the Regulations;
- the process for determining the resource requirements to deliver these actions; and
- how staff are being made aware of the requirements of the Regulations.

Limitations of scope

This audit was a high-level review of the actions the health board had taken to assess the impact of, and achieve compliance with, the Regulations. We did not assess compliance with the Regulations. The audit focused on phase one of the health board's approach and did not consider phase two (i.e., the implementation of the action plans).

3. Associated Risks

The main risk considered in the review was the potential for financial penalties and reputational damage because the health board is unable to comply with the Regulations within the timescales agreed with the Welsh Language Commissioner.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Welsh Language Standards Implementation is **limited** assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

					
1	Impact Assessment		✓		
2	Action Plans		✓		
3	Resource Requirements		✓		
4	Staff Awareness			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of System / Control

The findings from the review have highlighted two issues that are classified as weakness in the system control/design for Welsh Language Standards Implementation.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for Welsh Language Standards Implementation.

6. Summary of Audit Findings

The draft compliance notice for the Welsh Language Standards was issued by the Welsh Language Commissioner to all NHS Organisations in July 2018. The final notice was issued in November 2018. There is limited evidence to demonstrate that an assessment of the Regulations had been undertaken within the health board until the completion of the Baseline Assessment in January 2019. When comparing progress with other NHS organisations it is noted that the health board was behind its peers, as some had reviewed and assessed the impact of the draft compliance notice during the summer of 2018 in preparation for the final compliance notice.

The results from the baseline assessment highlighted the position across the health board as 'inadequate'. The Board update paper also found there had been '*no formal approach for the development of the Welsh Language and the Welsh Language Scheme for Powys had not been updated since 2010'*. As a result, the implementation of the Welsh Language Standards was included on the health board's corporate risk register.

Following the appointment of the Service Improvement Manager of Welsh and Equality in April 2019 there has been increased activity and progress towards the assessment and implementation of the Standards. The Service Improvement Manager introduced the directorate action plans and established the Welsh Language Service Leads Group in July 2019. Leads from each directorate are invited to facilitate implementation and monitoring of the Standards, discuss and monitor concerns / investigations and develop initiatives to improve the bilingual service provision. Attendance levels at the meetings have been good on the whole, however there is a link between those Service Leads not attending regularly and the quality and completeness of their directorate action plans. There is also evidence to demonstrate updates being provided to Board, the Executive Committee and Experience, Quality and Safety (EQS) Committee.

Despite the Service Improvement manager holding one to one meetings with Service Leads, the majority of directorate action plans are still under development. These need to be finalised in time to feed into the health board's overall compliance assessment which will be included in the end-of-year progress report due to be presented to Board in May 2020, along with the Welsh Language Commissioner's Annual Monitoring Report.

It is apparent that the health board again appears to be behind in comparison to other NHS organisations where, from completion of similar reviews, we noted another health board had ensured an action plan was in place to complement the impact assessment and had considered the associated resource requirements. As the overarching action plan within the health board has yet to be completed, we are unsure of its format, how it

will be used to co-ordinate implementation and whether it will detail the resource requirements to comply with the Standards.

A range of resources have been made available within the health board to ensure staff are familiar with the requirements of the Standards and awareness sessions are in the early stages of roll out. Whilst this is in line with other NHS organisations, we have identified examples elsewhere of where a Welsh Language Policy and communication strategy have been developed, alongside more frequent communication being issued from an earlier stage to support staff through the implementation.

Although progress is now being made, it is evident that the health board has a significant amount of work to do to ensure compliance with the Standards. In terms of the implementation process, we would have expected phase one (including the impact assessment, response to the draft compliance notice and the development of action plans) to have been completed, noting the implementation date of May 2019. However, our review has identified that this is still in progress. We would expect the health board to now be progressing phase two (implementation date November 2019 and November 2020), and working to implement the agreed action plans. However we note that this is still in its early stages.

7. Detailed Audit findings

In this section, we summarise the findings from our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: how the health board has assessed the impact of the Regulations in the organisation;

The draft compliance notice for the Welsh Language Standards was issued by the Welsh Language Commissioner to all NHS Organisations in July 2018. The final notice was issued in November 2018. There is limited evidence to demonstrate that an assessment of the Regulations had been undertaken within the health board until the completion of the Baseline Assessment in January 2019. When comparing progress with other NHS organisations, it is noted that the health board was behind its peers, as some had reviewed and assessed the impact of the draft compliance notice during the summer of 2018 in preparation for the final compliance notice. The assessment completed was at an overall health board and directorate level. It is unclear how the assessment process was completed as no evidence was retained to demonstrate the approach taken by the previous Welsh Language Officer, who is no longer in post.

The results of the baseline assessment highlighted the position across the health board as 'inadequate' and the implementation of the Welsh Language Standards was included on the Corporate Risk Register. As stated in the Welsh Language update paper presented to Board in March 2019: 'the

baseline assessment also highlighted there was *no formal approach of the Welsh Language and the Welsh Language scheme had not been updated since 2010'*. The paper also noted that *'there had been sporadic internal reporting of compliance with the Welsh Language Scheme and 'More Than Just Words' with very little Board oversight of Welsh Language in recent years'*. Also, the assessment did not detail the challenges the health board would encounter or the resource requirements to implement and comply with the Standards.

The key next steps highlighted in the Board paper included a full analysis of the baseline assessment, a RAG rated report against each of the 121 Standards and to establish the Welsh Language Steering Group.

We identified a **High** priority issue. See finding 1 in Appendix A.

