Audit, Risk & Assurance Committee

Tue 26 January 2021, 10:00 - 13:00

Microsoft Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_26Jan21.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 3 November 2020 for approval

ARA_Item_1.3_Minutes_03 November 2020.pdf (16 pages)

1.4. Matters arising from previous meeting held on 3 November 2020

1.5. Committee Action Log

ARA_Item_1.5_Action Log_26 January 2021.pdf (3 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waivers

ARA_Item_2.1_Application for Single Tender Waiver January 2021.pdf (14 pages)

2.2. COVID-19 Decision Making & Financial Governance

ARA_Item_2.2_COVID-19 Decision Making & Financial Governance.pdf (2 pages)
ARA_Item_2.2a_Interim FCP - COVID-19 Update #5.pdf (23 pages)

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Audit Recommendation Tracking

ARA_Item_3.1_Audit Recommendation Tracking.pdf (10 pages)
ARA_Item_3.1a_Appendix C - Audit Recs - Internal - Priority 1.pdf (1 pages)
ARA_Item_3.1b_Appendix D - Audit Recs - Internal - Priority 2.pdf (2 pages)
ARA_Item_3.1c_Appendix E - Audit Recs - Internal - Priority 3.pdf (2 pages)
ARA_Item_3.1d_Appendix F - Audit Recs - Internal - Not Yet Prioritised.pdf (1 pages)
ARA_Item_3.1e_Appendix G - Audit Recs - External - Priority 2.pdf (2 pages)
ARA_Item_3.1f_Appendix H - Audit Recs - External - Priority 3.pdf (2 pages)
ARA_Item_3.1g_Appendix I - Audit Recs - External - Not Yet Prioritised.pdf (2 pages)

3.2. Losses and Special Payments Report, Including Benchmarking

ARA_Item_3.2_Losses and Special Payments Interim Report 2020-21.pdf (8 pages)

3.3. Internal Audit Update

ARA_Item_3.3_PTHB Audit & Assurance Progress Report.pdf (12 pages)

3.4. Internal Audit Reports, 2020-21: Substantial Assurance: a) Capital Systems b) GP Access Standards Limited Assurance: c) Partnership Governance

ARA_Item_3.4a_PTHB 202021 Capital Systems_Final Report.pdf (23 pages)
ARA_Item_3.4b_PTHB 2020-21_GP Access Standards_FINAL Internal Audit Report.pdf (13 pages)
ARA_Item_3.4c_PTHB-2021-06 Partnership Governance Final Internal Audit Report.pdf (31 pages)

3.5. Counter Fraud Update

ARA_Item_3.5_Counter Fraud Update.pdf (2 pages)
ARA_Item_3.5a_Counter Fraud Update Report Jan 21.pdf (4 pages)
ARA_Item_3.5b_Appendix - Counter Fraud Investigations Update Report.pdf (3 pages)

3.6. Counter Fraud Proactive Exercise – Pre-Employment Checks

ARA_Item_3.6_Counter Fraud Proactive Exercise_Pre-Employment Checks.pdf (2 pages)
ARA_Item_3.6a_Proactive Exercise - Pre-Employment Checks.pdf (6 pages)

3.7. External Audit Update

ARA_Item_3.7_Audit Wales update January 2021.pdf (10 pages)

3.8. External Audit Annual Report

ARA_Item_3.8_2161A2020-21 PTHB Annual Audit Report 2020.pdf (18 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

4.1. Committee Workplan 2020/21

ARA_Item_4.1_Committee Work Programme 2020-21_November20_CE.pdf (4 pages)

4.2. Welsh Government Processes for Contracts and Interests in Property Exceeding £0.5M

ARA_Item_4.2_Revised Contract Procedures.pdf (3 pages)

10:00 - 10:00
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5. OTHER MATTERS

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

5.2. Any other urgent business

5.3. Date of next meeting: 9 March 2021, Microsoft Teams

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 26th JANUARY 2021
10.00AM – 12.00PM
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 03 November 2020	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 03 November 2020	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	COVID-19 Decision Making & Financial Governance	Attached	Director of Finance & IT
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Recommendation Tracking	Attached	Board Secretary
3.2	Losses and Special Payments Report, Including Benchmarking	Attached	Director of Finance & IT
3.3	Internal Audit Update	Attached	Head of Internal Audit
3.4	Internal Audit Reports, 2020-21: <u>Substantial Assurance</u> a. Capital Systems b. GP Access Standards <u>Limited Assurance</u> c. Partnership Governance	Attached	Head of Internal Audit
3.5	Counter Fraud Update	Attached	Head of Local Counter Fraud Services
3.6	Counter Fraud Proactive Exercise – Pre-Employment Checks	Attached	Head of Local Counter Fraud Services

3.7	External Audit Update	Attached	External Audit
3.8	External Audit Annual Report	Attached	External Audit
4	**ITEMS FOR INFORMATION**		
4.1	Committee Workplan 2020/21	Attached	Board Secretary
4.2	Welsh Government Processes for Contracts and Interests in Property Exceeding £0.5M	Attached	Director of Finance & IT
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: • 9th March 2021, Microsoft Teams		

Key:

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 3 NOVEMBER 2020 VIA MICROSOFT TEAMS MEETING

Present:

Tony Thomas	Independent Member – Finance (Committee Chair)
Professor Vivienne Harpwood	Independent Member – PTHB chair
Mark Taylor	Independent Member – Capital and Estates
Ian Phillips	Independent Member – ICT
Mel Davies	Independent Member – Vice Chair
Matthew Dorrance	Independent Member – Local Authority

In Attendance:

Carol Shillabeer	Chief Executive
Pete Hopgood	Director of Finance, Information and IT
Rani Mallison	Board Secretary
Sarah Pritchard	Head of Financial Services
Helen Higgs	Head of Internal Audit
Osian Lloyd	Internal Audit
Felicity Quance	Internal Audit
Melanie Goodman	Internal Audit
Elaine Matthews	External Audit (Audit Wales)
Julie Rowles	Director of Workforce & OD and Support Services (for items 3.6 a&b)

Committee Support

Caroline Evans	Head of Risk and Assurance

ARA/20/71	**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/20/72	**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/20/73	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 8 September 2020 were RECEIVED and AGREED as being a true and accurate record, subject to the following amendments: ARA/20/63: External Audit work currently underway: Follow-up of operating theatres. This item was included in the report in error as this work is not being undertaken, so is to be removed. ARA/20/65: Mark Taylor questioned whether it was recommended that the health board should employ more staff.
ARA/20/74	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/20/75	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/19/68: Policy approved by Board 25 May 2020. List of IOs to be developed. Proposal to develop a pool of IOs recently approved by Executive Committee. Action not identified as a priority in responding to COVID-19. ARA/19/115e: Action not identified as a priority in responding to COVID-19. ARA/20/56: Action complete. Summary report included at agenda item 3.1. ARA/20/58: Action complete. Re-prioritisation of audit recommendations is outlined within the report on agenda item 3.3, which seeks Committee approval of the new approach. Subject to approval, audit recommendations will be re-prioritised and presented to the Committee in January. ARA/20/59: The health board has approached NWSSP Legal and Risk to assist with this request. NWSSP Legal and Risk are currently finalising a review of all NHS Wales cases and Lessons Learnt and will be reporting on this shortly. Therefore, the findings of this NWSSP L&R review will be

	analysed and incorporated into the January 2021 interim update on Losses and Special Payments to provide a response to the committee's request. ARA/20/61: Action complete. Report included at agenda, item 3.2. ARA/20/64: To be arranged for 2021.
ARA/20/76	**APPLICATION OF SINGLE TENDER WAIVERS (STWs)** In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements. Sarah Pritchard presented the STW requests made between 1 August 2020 and 30 September 2020 and signed by the Chief Executive, detailing one 'Prospective' STW as follows: - 1. Construction Works (Urgency of Work due to Pandemic requirements [£30,000]). Ian Phillips asked queried the Dun and Bradstreet Report. Sarah Pritchard explained this is a financial check and credit check run on the suppliers to enhance governance. The Committee RATIFIED the approval of the STW.
ARA/20/77	**ANALYSIS OF SINGLE TENDER WAIVERS 2017-2020** In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements. At the September 2020 Audit Risk and Assurance Committee it was requested that a summary of STWs over a period of time is presented to the next meeting, to identify trends and themes where there is a greater use of STWs in a particular area.

	Pete Hopgood advised that an analysis of approved Single Tender documents covering the period 1st April 2017 to 30th September 2020 has been undertaken by the Head of Financial Services. It should be noted that the 2020/21 financial year metrics only includes 6 months data. Detail of Usage per Directorate is as follows with the majority being undertaken by the Directorate of Primary and Community Care and Mental Health and the Directorate of Planning and Performance (includes Estates and Commissioning):

Financial Year Approved	Directorate of Finance & ICT	Directorate of Nursing and Therapies	Directorate of Planning and Performance	Directorate of Primary Care, Community Services and Mental Health	Directorate of Public Health	Directorate of Workforce and Facilities	Grand Total
2017/18	1	3	4	7		2	17
2018/19			2	9		2	13
2019/20			3	8	1	1	13
2020/21			2	3			5
Grand Total	**1**	**3**	**11**	**27**	**1**	**5**	**48**

	Ian Phillips commented that it is a really helpful report. The Committee RECEIVED and NOTED the Analysis of Single Tender Waivers 2017-2020.
ARA/20/78	**COVID-19 Governance Arrangements: Key Learning Areas and Management Response** Rani Mallison presented the previously circulated report, which presents the health board's response to Internal Audit's review of governance arrangements during the COVID-19 pandemic. At its meeting on 08 September 2020, the Audit, Risk and Assurance Committee received a report of Internal Audit which outlined the findings of a review of the health board's governance arrangements during the COVID-19 pandemic. The review was undertaken in an advisory capacity and therefore no assurance rating applied. Rani Mallison advised that the review assessed the adequacy and effectiveness of internal controls in operation during the COVID-19 outbreak, with particular regard to the principles set out by the Welsh Government regarding maintaining financial governance. This review therefore focused on: governance and risk management; delegation and escalation; and departures from existing policies and processes. Ian Phillips commented that it is a really helpful report, and asked how are we capturing the learning to ensure we are being successful and continue to do so in these unprecedented times. Carol Shillabeer stated that there are a number of mechanisms that we are using to capture the learning, and as we have moved into each phase we

have used those mechanisms to inform each phase. One example is a piece of work led by the Innovation and Improvement Hub to gather the views of people across the organisation as to what they have felt has worked well, and what has not worked well, etc. There are additional mechanisms including regular feedback loops with Trade Unions, Reflection Sessions, and Planning Sessions. Additionally, at Board Development in December there will be a session to take a look back and a look forward in readiness for next year, to understand what we have learned through this year, and what are the new challenges in the context of the pandemic going forward.

Ian Phillips asked for reassurance that we are making the links with Incident Reporting mechanisms.
Rani Mallison stated that the findings of the audit were specifically around the risks associated with responding to the COVID-19 pandemic, so this response is in respect of that. There is work ongoing through the Clinical Quality Framework implementation plan to review and refine the Serious Incident reporting, and policy and system processes. This work will inevitably be linked to the risk management processes, but are not incorporated within this point.

Mel Davies stated that it is a really good report.
Mel asked that given the spike that we are currently going through, do we think that the committees will remain stood up?
Carol Shillabeer stated that the current scenario now in terms of the second wave is very different to the first wave, when we had no experience of COVID-19. The decision by the government at the time was to step down routine and some essential services, so we then had to adjust our working arrangements as a health board. This is one piece of evidence that demonstrates that we did that effectively. Where we are now with the second phase, is that we've learned that there is harm that is caused by stepping down non-COVID-19 services, and our commitment to try and keep that going as much as we possibly can as a health board and as a system in Wales, but actually, that and COVID-19, dealing with both of them coming in together, there is a very real potential of being overwhelmed. There is a realistic prospect of us needing to review our arrangements and review our priorities again as we go through winter. But hopefully we won't need to do that quite as significantly as we did previously, however, we don't quite know yet.
Rani Mallison added that we have committed to bring a further paper to the Board this month about maintaining good governance during Q3 and Q4 of our response. We have committed as a Board to maintain a risk-based approach, to achieve good governance standards.

The Committee RECEIVED and NOTED the COVID-19 Governance Arrangements: Key Learning Areas.

ARA/20/79	**RE-PRIORITISED APPROACH TO THE IMPLEMENTATION OF AUDIT RECOMMENDATIONS** Caroline Evans presented the previously circulated report, which sought approval from the Committee of a re-prioritised approach to implementation of audit recommendations due for implementation during the COVID-19 pandemic, which supports delivery of the health board's Winter Protection Plan. Significant work was taken forward previously, to implement robust systems for recording and monitoring audit recommendations arising from Internal and External Audit Reviews. Progress was made in closing down a large number of previously outstanding audit recommendations. COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this 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 advises 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. Recognising the pressures on NHS organisations during the pandemic, Audit Wales informed the health board that whilst audit recommendations previously made will remain valid, it was fully understood that the ability of NHS bodies to implement these recommendations as originally planned would be compromised, as the response to the pandemic takes priority. However, 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. Subject to approval of the new approach by the Audit, Risk & Assurance Committee, Executive Directors will be asked to reprioritise their remaining outstanding audit recommendations. Prioritisation should be based upon the following category ratings: -

Priority level 1	• Action(s) within the Winter Protection Plan are dependent on implementation of this recommendation • Delivery of the Board's agreed Strategic Priorities are dependent on implementation of this recommendation • High risk to patient or staff safety / wellbeing identified • Prioritised Compliance with legal requirement / statutory duty identified
Priority level 2	• Action(s) within the Winter Protection Plan are not supported by implementation of this recommendation • Low risk to patient or staff safety / wellbeing identified • Compliance with legal requirement / statutory duty identified
Priority level 3	• Action(s) within the Winter Protection Plan are not supported by implementation of this recommendation • No risk to patient or staff safety / wellbeing identified • No legal / compliance issues identified

The Committee Chair stated that Powys is not the only health board taking this approach.

Mark Taylor stated that he supports the approach, but asked what is the difference between prioritised compliance and compliance?
Carol Shillabeer stated that there was a discussion held about this in Executive Committee, and that when we prioritise the recommendations we will be able to see what are the pinch points, and there will need to be some choices about how we prioritise resource during this time.

The Committee RECEIVED and APPROVED the re-prioritised approach to the implementation of audit recommendations.

ARA/20/80

CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS 2019-20

Powys Teaching Health Board (PTHB) as Corporate Trustee must provide to the Charity Commission by 31st January 2021, an Annual Report and Accounts that have been subject to Independent Examination by Grant Thornton on behalf of Audit Wales and approved by the PTHB Board.
Pete Hopgood advised the Committee that the Charity has not exceeded the Charity Commission thresholds for statutory audit for the financial year to 31st March 2020 therefore an Independent Examination is currently being undertaken by Grant Thornton on behalf of Wales Audit Office.

	Pete Hopgood thanked Sarah Pritchard and the Team for completing the accounts and the report. Pete also stated that this is the final piece of work undertaken by Grant Thornton on behalf of Audit Wales, and expressed thanks to them for their support and service over the last five years. Mel Davies commented that the Annual Report and Accounts are once again really well presented, making it clear of the responsibility we as trustees are charged with, and thanked everyone for the work involved. Mark Taylor stated that next year's accounts will indicate a lot more movement in terms of the actions taken this year, and on the whole, this is very positive. Sarah Pritchard emphasised that the charity accounts are guided by the charity commission, therefore the layout and requirements are relatively a lot shorter than the health board annual accounts. The Committee RECEIVED and NOTED the Charitable Funds Annual Report and Accounts 2019-20.
ARA/20/81	**INTERNAL AUDIT PROGRESS UPDATE** Helen Higgs presented the previously circulated report which provides progress with the 2020/21 Internal Audit Plan as recorded at November 2020. Helen Higgs advised that progress against the Plan is as follows: Number of audits finalised: 7 Number of audits issued at draft: 0 Number of audits in progress: 8 Number of audits not started: 3 Year-end reporting: 2 **Total number of audits in 2020/21 plan: 20** The Committee RECEIVED and NOTED the Internal Audit Update.
ARA/20/82	**INTERNAL AUDIT REPORTS, 2020-21:** **a) FIRE SAFETY (LIMITED ASSURANCE)** Felicity Quance presented the findings of the review, which originated from the internal audit plan for 2020/21. It is noted that a change in Executive responsibility for Fire Safety was scheduled, for October 2020, from the Director of Planning & Performance to the Director of Workforce & Organisational Development. However, due to staff secondments, this has been delayed for a further six months. The Regulatory Reform (Fire Safety) Order 2005 requires a managed risk approach to fire safety. The process of fire risk assessment, mitigation and review requires a robust system of management, capable of identifying hazards, qualifying their impact, devising appropriate mitigation and continual monitoring.

The Firecode (WHTM 05-01: 'Managing Healthcare Fire Safely') provides guidance in respect of the management of fire safety in healthcare organisations. Therefore, an assessment was undertaken of the controls and practices in place within the health board to ensure that the key fire safety regulatory requirements were adequately addressed and appropriate management arrangements are embedded within the organisation.
The review was cognisant of the outputs from other assurance providers such as NWSSP: Specialist Estates Services (SES).
This was the third audit undertaken of this area [2013/14: No assurance; and 2016/17: Reasonable assurance]. Compliance testing at two THB sites was undertaken to determine compliance with the THB's and national legislative requirements:

- Llandrindod Wells County War Memorial Hospital; and
- Llanidloes War Memorial Hospital.

The review identified three high and four medium priority findings.

The Committee Chair noted they are quite serious comments on the fire risk element, albeit the report is 'limited assurance'. The Committee Chair stated he would have assumed that immediate action would have been taken to deal with the high risks indicated in the report.

Julie Rowles stated that the results of the review are correct. The focus of the health board has perhaps been on some of the estate's issues in relation to fire safety, where this review is about the health board's ability to manage successfully in the event of a fire. This concurs with the issues identified, and is why the fire risk has been escalated. Immediate action has been taken. Operational managers have provided assurance that fire drills are being completed and that all sites will have undertaken a fire drill by the end of December. The issue is about ownership at site level in the event of a fire occurring, and the assignment of site management across the piece will make a significant difference to this, and work is underway to ensure this is addressed.

The Committee Chair asked whether there are operatives within the locations with specific elements in their job descriptions that deal with the points raised in the report. Julie Rowles stated there are some areas where the job description identifies this, however, health and safety responsibility is clearly identified in Senior Managers job roles, but it is the ownership for the whole site that we have to determine.

Carol Shillabeer stated that we have a number of important building blocks in place, however, the issues is about ensuring it is deployed consistently, which is about getting absolute clarity about who has responsibility for ensuring those things are happening, and deployed on a site-by-site basis. This is a key focus, and we will move to get that sorted.

Mark Taylor stated he is pleased with these comments. This is also more important in terms of the COVID-19 situation, particularly where oxygen usage will increase at key sites, because that adds a different risk profile. This work needs to be taken forward, and previous comments provide assurance this is being done, but would welcome some feedback around how this is actually being delivered on the ground.

Julie Rowles stated it is about getting the leadership right on those sites, but require support to do this as in the absence of people stepping forward into that leadership role, we need to clarify that leadership role. It is clear for fire, but there are other aspects where we need a similar leadership approach moving forward. While I have responsibility at the Board, there are accountabilities across the piece, and it is about how we operationalise that responsibility. It was not an unknown issue, but this gives us the focus and attention that we need on addressing this issue.

The Committee Chair asked if there is any liaison with the health board and the fire authority for fire inspections.
Julie Rowles confirmed that is part of the inspection process. As identified in the review, we have received our fire audits that have identified this management issue.

Mark Taylor commented that whilst the fire authority carries out the inspections, the fire risk assessments are the responsibility of the health board. Julie Rowles agreed with this comment, and stated that every year we completed the Shared Services audit tool in terms of risk assessments. They are very clear they are an advisory role, not an assurance role.

Mel Davies stated that supporting people on the ground may be a way to get people to embrace that role more.

Carol Shillabeer confirmed that monitoring of the report will be actioned through the Audit Tracker, and a follow-up report will be presented to the Experience, Quality and Safety Committee.
Action: Board Secretary

b) HEALTH AND SAFETY FOLLOW-UP (REASONABLE ASSURANCE)
Osian Lloyd presented the findings of the review, which sought to assess whether the health board has implemented the Internal Audit recommendations made following our health and safety review in 2018/19. It is a legal requirement for the health board to comply with the Health and Safety at Work Act and other health and safety legislation. Health and safety management includes the responsibility to provide and maintain safe and healthy environment for all employees, patients, visitors, contractors and other members of the public who have contact with the organisation. Health and safety is a key responsibility for managers with effective health and

safety management being based on a good understanding of the risks and how to control them.
Our 2018/19 review of health and safety examined the extent to which a sample of key health and safety risks facing the health board were being managed in accordance with key operational policies and procedure, with a focus on lone workers and stress management. Our audit also assessed progress made against the '*Strategic Health and Safety Improvement Action Plan*' developed following the external review of health and safety management undertaken by Coleg Gwent in 2016. Our review was completed in October 2018 and delivered a limited assurance opinion overall and demonstrated there remained a need to improve the management of health and safety across the health board.
The purpose of this follow up review was to assess whether the health board has implemented the Internal Audit recommendations made following our health and safety review in 2018/19.

The review identified three medium and two low priority findings.

Julie Rowles stated that work is underway, and the Executive Team is fully focused on this area. We have had a lot of focus on Health and Safety in the organisation. This week we are taking a paper to Executive Committee that addresses one of the key issues highlighted in the report around the organisation's ability to undertake high quality risk assessments, so this is being addressed. Whilst we recognise there is still work to do, we have made progress and this is obviously as a result of the investment the health board has made into specialist knowledge within the team.

c) ANNUAL QUALITY STATEMENT (NOT RATED)

Osian Lloyd presented the findings of the review of the Annual Quality Statement (AQS), which sought to provide the health board with assurance that operational procedure is compliant with the requirements of the Welsh Health Circular: The Annual Quality Statement 2019/20 Guidance.
The health board is required to publish an Annual Quality Statement by 30th September 2020. The deadline is later than previous years due to the COVID-19 outbreak. The health board will report on the 2019 calendar year where data for the full financial year is not available. The AQS is a statement from the health board to encompass all key themes in line with the Health and Care Standards for Wales and the NHS Wales Outcome and Delivery Framework. It also provides the opportunity to reflect improvements being made to services in line with the expectations set out in A Healthier Wales, the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.
The AQS is an opportunity for the public to know in an open and honest way about what and how the health board is doing in making the best use of resources to provide and deliver safe, effective and user/patient-centred services and ensuring that care is dignified and compassionate.

The review identified one medium priority finding.

d) ADVANCED PRACTICE FRAMEWORK (NOT RATED)

The *NHS Wales Framework for Advanced Nursing, Midwifery & Allied Health Professional Practice in Wales* ('the Framework') was established in 2010 in response to a growing concern regarding the number of staff working with an advanced practice title in Wales and lack of clarity regarding what an Advanced Practitioner actually is. The framework was developed by a multidisciplinary professional group led by the former National Leadership & Innovation Agency for Healthcare (NLIAH) and is now available on the Heath Education & Improvement Wales (HEIW) website.