Objective 2: the process for creating implementation actions to achieve compliance with the Regulations; and

Objective 3: the process for determining the resource requirements to deliver these action plans

Following the assessment, the appointment of the Service Improvement Manager in April 2019 has helped to drive progress on what was an area lacking attention prior to the baseline assessment. The role of Service Improvement Manager has a dual purpose, with responsibility for Equality in addition to the Welsh Language Standards. The role is supported by a part time fixed term Welsh speaking communications colleague who assists with social media queries and interaction. Whilst it is a small team, it is in line with some NHS Wales organisations, although we do note that resources and support is varied.

The appointment of the Service Improvement Manager of Welsh and Equality has resulted in increased activity and progress towards the assessment and implementation of the Standards. The Service Improvement Manager introduced directorate action plans and established the Welsh Language Service Leads Group in July 2019. Leads from each directorate are invited to facilitate implementation and monitoring the Standards, discuss and monitor concerns and investigations and develop initiatives to improve the bilingual service provision. Attendance levels at the meetings has been good on the whole, however there is a link between those Service Leads not attending regularly and the quality and completeness of their directorate action plans. So far, the completed action plans are highlighting some of the key themes being reported to Board, Executive Committee and EQS Committee such as Welsh Language Resources including translation and interpretation services.

There is no overarching health board action or resource management plan at present to help co-ordinate the implementation of the Welsh Language

Standards. Regular updates on key themes such as Welsh Language Resources including translation and interpretation services, Welsh Language training and awareness, financial resources, compliance within the health board, breaches and formal challenges have been provided to Board, the Executive Committee and the EQS Committee. Despite the Service Improvement manager holding one to one meetings with Service Leads, the majority of directorate action plans are still under development. These need to be finalised in time to feed into the health board's overall compliance assessment which will be included in the end-of-year progress report due to be presented to Board in May 2020, along with the Welsh Language Commissioner's Annual Monitoring Report.

Whilst encouraging progress has been made since the Service Improvement Manager's appointment the health board appears to be behind other NHS organisations. From completion of similar reviews, we noted one organisation had ensured an action plan was in place to complement the impact assessment and had considered the associated resource requirements. Whilst another organisation had a draft resource management plan in place to give a high level overview of resource implications at phase one of the implementation process. As the overarching action plan within the health board has yet to be completed, we are unsure of its format, how it will be used to co-ordinate implementation and whether it will detail the resource requirements to comply with the Standards.

Even though the exact level of resource has yet to be determined this should be done once the overall assessment from the action plans are completed and collated. Whilst there is an absence of a resource management plan, the updates presented to the Executive Committee and EQS Committee have demonstrated consideration of resource requirements. The health board is aware of the areas where the Regulations will have the highest impact, mainly translation and interpretation services where a draft budget proposal has been prepared but not yet finalised and agreed.

The health board has formally challenged in total 22 of the standards due for compliance; 16 standards (4; 5; 7; 21; 22; 22A; 22CH; 24; 25; 29; 30; 32; 34; 36; 37 and 44) were challenged in May 2019 and a further six standards (10; 19; 50; 78; 106A and 107A) were challenged more recently. The Commissioner has accepted a variance to three standards (19, 29 and 32) as valid but has not agreed the other challenges and has given the health board until the end of April to appeal the remaining five standards from the most recent challenge. The health board accepted the Commissioner's decision on each standard challenged in May 2019. The six standards challenged recently relate to:

Policy and interpretation and translation services;

- telephone services - where health board staff must deal with patients in Welsh as much as possible, to a point where it is necessary to transfer to a Welsh speaker, if that is their wish (Standard 10);
- when phoning patients for the first time, the health board must ask and record if they wish to have further conversations in Welsh (Standard 19)
- any reception service made available in English must also be available in Welsh (Standard 50).
- publish a policy on providing Primary Care service and, in doing so, make decisions in relation to opportunities for patients to use the Welsh language and treating Welsh no less favourably than English (Standard 78).

Recruitment services (we were informed the following standards are being challenged at an All Wales level);

- making sure where Welsh language skills are essential, desirable or need to be learnt, this must be specified when being advertised. The post must also be advertised in Welsh (Standard 106A); and
- publishing all recruitment information including job descriptions, application forms and interview process information in Welsh (Standard 107A).

We identified a **High** priority issue. See finding 2 in Appendix A.

Objective 4: how staff are being made aware of the requirements of the Regulations

There are a range of resources available within the health board to ensure there is staff awareness of the requirements of the Regulations. For instance, the Welsh Language page on the health board's intranet site has been updated to include Welsh language resources and templates. Also a managers' resource pack has been developed to aid discussions with staff during team meetings to provide guidance on complying with the Standards.

Whilst general communications with staff on the impact of the Regulations commenced in July 2019, Service Leads were involved in the baseline assessment process (see objective 1 above), and therefore they would have been aware of the requirements of the Regulations from an earlier stage. Feedback from Service Leads highlighted there has been discussion on the Standards during team meetings and that the Service Improvement Manager has attended some of these meetings since January 2020 to discuss the requirements and raise awareness. Whilst this in line with other NHS organisations, we have identified examples elsewhere where a Welsh Language Policy and communication strategy have been developed and more frequent communications issued and from an earlier stage in order to cascade key information to support staff through implementation.

There has also been the offer of staff awareness sessions since July 2019, although in contrast, other NHS organisations ran these from a year earlier. The presentation is focused towards the 'active offer' of the Welsh Language; it covers the importance of the Standards, the challenges, resources available and good practice to make sure the health board is better equipped. To date the health board's awareness sessions have only taken place in three directorate areas with a further session scheduled to take place in another. Two of these areas have updated and finalised their directorate action plans. As no registers have been kept for these sessions there is no record of the staff attendance.

We have identified a **Medium** priority issue. See finding 3 in Appendix A.

8. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**1**	**-**	**3**

Finding 1 Impact Assessment (Design)	Risk
The draft compliance notice for the Welsh Language Standards was issued by the Welsh Language Commissioner to all NHS organisations in July 2018. The final notice was issued in November 2018. There is limited evidence to demonstrate that an assessment of the Regulations had been undertaken within the health board until the completion of the Baseline Assessment in January 2019. When comparing progress with other NHS organisations it is noted that the health board was behind its peers, as some had reviewed and assessed the impact of the draft compliance notice during summer 2018 in preparation for the final compliance notice. The assessment completed was at an overall health board and directorate level. However, it is unclear how the assessment process was completed as no evidence was retained to demonstrate the approach taken by the previous Welsh Language Officer, who is no longer in post. The results of the baseline assessment highlighted the position across the health board as 'inadequate' and the implementation of the Welsh Language Standards was included on the Corporate Risk Register. As stated in the Welsh Language update presented to Board in March 2019, '*the baseline assessment also highlighted there was no formal approach of the Welsh Language and the Welsh Language scheme had not been updated since 2010'.* Alongside this, *there had been 'sporadic internal reporting of compliance with the Welsh Language Scheme and 'More Than Just Words' with very little Board oversight of Welsh Language in recent years*. ' Also, the assessment did not detail the challenges the health board would encounter or the resource requirements to implement the Standards. The key steps highlighted in the Board papers was a full analysis of the baseline assessment, along with RAG rated report against each of the 121 Standards and to establish the Welsh Language Steering Group.	Failure to make timely progress with implementing the Regulations. Failure to comply with the Regulations. Potential financial penalties and/or reputational damage.

Recommendation 1	Priority level
The health board should ensure it reviews future changes in legislation and assess their implications in a timely manner, with supporting evidence retained.	High
Management Response 1	**Responsible Officer/ Deadline**

Finding 2 Action plans and resource requirements (Operation)	Risk
There is no overarching health board action or resource management plan at present to help co-ordinate the implementation of the Welsh Language Standards. Regular updates on key themes such as Welsh Language Resources including translation and interpretation services, Welsh Language training and awareness, financial resources, compliance within the health board, breaches and formal challenges have been provided to Board, the Executive Committee and the EQS Committee. Despite the Service Improvement manager holding one to one meetings with Service Leads, the majority of directorate action plans are still under development. These need to be finalised in time to feed into the health board's overall compliance assessment which will be included in the end-of-year progress report due to be presented to Board in May 2020, along with the Welsh Language Commissioner's Annual Monitoring Report. Whilst encouraging progress has been made since the Service Improvement Manager's appointment the health board appears to be behind other NHS organisations. From completion of similar reviews, we noted one organisation had ensured an action plan was in place to complement the impact assessment and had considered the associated resource requirements. Whilst another organisation had a draft resource management plan in place to give a high level overview of resource implications at phase one of the implementation process. As the overarching action plan within the health board has yet to be completed, we are unsure of its format, how it will be used to co-ordinate implementation and whether it will detail the resource requirements to comply with the Standards. Even though the exact level of resource has yet to be determined this should be done once the overall assessment from the action plans are completed and collated. Whilst there is an absence of a resource management plan, the updates presented to the Executive Committee and EQS Committee have demonstrated consideration of resource requirements. The health board is aware of the areas where the Regulations will have the highest impact, mainly translation and interpretation services where a draft budget proposal has been prepared but not yet finalised and agreed.	Inability to implement, or comply with, the Regulations. Failure to appropriately identify resource implications of implementing the Regulations. Potential financial penalties and/or reputational damage.

Recommendation 2	Priority level
All directorate action plans should be completed as a matter of priority to inform the health board's overarching action plan and compliance assessment. The health board should complete the process of determining the resource implications of implementing the Regulations. This will require the active involvement of all directorates. Resource implications should be filtered through into workforce and financial planning and included as necessary in directorate plans. Significant compliance issues and resource implications should be escalated through the governance structure to the Board.	**High**
Management Response 2	**Responsible Officer/ Deadline**

Finding 3 Staff Awareness (Design)	Risk
There are a range of resource available within the health board to ensure there is staff awareness of the requirements of the Regulations. For instance, the Welsh Language page on the health board's intranet site has been updated to include Welsh language resources and templates. Also a managers' resource pack has been developed to aid discussions with staff during team meetings to provide guidance on complying with the Standards. Whilst general communications with staff on the impact of the Regulations commenced in July 2019 Service Leads were involved in the baseline assessment process, therefore they would have been aware of the requirements of the Regulations from an earlier stage. Feedback from Service Leads highlighted there has been discussion on the Standards during team meetings and that the Service Improvement Manager has attended some of these meetings since January 2020 to discuss the requirements and raise awareness. Whilst this in line with other NHS organisations, we have identified examples elsewhere where a Welsh Language Policy and communication strategy have been developed and more frequent communications issued and from an earlier stage in order to cascade key information to support staff through implementation. There has also been the offer of staff awareness sessions since July 2019, although in contrast other NHS organisations ran these from a year earlier. The presentation is focused towards the 'active offer' of the Welsh Language; it covers the importance of the Standards, the challenges, resources available and good practice to make sure the health board is better equipped. To date the health board's awareness sessions have only taken place in three directorate areas with a further session scheduled to take place in another. Two of these areas have updated and finalised their directorate action plans. As no registers have been kept for these sessions there is no record of the staff attendance.	Staff are unaware of the requirements of the Regulations and in turn the impact it will have on the health board and their roles. Inability to implement, or comply with, the Regulations. Potential financial penalties and/or reputational damage.