Advanced Practice defined within the Framework as *"a role requiring a Registered Practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competences for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant Masters level education"*.

The Framework is intended to guide the successful development, implementation and evaluation of advanced practice roles within NHS Wales, to ensure a consistent approach is taken and appropriate governance arrangements are in place to support advanced level practice. It provides the foundation on which all future advanced practice roles are to be developed and existing roles are to be reviewed and managed.

Osian Lloyd advised the Committee that it is apparent that there has been very little development in Advanced Practice within the health board in recent years. Internal Audit was unable to identify an executive lead for Advanced Practice. The individuals spoken with recognised the need for strategic focus on establishing robust arrangements for the development and evaluation of Advanced Practice posts.

Given the relatively low number of Advanced Practice posts within the health board, the risk to patient safety from professionals taking on roles and responsibilities that they lack the competence to carry out safely and effectively is considered low. Instead, the risk is opportunities lost from failure to realise the benefits that Advanced Practice roles can bring to the health board and the population it serves.

It was agreed with the Director of WOD and Support Services and the Chief Executive Officer that a full audit of the Advanced Practice Framework would be premature and so fieldwork was not progressed further. It is proposed to defer the full review to the 2021/22 Internal Audit Plan.

A number of points have been identified for the health board to consider as a starting point for developing the arrangements for advanced practice.

Julie Rowles stated that the feedback was particularly useful. The Director of Nursing and Director of Therapies and Health Sciences will be key in the development of the Advance Practice Framework moving forward, and we can now take this forward in terms of our plans for the future, based on the advice and recommendations from the review.

Ian Phillips stated that we do have examples of good practice in this area, and didn't feel this was balanced, however not criticising the report. In the future we need to be looking at areas where we are potentially ahead of the game, we have the opportunity to put Professional Practice even further forward and lead the way.

Carol Shillabeer added that she agrees with this view, and that we have some really good examples of where we have been able to push forward. I feel as though we should be setting our ambitions higher. We have learned that we can change things swiftly and radically. Thanks to colleagues for the work on it.

The Committee RECEIVED and NOTED the update.

ARA/20/83

EXTERNAL AUDIT UPDATE

Elaine Matthews presented the previously circulated report, which provides an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).
Elaine Matthews advised on the following audit work that is currently underway: -

Topic	Executive Lead	Focus of the work	Current status
Orthopaedic services – follow up	Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted
Review of the Welsh Health Specialised Services Committee (WHSSC)	Chief Executive Officer	WHSSC is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales. This work will use aspects of our structured assessment methodology to examine the governance arrangements of WHSSC. Our findings will be summarised into a single national report.	Fieldwork underway
Test, Track and Protect	Director of Public Health	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	Report being drafted

The Committee RECEIVED and NOTED the External Audit Update.

ARA/20/84

a) AUDIT WALES STRUCTURED ASSESSMENT 2020

Elaine Matthews presented the previously circulated report, which sets out the findings from the Auditor General's 2020 structured assessment work at Powys Teaching Health Board. The work has been undertaken to help

discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.
Elaine Matthews advised that the health board has maintained good governance arrangements during the pandemic. The Board adapted its governance arrangements to maintain openness and transparency, support agile decision-making and ensure effective scrutiny and leadership during the pandemic. The Board is committed to using learning to help shape future arrangements.

The Committee Chair stated the report is encouraging and pleasing overall, and is particularly pleased with key message 6: '*Overall, we found that the Health Board has maintained good governance arrangements during the pandemic. The Board adapted its governance arrangements to maintain openness and transparency, support agile decision-making and ensure effective scrutiny and leadership during the pandemic. The Board is committed to using learning to help shape future arrangements*'.
We were aware of it as a Committee, but it is nice to see it highlighted in the report.

Carol Shillabeer stated that the organisation has come a long way, and the report should give us confidence to keep progressing. The report gives us confidence that we have mechanisms in place to capture issues. Thank you to our Audit Wales colleagues, recognising it has been tremendously difficult to carry out the work in the current environment. It did not feel onerous and that is probably testament to Elaine's consistent contact with us as we work on a day-to-day basis. In terms of public accountability, I think this report should be taken through the Board to provide the people we serve with the confidence they should have in the organisation.

Mark Taylor stated that the report is really helpful in terms of succinctness and clarity of the issues. Paragraph 72-74 of the report identifies the staff pressures and gaps we still have, particularly around 46 nursing vacancies. I know there is work ongoing around that, but important we are not blindsided about those pressures going forward. It's a very helpful report, thank you.

Viv Harpwood stated that transparency is part of good governance, and it is important that we let people see this. We have made progress, but we do have more progress to make, so I think it would be good for the report to be seen more widely. Thank you also to Rani Mallison for her support.

b) PTHB MANAGEMENT RESPONSE

Rani Mallison presented the previously circulated report, which sets out the health board's response to the Audit Wales' Structured Assessment 2020.

	Rani Mallison advised that ongoing oversight of the delivery of recommendations will be provided by the Audit, Risk and Assurance Committee via the Audit Recommendations Tracking System. Management oversight of progress will be monitored by the Executive Committee. Ian Phillips referred to reference 27 in item 3.8bii (management response 2019), Stakeholder Reference Group and Healthcare Professionals' Forum. Ian stated that engagement at the current time is more important than ever, and stated that the health board is very successful at stakeholder engagement and engaging with our staff. Ian Phillips asked whether there are any pre-existing mechanisms for engagement that could be adapted, as it appears that we are not engaging with these people, when this is clearly not the case. Rani Mallison stated that we do have existing mechanisms. The steps we will now take will be to articulate for the board the existing mechanisms we have in place to engage with stakeholders and our professional groups in the organisation as well as undertake a risk assessment of non-compliance with Standing Orders. Viv Harpwood seconded Ian's comment, noting that where we have a statutory requirement that we're not complying with that doesn't look right, but why would we not make use of what we're already doing in some way. Rani Mallison stated that the importance of complying with Standing Orders is recognised, but whilst non-compliant we should ensure we can demonstrate how we are adding value whilst achieving engagement in a different way to that as required. The Committee RECEIVED and NOTED the Audit Wales Structured Assessment 2020 and PTHB Management Response.
ARA/20/85	**COMMITTEE WORK PROGRAMME 2020-21** Rani Mallison advised that the work programme has been developed in-line with respective terms of reference, the Board's Assurance Framework and Corporate Risk Register. The work programme will be reviewed routinely at each meeting. The Committee RECEIVED and NOTED the Committee Work Programme.
ARA/20/86	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** • Structured Assessment and Management Response • Fire Safety (Limited Assurance) Internal Audit Report • Charitable Funds Annual Report
ARA/20/87	**ANY OTHER URGENT BUSINESS** There was no other urgent business for discussion, and the Chair declared the meeting closed at 15:05.

ARA/20/88	**DATE OF NEXT MEETING** 26 January 2021, 10:00 am, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(January 2021)

Minute	Date	Action	Responsible	Progress	Status
ARA/19/68	11 November 2019	Health Board to hold a designated list of investigative officers (IOs)in order to improve training and skills.	Chief Executive	Executive Committee has approved a training programme for Investigating Officers with a core pool of officers established.	To be agreed
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	It is proposed that this action is closed from the action tracker. Agenda item 3.4a provides the Committee with substantial assurance on capital systems. Any future issues would be addressed in individual audit reviews.	To be agreed
ARA/19/115e	9 March 2020	The Machynlleth Hospital Primary & Community Care	Board Secretary	This action has been identified as priority level 3 for implementation and will continue to be tracked via the audit recommendations process.	

		Project recommendation 6 (lessons learnt) would be shared with the Committee, once available.			
ARA/20/59	8 September 2020	Losses and Special Payments – benchmark position against previous years and against other health boards	Director of Finance, Information and IT	A Losses and Special Payments Report is scheduled on the agenda under item 3.3.	To be agreed
ARA/20/64	8 September 2020	PPV to attend a pre-meet of the Committee, to provide a broader understanding of the PPV service, and to advise how they can give assurance to the Committee of an anti-fraud culture.	Director of Finance, Information and IT / Board Secretary	To be arranged for March 2021.	
ARA/20/82	3 November 2020	Internal Audit Report: Fire Safety (Limited Assurance). A follow-up report to be presented to the Experience, Quality and Safety Committee.	Board Secretary / Director of Workforce & OD and Support Services	Action transferred to the Experience, Quality & Safety Committee Action Log, as requested by ARA Committee (November 2020)	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 26 January 2021**
Subject :	**SINGLE TENDER WAIVERS**
Approved and Presented by:	Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:
To seek the Audit, Risk and Assurance Committee RATIFICATION of Single Tender Waiver requests made between 1 Oct 2020 and 31 Dec 2020.
RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 2 items during the period of 1 Oct 2020 and 31 Dec 2020 and consider additional information provided regarding the individual single tender documents.

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

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its November 2020 meeting which covered the period from 1 Aug 2020 to 30 Sep 2020.

A summary of the use of Single Tender Action from 1 Oct 2020 and 31 Dec 2020 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold?	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2021010	Quote	Anne Phillimore	Independent Investigation services	Time critical response required to Ombudsman requirement	04/11/2020	£6,600	To complete 1 assignment	Prospective	A1
POW2021009	Tender	Oswestry Limited Liability Partnership	Healthcare service delivered on Health Board Premises	No NHS Provision available and clinical need	02/12/2020	£40,500	12 months	Prospective	A2

Full details including supporting documentation is attached at Appendix A1 & A2.

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

NEXT STEPS:

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

Appendix A1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW2021010

(Applicable to expenditure in excess of £5,000)

Request to Waive Standing Financial Instructions:

Single quote/tender action shall only be undertaken following the approval of this application in **advance** of procurement activity commencing and only in **exceptional circumstances**.

Approval to waive the requirement to seek competitive tenders (purchases between £25,000 & £122,976) & Quotations (purchases between £5,000 and £24,999). In relation to waiver requests over the OJEU threshold, a VEAT notice will also need to be published via Sell2Wales.

It is important that the form is completed **IN FULL** in order to satisfy the Health Board's Standing Orders which require competitive quotations/tenders to be obtained (to prove value of money) unless there are compelling reasons for single sourcing.

Consideration must be given to the Welsh Audit Office Guidance available from the Procurement Team.

Please Note: all requests to waive Standing Financial Instructions will be formally reported to the next Audit Committee for retrospective approval.

***Please complete all mandatory sections. Failure to complete will result in the form being returned to originator**

****To be completed by the Requesting Officer ****

Section 1

Request to Waive *Please tick as appropriate*	**Single Quotation**	**Single Tender**
***Supplier:**	Anne Phillimore	

The granting of this application for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate:

- **the service/good/works is follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);**
- **there is a compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;**
- **there is genuinely only one provider;**
- **there is a need to retain a particular contractor for real business continuity issues (not just preferences).**

NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the application process is not delayed

***Please provide detail of Goods/Services/Works required:**	a) To undertake a review of the PTHB's Concerns Team b) To review and establish the facts, in relation to the actions taken by the health board in the handling of a complaint, to meet the Public Services Ombudsman in Wales' requirements

If Services, is this for Consultancy/Individual?	**Yes**	**If 'yes', has an IR35 assessment been completed**	**Yes**
Does this requirement have an implication under GDPR?	**No**	**If 'yes', has the IG Department been consulted**	**Yes/ No or not applicable**
Proposed agreement period including start and end dates and any extension provision required. *NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.*	[redacted]		
***Unit Cost/Annual Cost:**	[redacted]		
***Total Cost** *(inc delivery & VAT):*	£6,600 + travel expenses if required		
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	N/A		
***New or Replacement Equipment/Service:** *(Please state)*	N/A		
***Life Expectancy of equipment**	N/A		
***Is this a Recurring Procurement?**	**Yes**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	Revenue	***Please provide Financial Code:**	B445
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*	None		
Have any revenue consequences (particularly staffing or maintenance implications), been agreed?	**No** **If yes give details**		
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.	No		
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)**	This piece of work has to be undertaken within a very strict timeframe, as identified by the Public Service Ombudsman in Wales. This piece of work requires somebody who has experience of high-level investigations and has worked at Director level within the NHS previously. Given the sensitivity and pace required for this piece of work, the individual identified has the experience and track record at working in such a sensitive environment. Failure to deliver within the timescales and to the standard required, would have a significant reputational risk to the Health Board, in an already very difficult situation.		

***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	The quote provided offers value for money when compared with other external consultancies. The Health Board is currently going through a call off contract review, which will prevent the need for Single Tender Waivers in future in this area.		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	**No**	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).			
***Consequence & Impact if not approved:**	The Health Board will be unable to meet the very tight deadline set by the Public Services Ombudsman in Wales. This would have a major impact on the organisation's reputation.		
***Is this an Essential or Non-Essential requirement?**	Essential		
If Yes, please give details (How many years etc)	[redacted]		
***Name:**	Julie Rowles		
***Title:**	Director of Workforce, OD & Support Services		
***Ward/Department:**	Workforce & OD		
***Contact No:**	01874 712 215		
***Budget Holder:**	Yes		
***Requisition Created?**	**No**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			
***Signature of requestor (please also print name & position):**	J Rowles Julie Rowles Director of Workforce, OD & Support Services	***Signature of budgetary approver (please also print name & position):**	RMallon Rani Mallison Board Secretary
Date of Request:	30th October 2020	**Date of Approval :**	2nd November 2020
Statement of Support by Approver:	The issues identified above.		

****Requesting Officer to Complete****

Section 2

Declaration of Interest

The Health Board is obliged to ensure that all procurement processes are carried out in accordance with the public procurement rules and NHS Wales's guidance. Where an employee is engaged in a procurement exercise a formal declaration is required to confirm that there is no potential interest which may give rise to a conflict.

Please confirm the following statements are correct:

		✓ x
1.	Neither I, my family, friends, acquaintances or work colleagues involved in this process, will receive any benefit or gain (financial or otherwise, directly or indirectly) if the contract is awarded to any of the bidders involved in the process as they become known.	✓
2a.	I have no material interest in whether the contract is awarded or not.	✓
2b.	I am not in possession of any Additional Information in respect of the procurement process. (Save for the information in the 'Additional Information box below)	✓
3.	I currently do not benefit in any way, financially or otherwise, including (but not limited to) the receipt of a grant or outside funding, that could influence my decision in respect of the procurement or any of the bidders involved in this process .	✓
4.	I have not received hospitality (other than of a nominal value or that declared in the register of gifts and hospitality maintained by Corporate Management) or any material gifts, as outlined in the Health Boards Standards of Behaviour Framework Policy http://howis.wales.nhs.uk/sitesplus/972/page/51681 from any of the bidders involved in the process.	✓
5.	I have read, understood and will abide by the NHS Guidance entitled "Standards of Business Conduct for NHS Staff" (DGM (93)84) and the Trust Standards of Behaviour Framework Policy. http://howis.wales.nhs.uk/sitesplus/972/page/51681	✓
6.	By signing this declaration I understand that it is my responsibility that should my circumstance change or a new relationship be established in relation to any bidding organisation, I will consult with the Lead Procurement contact and am aware that I may be required to complete a new Declaration of Interest or be required to withdraw my participation.	✓
7.	I will keep the identities of the bidders, the content of the bids and procurement documents confidential.	✓

I hereby certify that, to the best of my knowledge and belief, the statements set out above are correct. I understand that any failure on my part to declare an interest in a contract or otherwise to breach the rules and instructions mentioned above is a serious matter and could result in further legal or professional action being taken against me, including (but not limited to):

- Exclusion from the current procurement exercise and future procurement activities
- For Trust employees, it could result in disciplinary proceedings being initiated.
- For non-employees of the Trust we reserve the right to report the matter to their relevant employing organisation and professional body as potential professional misconduct
- Should the matter involve issues that are of a criminal nature e.g. fraud, bribery or corruption then the Trust will notify the appropriate authority to take any necessary action which may include prosecution.

Signature:

Signature:	J Rowles
Print Name:	**Julie Rowles**
Position:	**Director of Workforce, OD & Support Services**
Date:	**30th October 2020**

Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	Signature	Date
Executive Director/Director	C Rowles	**2nd November 2020**
Comments:	**This piece of work must be completed by 7th December 2020 as identified by the Public Services Ombudsman report. It is critical that we start this work immediately. The Health Board is currently going through a process to develop a number of consultants on a call off contract. This will prevent the need to use Single Tender Waivers for these types of issues in the future.**	

Please note Single Tender/Quotation Action requests cannot be processed unless supported by the above signatures, electronic signatures will NOT be accepted, unless accompanied by an e-mail trail to prove that the authorisation has been completed correctly.

Please now forward to Procurement Department

**** For Procurement Department Completion Only****

Section 4

Procurement Advice *(Delete or cross through as appropriate)*	• **Yes, the SQA or STA is an appropriate course** • ~~**No, an alternative option can be pursued**~~ • ~~**No Option**~~		
Procurement Advice or Rejection Comments: *(including any conditions/future actions):*	Procurement support this request. A tender exercise is underway and this will provide a network of individuals who meet the specific requirements. As the tender will not be awarded in time to meet the tight timescales governed by the Ombudsman a waiver is a suitable course of action.		
Endorsed	**Yes**		
Head of Procurement Signature:	SOwens	**Date:**	03/11/2020

**** Chief Executive Approval****

Section 5

Request Supported?	**Yes/No**		
Supporting or Rejection Comments: *(including any conditions/future actions):*	Procurement advice noted.		
Signed:	Mellar.	**Date:**	04/11/2020.
Please Print Name &Position:	Carol Shillabeer.	CEO	

Notes:

- Upon completion of this section, please forward to: Sarah Pritchard – Head of Financial Services, Powys THB
- In the event that the Head of Procurement/Sourcing and Chief Executive do not authorise the request to waive the Standing Financial Instructions the budget holder will be advised immediately of the decision.

Appendix 2

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW2021009

(Applicable to expenditure in excess of £5,000)

Request to Waive Standing Financial Instructions:

Single quote/tender action shall only be undertaken following the approval of this application in **advance** of procurement activity commencing and only in **exceptional circumstances**.

Approval to waive the requirement to seek competitive tenders (purchases between £25,000 & £122,976) & Quotations (purchases between £5,000 and £24,999). In relation to waiver requests over the OJEU threshold, a VEAT notice will also need to be published via Sell2Wales.

It is important that the form is completed **IN FULL** in order to satisfy the Health Board's Standing Orders which require competitive quotations/tenders to be obtained (to prove value of money) unless there are compelling reasons for single sourcing.

Consideration must be given to the Welsh Audit Office Guidance available from the Procurement Team.

Please Note: all requests to waive Standing Financial Instructions will be formally reported to the next Audit Committee for retrospective approval.

***Please complete all mandatory sections. Failure to complete will result in the form being returned to originator**

****To be completed by the Requesting Officer ****

Section 1

Request to Waive *Please tick as appropriate*	**Single Quotation**	**Single Tender**
***Supplier:**	Oswestry Limited Liability Partnership	
The granting of this application for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate: • **the service/good/works is follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);** • **there is a compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;** • **there is genuinely only one provider;** • **there is a need to retain a particular contractor for real business continuity issues (not just preferences).** *NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the application process is not delayed*		
***Please provide detail of Goods/Services/Works required:**	Orthopaedic upper limb service. Includes Theatre and Outpatient clinics although Theatre work is currently suspended.	

If Services, is this for Consultancy/Individual?	**Yes/ No**	**If 'yes', has an IR35 assessment been completed**	**Yes/ No or not applicable**
Does this requirement have an implication under GDPR?	**Yes/ No**	**If 'yes', has the IG Department been consulted**	**Yes/ No or not applicable**
Proposed agreement period including start and end dates and any extension provision required. *NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.*	Period of extension November 2020 to October 2021. This will enable the service to set up service provision through a preferred NHS Provider.		
***Unit Cost/Annual Cost:**	£1,000 per session plus daily travel cost of £250.		
***Total Cost** *(inc delivery & VAT):*	Cost for 12 months based on 3 sessions per month :- Sessions 36 X £1,000 £36,000 Travel 18 x £250 £4,500 Total Cost £40,500		
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	Annual cost based on 3 sessions per month. Sessions 36 X £1,000 £36,000 Travel 18 x £250 £4,500 Total Cost £40,500		
***New or Replacement Equipment/Service:** *(Please state)*	Not applicable		
***Life Expectancy of equipment**	Not applicable		
***Is this a Recurring Procurement?**	**Yes / No**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	Revenue	***Please provide Financial Code:**	F020 31570
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*	No additional Capital resources required.		
Have any revenue consequences (particularly staffing or maintenance implications), been agreed?	**Yes / No** **If yes give details**		
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.	If an extension to the current contract is not agreed patients will need to transfer onto the Wye Valley Trust list.		
***Background: Reason for single supplier & details of any**	Oswestry Limited Liability Partnership have been working at Llandrindod Wells Hospital for a number of years and the contract		

alternatives considered & reasons for their rejection (supplier(s) details required)	for this service expired in October 2020. As the Health Board is unable to secure resources through the usual NHS service level agreement channel we have used alternative providers to ensure out patients are treated in a timely way in line with Welsh Government Referral to treatment times. It is anticipated that the Health Board will need this service for 12 months in order to recruit an alternative (NHS) Service Provider. Discussions have commenced with a preferred NHS Provider under the Service Level Agreement (SLA) framework.		
***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	Treating patients at out local Community Hospital is more cost effective than sending patients out of county into secondary care. Treating patients locally is also better for the patients as reduced travel time and also more environmentally friendly. The Health Board has invested significantly in the Outpatients department at Llandrindod Wells Hospital and we are committed to ensure the facility is utilised as much as possible.		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	**Yes/ No**	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).	Through a financial evaluation it is more cost effective to use the Oswestry LLP that alternative options.		
***Consequence & Impact if not approved:**	Patients will need to travel to the nearest District General Hospital to receive treatment.		
***Is this an Essential or Non-Essential requirement?**	Essential		
If Yes, please give details (How many years etc)	Yes – as per the Welsh Government access rules.		
***Name:**	Jason Crowl		
***Title:**	Assistant Director – Community Services Group		
***Ward/Department:**	Community Services		
***Contact No:**	01686 617234		

***Budget Holder:**	Yes		
***Requisition Created?**	**Yes/ No**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			
***Signature of requestor (please also print name & position):**	Jason Crowl – Assistant Director – Community Services.	***Signature of budgetary approver (please also print name & position):**	
Date of Request:	12th November 2020	**Date of Approval :**	18/11/20
Statement of Support by Approver:			

****Requesting Officer to Complete****

Section 2

Declaration of Interest

The Health Board is obliged to ensure that all procurement processes are carried out in accordance with the public procurement rules and NHS Wales's guidance. Where an employee is engaged in a procurement exercise a formal declaration is required to confirm that there is no potential interest which may give rise to a conflict.