Recommendation 3	Priority level
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 communications; and • the Standards included as a standing agenda item at Directorate and service level meetings to ensure progress against action plans is monitored. Consideration should be given to developing a communications strategy to ensure staff are familiar with the Standards, understand its impact on their roles and the support and resources available to them to comply.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The health board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Carol Shillabeer
Chief Executive
Powys Teaching Health Board
Headquarters, Glasbury House
Bronllys Hospital,
Bronllys
Powys LD3 0LU

Reference: Covid-19/AuditPlan/Powys
Date issued: 6 April 2020

Dear Carol,

Annual Audit Plan 2020 – Impact of COVID-19

The COVID-19 national emergency has had an unprecedented impact on the UK and will significantly impact on public bodies' preparation of the 2019-20 accounts and our audit work, both financial audit and performance audit.

Due to the UK Government's restrictions on movement and anticipated sickness absence levels, we understand that many public bodies will not be able to prepare accounts in line with the timetables set out.

Alongside the delivery of the Auditor General's statutory responsibilities, our priority is to ensure the health, safety and well-being of Audit Wales staff, their families and those of our partners elsewhere in the public service at this incredibly challenging time.

In response to the government advice and subsequent restrictions, we have ceased on all on site work at audited bodies and our own offices have closed. Audit Wales staff are working from home and we will continue to make whatever progress we can whilst working and engaging with you remotely.

We commit to ensuring that our audit work will not have a detrimental impact on you at a time when public bodies are stretched and focused on dealing with the COVID-19 national emergency.

Amendments to the audit plan agreed at the Audit Committee 9th March 2020

Timetable

In light of the above, the audit plan agreed with the Health Board's Audit Committee on 9th March 2020 will need to be amended.

In respect of our financial audit work, we are aware that Welsh Government have revised draft accounts preparation and submission deadlines to 22 May and 30 June respectively, although these will continue to be under review. Achieving legislative deadlines for preparation of draft accounts (31 August 2020) and audit (some four months after draft submission) are not currently thought likely to be problematic.

We will need to discuss amended timetables for the audit of accounts with you but will continue to work as flexibly as we can.

Our annual audit plan also set out a programme of performance audit work at the Health Board. We will make as much progress as possible with these activities by working remotely. However, the cessation of on-site work will have an inevitable impact on the delivery of our performance audit work. We are keeping this under on-going review and will communicate further information on revised timings and performance audit outputs when more is known about the duration of the COVID-19 restrictions and the wider impact of the outbreak on the NHS.

Audit risks

As a result of the COVID-19 national emergency, we need to update our assessment of audit risks. The following schedule replaces Exhibit 2 in the 2020 audit plan.

Exhibit 2: financial audit 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].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business.

Financial audit risks	Proposed audit response
Healthcare Commissioning contracts are a high value expenditure stream which could potentially be incorrectly stated resulting in a material misstatement with the greatest risk arising from variations that have not yet been settled in Q4.	My audit team will: • walkthrough the controls; • substantively test contract expenditure; • agree NHS creditors, debtors, income and expenditure to balance agreements; • test around the year-end transactions to ensure that accruals are complete; and • substantively test accruals.
Impact of COVID-19 The COVID-19 national emergency may see a significant delay in the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers e.g. around estimate and valuations, may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
Other areas of audit attention	
On 18 December 2019 the First Minister issued a formal Ministerial Direction to the Permanent Secretary requiring her to implement a 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.	We are considering the accounting treatment and audit implications of the direction (the first in Wales since 1999) in conjunction with the NAO who are currently addressing the same issue in NHS England.
IFRS16 was scheduled to replace the current leases standard IAS17 in 2020-21. In light of COVID-19, this has now been deferred by the Welsh Government to 2021-22, but the new standard may pose some implementations risks for the health board. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognize assets and	My team will roll forward any knowledge gained through audit work already undertaken to assess the Health Board's preparedness for the introduction of the new standard to our 2021-22 audit planning.

Financial audit risks	Proposed audit response
liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognized on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.	

We will provide further updates as and when necessary. In the meantime, if you have any questions, please don't hesitate to contact myself or another member of our audit team.

Yours sincerely

Engagement Director

Evans,Caroline
05/11/2020 15:54:16

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Reference: AC/190/caf
Date issued: 30 April 2020

Dear Colleague

Audit Wales work programme

I am writing to update you on some important aspects of the work that my office will be undertaking over the coming weeks and months. Firstly though, I would like to pay tribute to all the public servants who are working so hard to see our country through this crisis. As the organisation responsible for scrutinising so many of these public bodies, we have a privileged insight into how vital they are to everyone's lives, every day – and even more so at a time like this. As Auditor General, on behalf of everyone at Audit Wales, and simply as a member of the public - thank you.

As you know, last month I decided to pull back from all on-site audit work as the public service focused on the pandemic. We have continued to make progress on other activity whilst working and engaging with you remotely. I remain committed to ensuring that our audit work does not have a detrimental impact on the efforts of severely stretched public bodies to deal with the national emergency. That is not to say, however, that I want us to be entirely passive. Well targeted and well delivered public audit has a vital part to play at this time in ensuring value for money, good governance and accountability. This letter explains how we will be approaching our work over the coming months.

Well-being of Future Generations report

In line with statutory requirements, we have published our Annual Plan for 2020-21, recognising that much of the performance audit work programme described in it will now need to be re-shaped or deferred.