Please confirm the following statements are correct:

		✓ ✗
1.	Neither I, my family, friends, acquaintances or work colleagues involved in this process, will receive any benefit or gain (financial or otherwise, directly or indirectly) if the contract is awarded to any of the bidders involved in the process as they become known.	
2a.	I have no material interest in whether the contract is awarded or not.	
2b.	I am not in possession of any Additional Information in respect of the procurement process. (Save for the information in the 'Additional Information box below)	
3.	I currently do not benefit in any way, financially or otherwise, including (but not limited to) the receipt of a grant or outside funding, that could influence my decision in respect of the procurement or any of the bidders involved in this process .	
4.	I have not received hospitality (other than of a nominal value or that declared in the register of gifts and hospitality maintained by Corporate Management) or any material gifts, as outlined in the Health Boards Standards of Behaviour Framework Policy http://howis.wales.nhs.uk/sitesplus/972/page/51681 from any of the bidders involved in the process.	
5.	I have read, understood and will abide by the NHS Guidance entitled "Standards of Business Conduct for NHS Staff" (DGM (93)84) and the Trust Standards of Behaviour Framework Policy. http://howis.wales.nhs.uk/sitesplus/972/page/51681	
6.	By signing this declaration I understand that it is my responsibility that should my circumstance change or a new relationship be established in relation to any bidding organisation, I will consult with the Lead Procurement contact and am aware that I may be required to complete a new Declaration of Interest or be required to withdraw my participation.	
7.	I will keep the identities of the bidders, the content of the bids and procurement documents confidential.	

I hereby certify that, to the best of my knowledge and belief, the statements set out above are correct. I understand that any failure on my part to declare an interest in a contract or otherwise to breach the rules and instructions mentioned

above is a serious matter and could result in further legal or professional action being taken against me, including (but not limited to):

- Exclusion from the current procurement exercise and future procurement activities
- For Trust employees, it could result in disciplinary proceedings being initiated.
- For non-employees of the Trust we reserve the right to report the matter to their relevant employing organisation and professional body as potential professional misconduct
- Should the matter involve issues that are of a criminal nature e.g. fraud, bribery or corruption then the Trust will notify the appropriate authority to take any necessary action which may include prosecution.

Signature:

Signature:	
Print Name:	
Position:	
Date:	

Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	**Signature**	**Date**
Executive Director/Director	**Jamie Marchant DPCCMH**	**20.11.2020**
Comments:		

Please note Single Tender/Quotation Action requests cannot be processed unless supported by the above signatures, electronic signatures will NOT be accepted, unless accompanied by an e-mail trail to prove that the authorisation has been completed correctly.

Please now forward to Procurement Department

**** For Procurement Department Completion Only****

Section 4

Procurement Advice *(Delete or cross through as appropriate)*	• **Yes, the SQA or STA is an appropriate course** • ~~**No, an alternative option can be pursued**~~ • ~~**No Option**~~
Procurement Advice or Rejection Comments: *(including any conditions/future actions):*	Procurement supports this request as an interim measure pending a tender process. It's understood that awarding an extension to Oswestry Limited Liability Partnership is the most viable route pending a procurement exercise.
Endorsed	**Yes/No**

McLellan Holly 01/22/2021 14:57:06

Head of Procurement Signature:	SOwens	**Date:**	23/11/2020

**** Chief Executive Approval****

Section 5

Request Supported?	**Yes/No**		
Supporting or Rejection Comments: *(including any conditions/future actions):*	Procurement advice noted. Work now needs to progress to establish service provision arrangements via appropriate procurement route.		
Signed:		**Date:**	02/12/2020
Please Print Name &Position:	Carol Shillabeer CEO.		

Notes:

- Upon completion of this section, please forward to: Sarah Pritchard – Head of Financial Services, Powys THB
- In the event that the Head of Procurement/Sourcing and Chief Executive do not authorise the request to waive the Standing Financial Instructions the budget holder will be advised immediately of the decision.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 2.2

AUDIT, RISK & ASSURANCE COMMITTEE	**Date of Meeting: 26th January 2021**
Subject :	**UPDATE COVID 19: DECISION MAKING & FINANCIAL GOVERNANCE**
Approved and Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Sam Moss, Deputy Director of Finance
Other Committees and meetings considered at:	Covid-19 Gold Group

PURPOSE:

The purpose of this paper is to provide the committee with:

- An updated 'FCP Interim Covid-19 Decision Making & Financial Governance', highlighting the changes from the document approved by the Committee on 8th September 2020.

RECOMMENDATION(S):

Audit Committee is requested to:

- APPROVE the latest version (Update #5) presented to Audit, Risk & Assurance Committee

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

FCP Interim Covid-19

Background:

Following the publication of the WG guidance on 30th March an initial draft of the FCP was submitted for approval at Gold.

The pace of the pandemic has resulted in updated guidance and direction being published on a regular basis. To ensure the Interim FCP remains 'live' and relevant it was agreed the FCP would be updated as required.

Approval & Publication:

Each version of the FCP is presented to Gold for approval. Following the initial approval by Gold in w/c 13th April the FCP was shared with all staff via the Daily Bulletin on 23rd April 2020. The FCP was then uploaded to the PTHB intranet site.

Updated versions are uploaded to the intranet following sign off by Audit, Risk & Assurance Committee, thus enabling the latest version to be available to PTHB staff at all times.

Recommendations

Audit Committee is requested to:

- APPROVE the latest version (Update #5) presented to Audit, Risk & Assurance Committee

FCP (INTERIM) – COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

Document Reference No:	PTHB / FCP INTERIM	
Version No:	6	
Issue Date:	November 2020	
Review Date:	n/a	
Author:	Assistant Director of Finance	
Document Owner:	Finance Department	
Accountable Executive:	Director of Finance	
Approved By:	Gold Command	
Approval Date:	November 2020	
Document Type:	Policy	Non-clinical
Scope:	PTHB wide (including Hosted Services)	

The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	April 2020
2	Update #1 Addition = Section 15 : Two way matching Addition = Section 16 : Advance Payment Addition = Section 4 COVID-19 Gold Reporting Summary Revision = Section 4 : Non Pay Reporting Revision = Appendix A in line with update to Section 4.	End April 2020
3	Update #2 Addition = Section 4: Cost Centres for coding C-19 staff cost Revision = Section 4: change to calculation of variable pay allocated to Covid-19 Revision = Section 5: process notifying WG following publication and use of formal reporting tables Revision = Section 8: updated MMR guidance issued by WG on 5th May 2020	11th May 2020
4	Update #3 Revision = Section 4: reflect change from weekly to a monthly Gold Report Revision = Section 4: reflect additional Cost Centre for TTP	20th July (AC)
5	Update #4 Revision = Various sections to support reintroduction of some 'standard' services Revision = Various sections for updates on areas including Letters of Accountability, LTAs and Two Way Matching Revision = additional Cost Centre added to identify future Covid-19 expenditure.	8th September (AC)

	Revision = detail on the authorisation limits changed to direct the reader to the Approved Signatory Forms as per PtHB standard operating processes. Addition = Section 15 Capital: to ensure there is clarity on the management and approval of capital expenditure which may need to vary from the approach used for revenue	
6	Update # 5 Revision = update on commencement of standard BC processes pending launch of new IBG process. Revision = additional cost centres added since August Revision = section Gold Reporting Revision = Reimbursement Section New = Adult Social Care Section Revision = LTA payments to simply FCP and refer to general principles only Revision = TRACs process Revision – 2 Way Matching linked to updates by NWSSP and All Wales P2P	

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Finance Directorate
COVID-19 Gold Command Group
All Budget Holders via daily Communication Update (23rd April 2020)

Circulated to the following for Consultation

Date	Role / Designation

Evidence Base

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	√				
Disability	√				
Gender	√				
Race	√				
Religion/ Belief	√				
Sexual Orientation	√				
Welsh Language	√				
Human Rights	√				
Risk Assessment Summary					
No risks identified					
No Information Governance issues identified					
No Training or Resource implications identified					

1 Policy Statement / Introduction

This procedure describes how the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented within the Powys tHB, including those services hosted by the Health Board as consequence of COVID-19.

This procedure needs to be read in conjunction with the documents listed below. The documents listed remain valid and no changes have been made to these. However this FCP may override certain elements of listed

documents where changes are necessary to address the pace of change required for COVID-19.

In addition this interim FCP also outlines the additional processes required to capture and manage COVID-19 expenditure, which must comply with the documents listed below unless specific changes are detailed in this FCP.

- Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- FCP 21 Budgetary Control
- Other Financial Procedures

2 Objective

This procedure prescribes the responsibilities of the Health Board in maintaining sound financial management and the minimum procedures needed to ensure this in maintained during COVID-19. This procedure is relevant for all staff including those within the hosted bodies.

3 Definitions

- **PTHB** – Powys Teaching Health Board;
- **SO's** – Standing Orders;
- **SFI's** – Standing Financial Instructions;
- **WG** – Welsh Government;
- **IMTP** – Integrated Medium Term Plan;
- **SLA** – Service Level Agreement;
- **LTA** – Long Term Agreement;
- **IBG** – Investments Benefits Group
- **MMR** – Monthly Monitoring Return

4 Responsibilities

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

4.1 Staff Group or Specific Role

Budget Holders are required to review procedures for financial management during COVID-19 to ensure that they meet the standards laid down and must comply with the directions and guidance contained within this financial control procedure.

4.2 Other staff

5 Monitoring Compliance, Audit & Review

Monitoring compliance will take place regularly as part of the financial monitoring process laid down by WG and may be supported by internal audit and external audit reviews.

This document will be valid for the period the COVID-19 outbreak and during this time may be updated to reflect the pace of change. All changes to this FCP will be approved by Gold Command Group as required.

6 References / Bibliography

This document has been produced in support of the WG guidance issued by the Director General for Health & Social Care / NHS Wales Chief Executive on 30th March 2020. Guidance issued is embedded below:

COVID-19 Financial Guidance_FINAL.doc

FINANCIAL CONTROL POLICY

COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

1. Introduction

This procedure describes how the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented within PTHB, including those services hosted by the Health Board as consequence of COVID-19.

During COVID-19 it is vital that within this disrupted environment, individual and collective decision making is effective and stands the test of scrutiny when our services and systems return to a normalised position in the future. Once the NHS has returned to a normalised position, PTHB will be called to account for its stewardship of public funding.

To support this disrupted environment WG have issued COVID-19 Financial Guidance to NHS Wales' organisations. The key principles of the document are as follows:

- Financial resources will not be a barrier to delivering the operational needs of the service in response to the COVID-19 pandemic but needs to be managed and monitored in a structured manner;
- Funds will flow to and from NHS Wales' organisations in a timely manner;
- Organisations are expected to work together to ensure that services are not disrupted during this period as a result of cross-border flows and commissioning;
- Requests for COVID-19 funding will be facilitated through a simplified process that balances financial governance and operational need; and
- Organisations will track both the additional costs arising from COVID-19, and reductions in expenditure due to COVID-19 (i.e. reduced elective activity) in a structured and transparent manner.
- The maintenance of financial control and stewardship of public funds will remain critical during the NHS Wales response to COVID-19.

2. Interpretation

Following publication of WG guidance on 30th March 2020 PTHB has undertaken a review of financial governance arrangements to ensure decisions to commit resources in response to COVID-19 are robust and appropriate. Value for money is expected to remain a consideration when making decisions with a significant financial impact.

PTHB will be expected to ensure that systems are in place to support decision making at pace, whilst maintaining appropriate governance and control.

The remainder of this paper outlines the processes to be adopted to support these requirements during the COVID-19 outbreak.

3. Investments and Business Cases – (Change FCP 21)

New revenue or capital business case investment should be progressed as per standard processes but this will change from the start of 2021/22 with the new IBG process to be adopted by PTHB.

4. COVID-19 Expenditure – (Enhancement to SFI)

In line with the WG requirements PTHB need to capture and understand the additional financial commitments made as a result of COVID-19. PTHB has established a number of COVID-19 cost centres (B259, B452-B459) to capture all additional expenditure.

The approval limits for these dedicated cost centre will be noted on the Approved Signatory Forms as per PtHB standard operating processes. All orders over £50,000 must first be approved by Gold Command before being signed by CEO and Chairman as required and in line with the SFI.

COVID-19 expenditure that needs to be monitored is expenditure that PTHB is incurring above its normal expenditure commitment. So examples of COVID-19 additional expenditure include:

- Procuring additional beds or clinical supplies for the hospitals
- Increasing overtime costs for areas to meet COVID-19 demand above levels from previous financial years;
- Appointment of temporary staff, students or those returning from retirement to support COVID-19.

However redeployment of existing resources/staff from one service areas to another to support COVID-19 is not additional COVID expenditure and will be met from existing PTHB resources.

To ensure PTHB is complying with the WG requirements the following process will be adopted to ensure PTHB maintains stewardship of its public funds. These processes are applicable for revenue and capital (pay and non pay) requirements. A map of the pay and non pay process is provided in Appendix A and B and summarised in the sections below.

Non Pay (Revenue):

- All dedicated COVID-19 expenditure needs to be raised against the relevant cost centres set up to support Covid-19 and its component parts as per the full list provided under the pay section below.
- The approval limits for these dedicated cost centre will be noted on the Approved Signatory Forms as per PtHB standard operating processes. The Director of Public Health can approve orders up to £50,000, subject to approval at Gold Command for orders between £25,000-£50,000. All orders over £50,000 must first be approved by Gold Command before being signed by CEO and Chairman as required and in line with the SFI.
- Requests to commit expenditure not already on an order or where the order exceeds £25,000 will need to be supported by small summary. A template for use can be found in Appendix C. It is the responsibility of the Director for that service area to ensure that the Finance Team via Finance Business Partner (GC) or Assistant Director of Finance are provided with Appendix C or other schedule/business case, completed and approved as per the directions on the form. Where the appendix or supporting information is not submitted directly from a Director there must be a sufficient audit trail to ensure it is clear that the Director has approved this request.
- Finance will keep a log of all requests for additional expenditure presented to Gold.
- Using the log and information from the Financial Ledger, within the Monthly Gold report the paper will:
    - Those orders already raised on the system. This list will be updated monthly so the Health Board can see the total value of services and goods ordered placed since start of Covid-19 on these cost centres.
    - Orders Over £5k for which 3 Quotes Not Secured as per Interim Covid-19 FCP using the latest information from Procurement.
    - Summary of all WHS charges allocated to Covid-19, using the data from the WHS feeder file.
    - List of requests received that require approval from Gold. And where deemed helpful the appendix C forms or other supporting information submitted will be embedded into the

report should Gold members require full details on the expenditure requested.

- This report will ensure expenditure is both captured and reported and approved by Gold. It is the intention that all expenditure is approved in advance, but where this is not possible this report will ensure that all expenditure not approved in advance is approved retrospectively in a timely manner.
- It will be the responsibility of the Director of Finance to update the Finance Team on the decisions made by Gold.

Pay:

WG will be requiring pay costs associated with COVID-19 to be tracked in the following groupings:

- Temporary staff (Cost Centre B454)
- Students (Cost Centre B453)
- Returning from Retirement (Cost Centre B455)
- Bank (Cost Centre B452)
- Test, Trace & Protect (Cost Centre B456)
- PPE (Cost Centre B457)
- RPB Covid-19 Funding (B458)
- Mass Vaccinations (B459)

As detailed above each grouping will be allocated a specific cost centre for payments to be made via ESR. This will allow PTHB to monitor the cost and the WTE.

Shared Services will be using these codes to report the spend to date directly to Welsh Government. (see Section 5 below)

For variable pay costs such as overtime, costs will initially be allocated to the cost centre where the substantive post holder is paid. In addition PTHB has historically committed expenditure for overtime, bank and agency to support 'standard non COVID' service provision. Therefore it is proposed that apportionment of expenditure for these areas to COVID-19 will be based on the increase above pervious years monthly spend, using the monthly average from the last financial year. So for example the variable pay costs for Mth 1 in 2020/21 attributable to COVID-19 =

Total Variable Pay Costs Mth 1 20/21
less average of the variable pay cost in 19/20 **=** COVID-19 Variable Pay Cost in Mth 1 20/21

This will be provided to Gold after each month closedown and will be claimed and reported to WG retrospectively as per the WG process detailed in section 5.

COVID-19 Gold Reporting Summary:

A monthly report will also be produced. This report will include as a minimum:

- Summary of orders by non pay subjective for goods and services paid on B259-B459 both within the month and since the outbreak began in March 2020.
- The Gold Report will also include a summary of the Covid spend to date and forecast. Embedded within the report will be the full Table B3, which will provide further details on all covid spend both to date and forecast. This will ensure that all spend allocated to the Covid Cost Centres /Table B3 is noted and approved by Gold. Therefore, if spend has been allocated which is not included in the Appendix of the report or due to its nature is not recorded on Appendix C (e.g. Prescribing, Block Contracts) Gold have the opportunity to review, note and approve this.
- The Gold report will also include other submissions that may be required by WG linked to Covid that require retrospective sign off. This will include but is not exhaustive list on TTP, Mass Vaccinations, Capital and Adult Social Care. Where necessary these will be embedded within the Gold Report.

5. Cost Reimbursement Revenue & Capital Costs - (Enhancement to SFI)

Where PTHB has needed to incur additional expenditure whether revenue or capital WG will consider making additional funding available.

PTHB will be required to make ongoing submissions which will include information on:

- what additional cost is i.e. pay or non pay
- within pay / non-pay type of expenditure
- the timeframe within which it will be incurred
- whether the cost is Capital or Revenue

Non Pay Reimbursement:
Where the expenditure is related to Non Pay and is not on a standard order an additional template should be completed and submitted to Gold, via the Finance Report as detailed in Appendix A and C, however the use of decidated cost centres allows Finance to easily identify all Covid costs.

In addition there will be other areas of Non-Pay for example increases in Prescribing costs and on LTA arrangements that will neither be on a order

or coded directly to a Covid Cost Centre. However this will be identified via the Finance Team and costs allocated to Covid as required.

WG will be therefore be notified of non-pay spend via the revised Monthly Monitoring Return including Table B3 and the other supplementary Covid returns required. This will be completed by Finance using all the information provided.

Pay Reimbursement:
For basic pay this will be linked to the Covid-19 Cost Centres that have been established and detailed in Section 4. Share Services will be reporting this directly to WG via the dedicated codes using the data from ESR. Therefore it is vital that all Covid-19 basic pay costs excluding variable pay is allocated on ESR directly to one of the 3 codes (B453-B459).

The information provided via Section 4 will be also used to support the completion of the Monthly Monitoring Return required by WG. The Monthly Monitoring Return will be completed by Finance as required and retrospectively presented to one of all of the following (1) Executives, (2) HB Committees and (3) Board for information and approval.

[The previous requirement to submit all requests for funding to NHS Financial Management mailbox at NHSFinancialManagement@gov.wales , was superseded by the use of the all Wales templates/Monthly Monitoring Return as confirmed in email from SE WG 010520.]

General
The funding for Covid will be provided via in year allocation adjustments and will be managed and controlled as per the standard processes within the overall management of the financial position. But recognising that there will be a significant amount of reporting required for this above normal processes, both to WG and the Board.

6. Adult Social Care Funding - (Change to FCP/SFI)

WG issued guidance and funding to support care homes during the pandemic.

Guidance issued by WG is provided below:

A summary of the stance to be adopted by the HB is summarised in the paper below approved by Gold:

7. Procurement Tendering Levels – COVID 19 Expenditure Only (Change SFI)

Under SFI's Purchase Orders over £5,000 but under £25,000 require three quotes, where no framework is in place.

As of week commencing 23rd March 2020 it has been agreed with Shared Services that this requirement will be stood down during the period of COVID-19.

This has been agreed to ensure there are no delays with orders being awarded to suppliers and is in line with the approach adopted in other Health Boards.

But this adjustment to the standard procurement process is ONLY for expenditure relating to COVID-19

For orders above £25,000 a formal tender may still be required where the goods and services cannot be secured from an existing framework agreement. In these circumstances advice from procurement and finance will be required before orders are placed.

8. Financial Reporting WG / Board Reporting - (Change SFI / Standard Reporting)

Welsh Government has reviewed its existing monitoring arrangements to ensure routine monitoring is focused on the minimum to sustain clear financial reporting and integrity. So at the high level the Director of Finance will be responsible for reporting to the Board and Welsh Government the following information:

- Baseline position pre COVID-19 as per previous plans
- Year to Date & Forecast outturn position
- Risks & opportunities
- Allocation & Income assumptions
- Cash flow
- Capital
- COVID-19 expenditure incurred

This will be in line with the guidance issued by WG on 5th May and will be subject to change over the financial year as additional information linked

to Covid is required. A copy of the guidance issues in May is embedded below.

Financial Monitoring Return (

9. Savings Monitoring

Each month a full review of all savings schemes listed on the savings tracker at the end of March will be undertaken to assess which schemes will or will not be maintained during COVID-19 and then the likely delivery of each scheme in 2020/21. This will be in line with WG guidance and will also be used to support the full WG reporting requirement as part of the WG MMR Table B3, which is subsequently presented to Board and its sub committees.

The output from this would will then be used to support PTHBs assessment of its wider forecast outturn position.

Updates on this assessment will be provided through the standard reporting processes to one of the following groups Gold, D&P, P&R or Board to ensure there a robust sign off process to assumptions made on savings delivery in 2020/21.

This review will be a monthly task undertaken by the Finance function to ensure that the impact of changes to services as a result of Covid-19 are reflected in forecast deliver of savings.

10. Changes to LTA Payments - (Change SFI)

LTA and SLA payments to other providers, whether in England or Wales is primarily based on the previous year's LTA value, uplifted by an agreed national percentage, with further adjustment for agreed service changes. This will then form the basis of the financial agreement of the LTA signed by both parties. A 12th of this value is then paid in cash to the provider on the 1st of each month and then at the end of the financial year adjustments are made for under or over performance.

However NHS England and WG (via All Wales DOF's) have agreed that the payments made to providers during the COVID-19 period will change to support the pressures seen by providers. The key principle behind this is to ensure providers are not financially de-stabilised as a result of the likely non-delivery of elective or other planned care.

Payments to NHS England will be agreed via discussions between NHS England and WG, supported by representation from various Health Boards. Payments to NHS Wales will be in line with any all Wales agreement signed of by DOF in Wales.

PtHB will ensure that any national agreements are correctly reflected in the payments made to providers on the 1st working day of each month and full reconciliation is maintained, which is in line with standard procedures.

11. Letter of Accountability & Budget Upload 2020/21 (Change FCP 21)

The initial FCP notes that whilst the IMTP was agreed by WG on 19th March 2020 the letters of accountability will not be issued whilst the COVID-19 work is ongoing. However following COVID-19 the standard letters will be issued effective from 1st April 2020.

As essential services are reintroduced in Q2 it was important that the HB issue the letters outlining the budgets as at 1st April to ensure that Budget Holders are aware of their budget for supporting 'normal' services. Whilst Covid-19 costs are manged separately as per this FCP. Therefore during Q2 the Directors were issued with their letters of accountability. However in recognition that Covid-19 is still resulting in additional pressures the normal timescales for returning the letters signed will be extended and revised deadlines included in the letters issued.

Whilst the letters were not issued as normal to ensure that PTB reports its financial position the revised 2020/21 budget were uploaded to the ledger at the end of April. This has allowed budget holders to review their budgets via Qlikview, prior to receipt of the letter of accountability, whilst also supporting finance in its ability to monitor and report the financial position as per Section 8.

12. Budget Holder Meetings (Change FCP 21)

Initially April 2020 all meetings with Budget Holders were be stood down. However Budget Holders were expected to ensure that requests for new posts via TRACs and expenditure for non-COVID-19 areas is managed within existing resources/budgets by using the Qlikview system.

At the end of Q2 meetings with Budget Holders restarted and will be as a minimum held on a quarterly basis as per Budgetary Control FCP 21.