One important exception to this is my national report under the Well-Being of Future Generations (Wales) Act 2015, which I am required by statute to lay by 5 May 2020. I have decided to lay my report 'without fanfare' before the Senedd on 5 May, and to defer any significant engagement with public service leaders and others regarding the key report messages until later in the year. I consider this to be a pragmatic way of discharging my statutory duty under the 2015 Act, whilst minimising any unnecessary distractions for the wider public sector at this difficult time. I hope the delay in engagement will also help to ensure that the impact of this important report in supporting constructive change is not significantly diminished.

Real-time audit work in respect of COVID-19

It is already apparent to my audit teams that people and organisations right across the Welsh public services are developing novel and innovative ways of working in response to COVID-19. The crisis is forcing us all to innovate and address long-standing issues with urgency. Both opportunities and risks will doubtless emerge during this period which, if acted upon sooner rather than later, can generate real-time benefits and help to mitigate other risks.

To that end, I want to deploy the capability and capacity of Audit Wales for the good of the wider public sector. Specifically, I propose to undertake work providing real-time capture and sharing of learning and experience across our audited bodies. This will involve our staff in gathering novel and other practice as it emerges and analysing it rapidly to draw out relevant points of learning. We are developing a software tool to assist us in gathering and processing this information. We will share the resulting insights swiftly to our key contacts across the Welsh public service.

I am acutely conscious that we will need to conduct any activity in a manner that doesn't impede the very important work that is happening across Wales, and which can add substantial value in informing that work. My intention is therefore to work closely with audited bodies to support them to improve their evolving responses to COVID-19, whilst preserving my objectivity and independence as Auditor General.

I am pleased to say that we have received support for this proposal from the Permanent Secretary and other senior officials at Welsh Government, the WLGA and the NHS Wales Confederation. As soon as we are able, my staff will be in touch to discuss practicalities which, as I say, will be designed to be as least intrusive as possible.

I attach a short summary of the project for your information. If you have any queries or concerns with this approach, or if you can suggest particular areas where it could be usefully directed, please let me or a member of my team know.

Other audit work in respect of Wales' response to COVID-19

Given the impact of COVID-19, I will be re-shaping my previously planned programmes of audit work. You won't be surprised, for example, that I am tracking the various COVID-19 funding flows from both UK and Welsh Governments and considering how best I can assure the people of Wales that those funds are well managed and that there is appropriate governance and accountability for the use of public money. Looking a little further ahead, I envisage a focus on what the impact of the current crisis means both in terms of the resilience and the future shape of public services in Wales. Of course, timing is everything, and I will ensure that our work does not prejudice the efforts of the public sector to tackle the crisis, whilst still reporting sufficiently thoroughly and promptly to support both scrutiny and learning.

Audit of accounts

My Engagement Directors have written to each of you about the impact of the COVID-19 emergency on your audit plan. This includes specific audit risks, as well as

revisions to the audit timetable and accounting requirements (where relevant). My staff will continue our close engagement with you and your senior team over the coming weeks and months to ensure that we deliver a high quality audit of your accounts in these changed circumstances.

Other matters

As well as considering how best to deploy Audit Wales resources to support the COVID-19 effort through our audit work, I am very aware that staff resources across public services are being stretched as never before. I want to let you know that, subject to availability and provided that the future independence of our work is not compromised, I am very willing to consider how my staff can assist wherever their skills and expertise may be required. Please let me (or a member of my team) know if there is anything specific that we can do to assist.

And finally, you will have noticed the identity and name change in this letter. Such a secondary issue in the current climate, I know, but in response to feedback on how we communicate and engage, we took the decision last year to bring together the various strands of our work under a new, clearer umbrella identity – Audit Wales. While not affecting our formal legal status, we will operate as Audit Wales henceforth in the vast majority of our public facing work. It is just one part of a wider programme of change for our audit reports; our website; our communications style and the way we engage more generally, that I hope you will recognise and value.

In closing, I would like to pay tribute once again to my colleagues across the Welsh public service and the phenomenal work they are doing for the people of Wales.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Title

Project Briefing note:

The Auditor General for Wales plans to support the rapid collection, analysis and sharing of knowledge and insights during COVID-19

Novel Practice Emerges During a Crisis.

During any emergency or crisis people will develop solutions and work in ways that are novel. Practices will emerge that are outside the range of what could be described as business as usual.

The prolonged duration of COVID-19 provides the opportunity to capture and consider this novel practice from three perspectives:

1. The identification of opportunities to improve the current response to the situation, in as close to real time as possible;
2. The identification of emerging risks (for example widespread fraud attempts) that can then be mitigated before they develop to a large scale; and
3. The recording and consolidation of novel practice, that could be shared more widely in real time and also incorporated as good practice into 'business as usual' once COVID-19 has subsided.

Collecting and Recording Novel Practice

Organisations that are experienced in emergency and crisis situations often deploy observers / information gatherers alongside their recovery teams, to identify the novel practice as it emerges. This role is recognised as a vital part of learning from what has happened and facilitates being better prepared to face the future.

The collection of information can be achieved through a range of approaches that include impartial observation, conversations and document review. It is supported by rapid analysis to draw out key insights and feedback learning. This 'closes the loop' and supports a process of real time learning and improvement.

The role of Audit Wales in supporting the Welsh Public Services response to COVID-19

The Auditor General's statutory remit places Audit Wales in a unique position to observe activity wherever public resources are being used. Our staff have strong networks and trusted relationships with people across the Welsh public services. Consistent with preserving his independence, the Auditor General plans to deploy Audit Wales staff in the three areas identified above, in support of the 'team Wales' efforts to respond to COVID-19.

Importantly, the approach taken will not impose an additional burden upon public bodies and will be predicated upon sharing useful information and analysis in real time alongside collecting what might be useful insights and learning for others.

Specifically, this will involve:

- Audit Wales staff collecting information through methods including reviews of documents and published materials, discussions with individuals and groups and observations of meetings (generally via remote working);
- The collation of this material within and across our audit teams, using our SenseMaker data tool, to provide rapid analysis; and
- The rapid dissemination of insights, additional knowledge and potential shared learning points to their original data sources, and more widely across Welsh public services where appropriate.

We anticipate that this will be an ongoing process of 'collect, analyse, share and repeat'. Greater value will potentially be generated over time as more information is gathered and shared with the people who can use it to support their response to COVID-19. We will also keep the process itself under close review and adjust it as needed in response to feedback and changing circumstances.

The overall approach taken will be consistent with how our Good Practice work has been developed over the last decade - working with public services to support them to improve, whilst maintaining the objectivity and independence that is required of the Auditor General.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.4

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 18 MAY 2020**
Subject :	**MANAGEMENT OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Board Secretary
Prepared by:	Board Secretary
Considered by Executive Committee on:	06 May 2020
Other Committees and meetings considered at:	Executive Committee, 18 May 2020

PURPOSE:

The purpose of this paper is to seek the Audit, Risk and Assurance Committee's approval for the re-prioritisation of audit recommendations due for implementation during the COVID-19 pandemic.

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee is asked to:

- APPROVE the re-prioritised approach for audit recommendation implementation, as outlined;
- NOTE the status of audit recommendations as reported in March 2020; and
- NOTE that a trajectory for implementation during the COVID_19 pandemic will be brought forward to the Committee in June 2020, based on an agreed re-prioritised approach.

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	✓

INTRODUCTION:

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this has subsequently led to NHS organisations, including Powys Teaching Health Board, needing to focus on preparations and plans for dealing with an expected surge in demand of patients requiring interventions. The nature and scale of the response depends on the course of the disease. The situation is changing constantly and will require an agile response.

Whilst the health board operates in unprecedented times, the Board remains accountable as always. The Good Governance Institute advise that during this developing situation, boards should be mindful of their statutory duties but equally they must be conscious of and receptive to the expectations that their staff, stakeholders and communities will reasonably place upon them.

Auditors, via internal and external audit teams, play an important independent role in providing the Board with assurance on the effectiveness and appropriateness of internal controls, systems and processes. It is therefore important that recommendations from such audits are implemented in a timely manner, ensuring that the health board operates effectively and efficiently, mitigating any identified risks.

During the pandemic, the priority of implementing audit recommendations will need to be balanced with the level of resources required to plan and respond to the impact posed by COVID-19.

BACKGROUND AND ASSESSMENT:

Recognising the pressures on NHS organisations during the pandemic, the following should be noted in respect of audit arrangements, particularly audit recommendations:

1. Audit Wales (the new corporate identity for Wales Audit Office) has informed the health board that audit recommendations made previously will remain valid, however it was fully understood that the ability of NHS bodies to implement them as originally planned would be compromised as the response to the pandemic takes priority. Audit Wales did, however, outline that audit recommendations which are related to important aspects of organisational governance and financial management should remain firmly within NHS bodies' line of sight as a means of ensuring business is conducted as effectively as possible in the current circumstances.
2. Internal Audit have confirmed that they will be working to agree an approach to reassess risk and undertake audit programmes for 2020/21, recognising that work will be delayed for at least Q1, including audit recommendation tracking and follow-up work.
3. Welsh Government (WG) contacted Health Boards on 31 March 2020 to confirm as part of their exercise to relieve administrative pressure on the NHS at this time, they are suspending until 01 October 2020 the requirement for organisations to submit quarterly limited or no assurance NHS Internal Audit Report returns for 2019/20 Q4; 2020/21 Q1 and 2020/21 Q2 (i.e. up to September 2020). WG will review the requirement prior to the start of October 2020 and confirm the position with the health board.

As the health board has been preparing its response to the COVID-19 pandemic, capacity to implement audit recommendations across services has inevitably been reduced. Whilst there is recognition of the significant pressure on services, there does need to be a balance between managing capacity pressures and challenges presented by the COVID-19 pandemic and managing the 'business as usual' issues and risks.

It is therefore proposed that the Audit, Risk and Assurance Committee establishes a re-prioritised approach to the implementation of audit recommendations, as follows:

Priority level 1 (May & June)	• High rated recommendations overdue and due within this period • External audit recommendations due within this period • Medium rated recommendations overdue (wherever possible)
Priority level 2 (July – September)	• High rated recommendations due within this period • External audit recommendations due within this period • Medium rated recommendations overdue • Medium rated recommendations due within this period (wherever possible)
Priority level 3 October – March)	• High rated recommendations due within this period • External audit recommendations due within this period • Medium rated recommendations overdue and due within this period • Low rated recommendations overdue and due within this period

As services have been prioritising COVID-19 planning, updates on the implementation of audit recommendations have not been requested since March 2020. It should therefore be noted that some recommendations may have by now been implemented. Additionally, there may be some audit recommendations that have now triggered as overdue.

INTERNAL AUDIT

The current status of internal audit recommendations is as reported to the Audit, Risk and Assurance Committee on 9th March 2020, with the addition of those recommendations contained within the internal audit reports presented at the same meeting.

Based on original agreed deadlines, the overall summary position in respect of **overdue** internal audit recommendations is:

Overdue Internal Audit Recommendations				
	2017/18	**2018/19**	**2019/20**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	
High	1	2	2	5
Medium	6	2	7	15
Low	4	0	3	7
TOTAL	**11**	**4**	**12**	**27**

Detail of overdue, due and not yet internal audit recommendations can be found at **Appendix A**.