13. Procurement Hierarchy

With the exception of changes linked to the establishment of new COVID-19 cost centres there are no plans to review the procurement hierarchy, unless staff sickness requires PTHB to review on an ad hoc basis to ensure goods and services continue to flow as normal.

14. Changes TRACs Approval Process

Under the current process when a post is added onto TRACS and approved by the Budget Holder it is then sent to Finance to validate that the funding is available.

As each area has dedicated Finance Leads, it is these specific staff who would be able to confirm if a TRACs request can be approved. As the relevant Finance member maybe absent due to COVID-19 there is a risk that the approval is delayed.

To avoid delays effective from 30th March 2020 there is an option for all TRACS orders added from this date to be automatically approved to ensure all posts are processed as efficiently and effectively as possible. However if possible Finance will continue to check and approve.

However it remains the responsibility of the Budget Holder to ensure that during this time appointment of non-COVID specific staff remains within the budgeted establishment.

Where additional resources are required linked to COVID-19 this will need to be approved by Gold Command as per the process detailed in section 4 above.

15. Capital

Since the start of the pandemic the HB has ben required to submitted various reports to WG on Covid-19 actual and planned expenditure. Initially the submissions were joint for capital and revenue. However since the end of April the submissions have been kept separate with revenue submissions included within the WG MMR and the capital submissions requested on an ad hoc basis.

The approval of Capital submissions to WG must first be reported to Gold and then to the relevant committees of the Board for final approval. However where the timescales imposed by WG do not allow approval to be sought from Gold before submission the information will be shared with the relevant Executives/Senior Managers via email, as per list below:

- Director of Finance
- Director of Planning
- Head of Estates & Property

Then will be presented for retrospective approval at the next available Gold (or Executive Meeting).

As WG increase the HB Capital Resource Limit to reflect Covid-19 requirements the Financial Accounting team will be responsible for

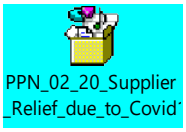
monitoring and reporting on the capital spend as required by WG and Board, in line with the management of the standard Capital Resource Limit.

16. Two Way Matching

NHS Wales has agreed via the DOF governance structure a change to the 3 way matching process (PO Raised, Goods Receipted and Invoice Received). The key change is that suppliers will be paid using a 2 way matching process .i.e. the supplier is paid when PO in place and the invoice received, removing the need for good to be receipted. 2 way matching is not new and has been piloted for stationery orders for a numbers of months across NHS Wales.

These interim arrangements will help with the cash-flow to suppliers and will be kept under review by shared services.

This change was also applied for invoices which are currently deemed as in dispute, either in relation to price or goods receipting queries and is in line with the Cabinet Office – Procurement Policy Note – Supplier Relief due to Covid-19 embedded below.



For clarity the initial agreement for two way matching process was for all invoices with a value of less than £500 (excl VAT) and where a matching PO had been received. As well as applying to future invoices it would also apply to invoices that are currently on hold.

In September the process was changed. And the key points are as follows:

- Focus only on Quantity Received holds only, which accounted for 52% of the total.
- Retain the same financial threshold i.e. up to £500 excluding VAT, in respect of Quantity Received Holds only.
- There will still be the requirement for retrospective checks to be undertaken.

This revised process was agreed by DOF in September and ratified by All Wales P2P and All Wales DDOF in October.

The two-way matching process will continue to operate until it is agreed at all Wales level to stop. However further work will be undertaken by NWSSP and the All Wales P2P Group to look at options.

17. Advanced Payments

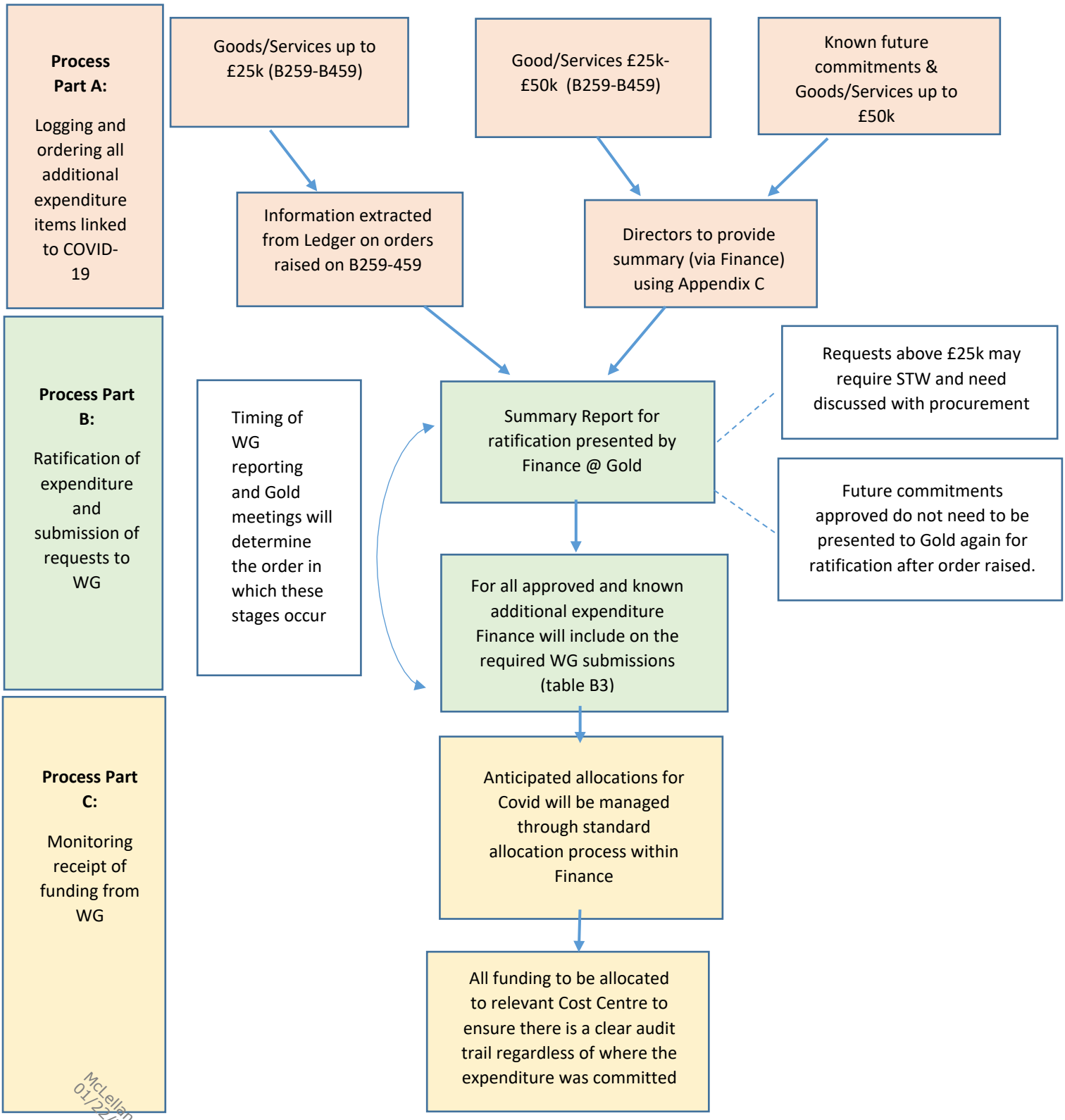
In April 2020 Welsh Government guidance was issued to all Health Boards in respect of requests for advance payments.

The guidance clearly outlines requirements to document decisions and maintain an appropriate audit trail, recognising that organisations may already have their own governance framework in place. It also highlights the importance of Welsh Government approval for advance payments in excess of 25% of the contract value and early notification of potential cash requirements. Other Standing Financial Instruction requirements to note contracts >£500k in value and approve contracts >£1m remain in place.

A copy of the guidance is provided below:

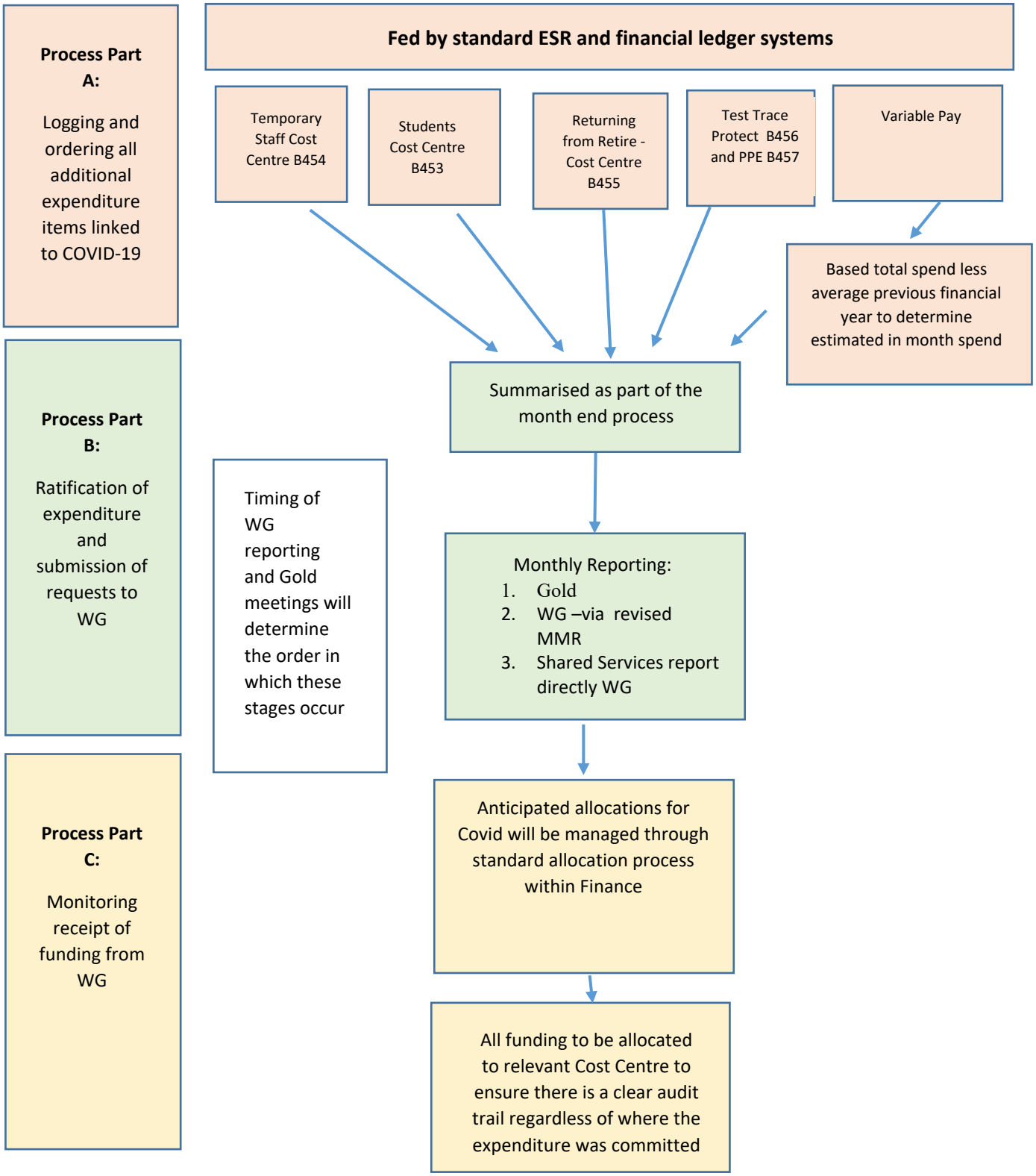
Advance Payments - Guidance FINAL.pdf

APPENDIX A – PROCESS MAP COVID 19 REVENUE EXPENDITURE NON PAY



NOTE: THE ABOVE PROCESS IS FOR COVID-19 EXPENDITURE ONLY. NON-COVID EXPENDITURE IS SUBJECT TO STANDARD SFI/SO AND FCP'S

APPENDIX B – PROCESS MAP COVID 19 REVENUE EXPENDITURE PAY



APPENDIX C – FUNDING REQUEST TEMPLATE

HB Ref No. ***(Finance Complete once submitted)***	
Health Board	Powys Teaching Health Board
Capital or Revenue ***(Completed by Service)***	
Date Request ***(Completed by Service)***	
Date Ratified by Gold Command ***(Completed Finance)***	
Summary Expenditure to be committed ***(Completed by Service)***	
Purpose/Justification ***(Completed by Service)***	
Funding Requested inc VAT ***(Completed by Service)***	£
Timeframe Expenditure Incurred ***(Completed by Service)***	Date
Director Approving Form ***(insert name and ensure form sent from Director email to Finance contacts as per below):***	
Powys Health Board Finance contacts:	Greg Chambers: Greg.Chambers@wales.nhs.uk OR Sam Moss: samantha.moss@wales.nhs.uk

AGENDA ITEM: 3.1

AUDIT, RISK AND ASSURANCE COMMITTEE	DATE OF MEETING: 26 JANUARY 2021
Subject :	**AUDIT RECOMMENDATIONS TRACKING**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	n/a

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of outstanding audit recommendations, and the re-prioritisation for implementation of these audit recommendations during the COVID-19 pandemic.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- NOTE the re-prioritised approach for audit recommendation implementation, as outlined;
- NOTE the status of audit recommendations as reported in January 2021; and
- NOTE the trajectory for implementation of outstanding audit recommendations 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:

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:

As the health board has been responding 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.