EXTERNAL AUDIT

The current status of external audit recommendations is as reported to the Audit, Risk and Assurance Committee on 9th March 2020. There have been no additional recommendations made for inclusion since that time.

Based on original agreed deadlines, the overall summary position in respect of **overdue** external audit recommendations is:

Overdue External Audit Recommendations	
	Number
2018/19	7
2019/20	0
TOTAL	**7**

Detail of overdue, due and not yet internal audit recommendations can be found at **Appendix B**.

NEXT STEPS:

Upon agreement from the Audit, Risk and Assurance Committee an exercise will be undertake to re-prioritise audit recommendations based on priority levels 1 to 3. An update will then be brought forward to the Committee on 29th June 2020 to present the trajectory for implementation of audit recommendations during 2020/21, during the COVID-19 pandemic.

2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Recommendations Made			Recommendations Implemented			Recommendations Overdue (agreed timescale)			Overdue Recommendation Revised Timescale 2019/20	All recommendations implemented
			H	M	L	H	M	L	H	M	L	Q4	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1					✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	0	2	0	1	0	2	3	×
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1					✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	5	0	0	1	0	1	×
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	4	4	4	4	3	4	0	1	0	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	5	×
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	0	0	0	1	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			**30**	**81**	**36**	**29**	**75**	**32**	**1**	**6**	**4**	**11**	

2018/19 Internal Audits

Ref	Audit Title	Assurance Rating	Recommendations Made			Recommendations Implemented			Recommendations Overdue (agreed timescale)			Overdue Recommendation Revised Timescale 2019/20 – 2020/21		Recommendations Not Yet Due			All recommendations implemented
			H	M	L	H	M	L	H	M	L	Q4	Q1	H	M	L	
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				×
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	1	0	0	1	0	0	1	0	0	1	0	×
181922	Procurement of Consultant and Agency Staff Follow Up	Reasonable	0	3	1	0	2	1	0	1	0	0	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	0	2	1	1	0	0	1	0				✓
TOTAL			**25**	**70**	**32**	**23**	**67**	**32**	**2**	**2**	**0**	**2**	**2**	**0**	**1**	**0**	

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Recommendations Made			Recommendations Implemented			Recommendations Overdue (agreed timescale)			Overdue Recommendation Revised Timescale 2019/20 – 2020/21				Recommendations Not Yet Due			All recommendations implemented
			H	M	L	H	M	L	H	M	L	Q4	Q1	Q3	TBC	H	M	L	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	1	0	0	1	1	0	0	0	1	1				×
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	1	0	0	1	1	0	2	0	0				×
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	1	2	0	1	1	2	0	0	0				×
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3											✓
192006	Records Management	No Assurance	6	0	0	0	0	0								6	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	2								0	0	1	×
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0											0	3	0	×
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	0	0	0	3	0	0	0	0	3	0	1	2	×
192010	111 Service	Reasonable	2	3	0	0	0	0	1	1	0	0	0	0	2	1	2	0	×
192011	Catering Services Follow-up	Reasonable	0	3	2	0	1	0	0	0	0					0	2	2	×
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	0	3	1	0	0	0					2	0	0	×
192013	Podiatry Service Follow-up	Limited	1	5	4	0	1	0	0	0	0					1	4	4	×
192014	Care Homes Governance	Limited	1	2	3	0	0	0	0	0	1	0	0	0	1	1	2	2	×
192015	Primary Care Clusters	Reasonable	1	3	1	0	0	0	1	2	0	0	0	0	3	0	1	1	×
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	0	0	0	1	0	0	0	0	1	0	1	0	×
192017	Dental Services: Monitoring of the GDS Contract Follow-up	Reasonable	0	0	2	0	0	0	0	0	2	0	0	0	2	0	0	0	×
192018	IT Service Management	Reasonable	0	2	1	0	0	0	0	1	0	0	0	0	1	0	1	1	×
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	1	4	1	0	0	0	0	2	0	0	0	0	2	1	2	1	×
TOTAL			**18**	**44**	**27**	**3**	**12**	**8**	**3**	**13**	**5**	**2**	**2**	**1**	**16**	**12**	**19**	**14**	

2018/19 External Audits

Ref	Audit Title	Recommendations Made	Recommendations Implemented	Recommendations Overdue (agreed timescale)	Overdue Recommendation Revised Timescale 2019/20 – 2020/21				Recommendations Not Yet Due	All recommendations implemented
					Q4	Q1	Q2	TBC		
181951	Structured Assessment 2018	12	8	4	1	0	0	3	0	×
181952	Clinical coding follow-up review	4	1	3	0	0	2	1	0	×
181953	Audit of Financial Statements Report	4	2	0					2	×
TOTAL		**20**	**11**	**7**	**1**	**0**	**2**	**4**	**2**	

2019/20 External Audits

Ref	Audit Title	Recommendations Made	Recommendations Implemented	Recommendations Overdue (agreed timescale)	Recommendations Not Yet Due	All recommendations implemented
192051	Structured Assessment 2019	3	0	0	3	×
TOTAL		**3**	**0**	**0**	**3**	

AGENDA ITEM: 3.5

AUDIT, RISK & ASSURANCE COMMITTEE	DATE OF MEETING: 18 May 2020
Subject :	**RISK MANAGEMENT ARRANGEMENTS DURING THE COVID-19 PANDEMIC**
Approved and Presented by:	Board Secretary
Prepared by:	Board Secretary
Considered by Executive Committee on:	06 May 2020
Other Committees and meetings considered at:	Executive Committee

PURPOSE:
The purpose of this paper is to seek the Audit, Risk and Assurance Committee's support for the approach to risk management during the COVID-19 pandemic.
RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to SUPPORT the organisation's approach to risk management, during the COVID-19 pandemic.

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	✓

INTRODUCTION:

The Audit, Risk and Assurance Committee is responsible for overseeing risk management processes across the organisation, with a particular focus on seeking assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address strategic risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.

The Board approved its Risk Management Framework in September 2019, which sets out the components that provide the foundation and organisational arrangements for supporting risk management processes across the organisation. The Risk Management Framework includes the Board's Risk Appetite Statement, approved in July 2019.

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this has subsequently led to NHS organisations, including Powys Teaching Health Board, needing to focus on preparations and plans for dealing with an expected surge in demand of patients requiring interventions. The nature and scale of the response will depend on the course of the disease. The situation is changing constantly and will require an agile response.

The Board's approach to risk management will therefore need to be balanced and proportionate to ensure effective risk management arrangements, whilst

ensuring capacity is made available to plan and respond to COVID-19. The approach to releasing capacity and determining priorities (COVID and 'business as usual' related) during this period will need to be determined by an assessment of risk.

DETAILED BACKGROUND AND ASSESSMENT:

Management of Strategic Risks during COVID-19

Strategic risks are those risks that represent a threat to achieving the health board's strategic objectives or its continued existence.

Strategic risks are recorded in the Board's Corporate Risk Register (CRR), which provides an organisational-wide summary of significant risks facing the Board. The criteria for a risk to be included in the Corporate Risk register is:

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

The Corporate Risk Register (CRR) is considered by the Executive Committee and is considered by the Board at each of its meetings. This arrangement will continue during the COVID-19 pandemic.

The Executive Committee will review the existing CRR in light of the emerging COVID-19 pandemic to:

- Consider whether any existing risks may need to be updated to reflect the impact of COVID-19 on them which may reduce/increase the risk score in terms of likelihood and/or impact;
- Consider whether there are new risks emerging from the impact of COVID-19 on the achievement of the board's strategic objectives;
- Assess and make recommendations to the Board regarding those risks where appetite and tolerance may need adjusting to recognise the impact of COVID-19 on the organisation.

The Executive Committee is reviewing the Corporate Risk Register for presentation to the Board on 27th May 2020.

Management of COVID-19 Specific Risks

In light of the COVID-19 pandemic, the Chief Executive Officer established a command and control structure under Business Continuity Planning arrangements, led by a Strategic (Gold) Group. Gold Group is responsible for determining the coordinated strategy and policy for the overall management of the health board's response to COVID-19, to protect the reputation of the organisation and ensure the delivery of effective, efficient and safe care for the population of Powys.

In assessing the health board's ability to respond to COVID-19, Gold Group has identified the key risks which require mitigation and monitoring and a COVID-19 Risk Register developed. Risks contained within the COVID-19 Risk Register relate solely to the health board's arrangements for responding to COVID-19 and does not include the COVID-19 related risks relevant to the achievement of the Board's strategic objectives (recorded through the Corporate Risk Register) or those risks related to service delivery (recorded through Directorate Risk Registers).

The COVID-19 Risk Register is reviewed regularly by Strategic (Gold) Group and will be reported to the Board alongside the Corporate Risk Register on 27th May 2020.

Management of Operational Risks during COVID-19

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

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

In 'business as usual' times, the Risk and Assurance Group reviews Directorate Risk Registers to: consider risks that remain at a score of 12 or above after action to treat the risk is taken; and, highlight any new and emerging risks and present action plans for minimising and managing these risks. The Risk and Assurance Group makes recommendations to the Executive Committee on any risks which should be considered for inclusion in the Corporate Risk Register.

During the COVID-19 pandemic, it is proposed that monitoring and moderation of risks by the Risk and Assurance Group is suspended, recognising the impact of COVID-19 on managers and services.

During this period, it is proposed that a directive is sent from the Chief Executive Officer to Executive Directors confirming that whilst monitoring and scrutiny is being suspended in respect of the management of operational risks up to 31 July 2020, there is still the expectation that management will ensure their service is safe and the risk of harm to patients and staff is managed appropriately. Therefore managers will need to manage their

existing risks and any new risks to prevent harm, minimise loss and reduce damage.

Specifically, Executive Directors will be asked to review Directorate Risk Registers with teams to:

- Consider whether any existing risks may need to be updated to reflect the impact of COVID-19 on them which may reduce/increase the risk score in terms of likelihood and/or impact;
- Consider whether there are new risks emerging from the impact of COVID-19 on respective services;
- Review the capability (available resources and skills) of Managers to implement mitigating actions, and maintain the effectiveness of existing controls for identified risks;
- Assess and make recommendations to the Executive Committee regarding those risks which should be considered for inclusion in the Corporate Risk Register, particularly those risks that may need to be tolerated above the board's risk appetite.

Risk Appetite and Tolerance

The Board agreed its Risk Appetite Statement in July 2019. The Statement sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds (tolerance levels). Tolerance levels reflect the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while executing strategic objectives, in accordance with the board's strategy and risk appetite. Breaching the tolerance levels set requires escalation to the board for consideration of the impact on other objectives, competing resources and timescales. The Risk Appetite Statement, attached at **Appendix C**, will therefore be important during the COVID-19 pandemic to support strategic and operational risk management discussions and the re-prioritisation of management's attention.

NEXT STEPS:

- Corporate Risk Register to be reviewed by Executive Committee and presented to the Board for consideration;
- COVID-19 Risk Register to be reviewed regularly by Strategic (Gold) Group and reported to Board alongside the Corporate Risk Register; and
- Executive Directors to review and update Directorate Risk Registers in light of the impact of COVID-19.