At the last meeting of the Audit, Risk and Assurance Committee in November 2020, the Committee APPROVED a re-prioritised approach for the implementation of outstanding audit recommendations, based on the following criteria: -

Priority level 1	• Action(s) within the Q3/4 Winter Protection Plan are dependent on implementation of this recommendation • Delivery of the Board's agreed Strategic Priorities are dependent on implementation of this recommendation • High risk to patient or staff safety / wellbeing identified • Prioritised Compliance with legal requirement / statutory duty identified	All outstanding recommendations to be implemented by 31st March 2021, except for recommendations with original agreed deadlines that exceed this date.
Priority level 2	• Action(s) within the Q3/4 Winter Protection are not supported by implementation of this recommendation • Low risk to patient or staff safety / wellbeing identified • Compliance with legal requirement / statutory duty identified	All outstanding recommendations to be implemented during quarters 1 and 2, and by 30th September 2021, with the exception of recommendations with original agreed deadlines that exceed this date.
Priority level 3	• Action(s) within the Q3/4 Winter Protection are not supported by implementation of this recommendation • No risk to patient or staff safety / wellbeing identified • No legal / compliance issues identified	All outstanding recommendations to be implemented during quarters 2 and 3, and by 31st December 2021, with the exception of recommendations with original agreed deadlines that exceed this date.

Executive Directors have been asked to close any recommendations that have been implemented since the last reporting period, and re-prioritise all remaining outstanding recommendations. Future updates on progress of the re-prioritised recommendations will be presented to the Audit, Risk and Assurance Committee on the basis outlined in the re-prioritised approach.

INTERNAL AUDIT

Based on the re-prioritised approach, the overall summary position in respect of **overdue** internal audit recommendations is: -

Overdue Internal Audit Recommendations					
	2017/18	**2018/19**	**2019/20**	**2020/21**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**	**Number**
Priority 1	0	0	2	1	3
Priority 2	5	2	19	0	26
Priority 3	1	0	13	0	14
Not Yet Prioritised	2	0	3	1	6
TOTAL	**8**	**2**	**37**	**2**	**49**

Appendix A at the end of this report provides a dashboard with a break down of all internal audits undertaken since 2017/18, with detail of recommendations implemented, recommendations overdue and recommendations that are not yet due for implementation. In addition, the dashboard includes detail of the re-prioritisation.

Detail of re-prioritised internal audit recommendations can be found appended to this report as follows: -
Appendix C – Priority level 1 Internal Audit Recommendations
Appendix D – Priority level 2 Internal Audit Recommendations
Appendix E – Priority level 3 Internal Audit Recommendations
Appendix F – Not Yet Prioritised Internal Audit Recommendations

EXTERNAL AUDIT

Based on the re-prioritised approach, the overall summary position in respect of **overdue** external audit recommendations is: -

Overdue External Audit Recommendations				
	2018/19	**2019/20**	**2020/21**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**
Priority 1	0	0	0	0
Priority 2	2	1	4	7
Priority 3	1	0	2	3
Not Yet Prioritised	1	0	8	9
TOTAL	**4**	**1**	**14**	**19**

Appendix B at the end of this report provides a dashboard with a breakdown of all external audits undertaken since 2018/19, with detail of recommendations implemented, recommendations overdue and recommendations that are not yet due for implementation. In addition, the dashboard includes detail of the re-prioritisation.

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix G – Priority level 2 External Audit Recommendations
Appendix H – Priority level 3 External Audit Recommendations
Appendix I – Not Yet Prioritised External Audit Recommendations

NEXT STEPS:

Ahead of the Audit, Risk and Assurance Committee meeting in March 2021, Executive Directors will be asked to update progress on outstanding Priority level 1 recommendations, with an expectation that these recommendations will be implemented by 31st March 2021.

2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
												Priority			Not Yet Prioritised	
			H	M	L	H	M	L	H	M	L	1	2	3		
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1								✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	0	0	0	2	0	0	0	2	×
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1								✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0								✓
171806	Risk Management	Limited	2	1	0	2	1	0								✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0								✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0								✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0								✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1								✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1								✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0								✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1								✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0								✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1								✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3								✓
171817	Policies Management	Reasonable	0	4	2	0	0	1	0	4	1	0	5	0	0	×
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3								✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1								✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4								✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2								✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3								✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1								✓
171824	General Ledger	Substantial	0	0	1	0	0	1								✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1								✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1								✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	0	0	0	1	0	0	1	0	×
171828	Personal Appraisal Development Reviews (PADRs)	Reasonable	1	1	0	1	1	0								✓
171829	Records Management Follow-Up	Reasonable	1	4	2	1	4	2								✓
TOTAL			**28**	**81**	**33**	**28**	**77**	**29**	**0**	**4**	**4**	**0**	**5**	**1**	**2**	

2018/19 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
												Priority			Not Yet Prioritised	
			H	M	L	H	M	L	H	M	L	1	2	3		
181901	IMTP – Joint Planning Framework	Reasonable	0	1	1	0	1	1								✓
181902	Dental Services: Monitoring of the General Dental Services Contract	Limited	2	2	0	2	2	0								✓
181903	ICT Infrastructure	Reasonable	0	1	2	0	1	2								✓
181904	Podiatry Service	No Assurance	7	1	3	7	1	3								✓
181905	Recruitment and Retention	Reasonable	1	2	0	1	2	0								✓
181906	Environmental Sustainability Reporting	Reasonable	0	1	0	0	1	0								✓
181907	Commissioning – Primary Care (Advisory)	Not Rated	2	2	0	2	2	0								✓
181908	Asbestos Management	Reasonable	0	4	4	0	4	4								✓
181909	Occupational Therapy Service	Reasonable	0	6	0	0	5	0	0	1	0	0	1	0	0	×
181910	Health and Safety	Limited	1	6	1	1	6	1								✓
181911	Section 33 - Governance Arrangements	Limited	2	1	1	2	1	1								✓
181912	Annual Quality Statement	Substantial	0	1	0	0	1	0								✓
181913	Departmental Review - Catering	Limited	3	3	1	3	3	1								✓
181914	Capital Systems	Reasonable	0	6	1	0	6	1								✓
181915	Temporary Staffing Unit	Reasonable	0	4	1	0	4	1								✓
181916	Cyber-Security Follow-up of Stratia Report	Reasonable	0	2	2	0	2	2								✓
181917	Putting Things Right – Lessons Learned (Midwifery)	Reasonable	0	1	3	0	1	3								✓
181918	Single Tender Waivers	Reasonable	0	3	0	0	3	0								✓
181919	Business Continuity Planning	Reasonable	1	2	2	1	2	2								✓
181920	Information Governance: General Data Protection Regulation (GDPR) - Compliance	Reasonable	0	1	2	0	1	2								✓
181921	Risk Management	Limited	2	1	0	2	1	0								✓
181922	Procurement of Consultant and Agency Staff Follow Up	Reasonable	0	3	1	0	3	1								✓
181923	Medicines Management (Patient Group Directions) Follow-Up Review	Limited	3	3	0	3	3	0								✓
181924	Estates Assurance Follow Up	Reasonable	0	6	4	0	6	4								✓
181925	Capital Assurance Follow Up	Reasonable	0	5	1	0	5	1								✓
181926	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1								✓
181927	Engagement with Primary Care Providers Follow-up	Limited	1	2	1	0	2	1	1	0	0	0	1	0	0	✓
TOTAL			**25**	**70**	**32**	**24**	**69**	**32**	**1**	**1**	**0**	**0**	**2**	**0**	**0**	

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				Recommendations Not Yet Due			All Audit Recs Implemented
												Priority			Not Yet Prioritised				
			H	M	L	H	M	L	H	M	L	1	2	3		H	M	L	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0				×
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1											✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0											✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3											✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3											✓
192006	Records Management	No Assurance	6	0	0	1	0	0	5	0	0	0	5	0	0				×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3											✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	0	0	0	3	0	0	1	2	0				×
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2											✓
192010	111 Service	Reasonable	2	3	0	1	0	0	1	3	0	0	4	0	0				×
192011	Catering Services Follow-up	Reasonable	0	3	2	0	2	1	0	1	1	0	0	2	0				×
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	0	3	1	2	0	0	0	0	2	0				×
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4											✓
192014	Care Homes Governance	Limited	1	2	3	0	0	2	1	2	1	0	4	0	0				×
192015	Primary Care Clusters	Reasonable	1	3	1	0	3	0	1	0	1	0	1	1	0				×
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	0	0	0	2	0	0	0	2	0				×
192017	Dental Services: Monitoring of the GDS Contract Follow-up	Reasonable	0	0	2	0	0	2											✓
192018	IT Service Management	Reasonable	0	2	1	0	0	0	0	2	1	0	0	0	3				×
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	1	4	1	1	4	0	0	0	1	0	0	1	0				×
192020	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	0	0	0	1	0	0	1	0				×
192021	Capital Assurance Follow Up	Substantial	0	1	0	0	1	0											✓
192022	Outpatients Planned Activity	Reasonable	1	3	0	0	0	0	0	0	0	0	0	3	1	1	3	0	×
192023	Estates Assurance Follow Up	Reasonable	0	1	2	0	0	0	0	1	2	2	0	1	0				×
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1											✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0											✓
192026	Risk Management and Board Assurance	Limited	2	3	0	0	0	0	2	2	0	0	5	0	0	0	1	0	×
192027	Welsh Language Standards Implementation	Limited	2	1	0	2	0	0	0	0	0	0	0	1	0	0	1	0	×
192028	Section 33 Governance Arrangements Follow Up	Reasonable	0	2	1	0	0	0	0	0	0	0	0	3	0	0	2	1	×
TOTAL			**23**	**63**	**32**	**10**	**39**	**23**	**12**	**17**	**8**	**2**	**20**	**20**	**4**	**1**	**7**	**1**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				Recommendations Not Yet Due			All Audit Recs Implemented
												Priority			Not Yet Prioritised				
			H	M	L	H	M	L	H	M	L	1	2	3		H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0											✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	0	1	0	0	0	0	6	0	0	0	2	4	0	×
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	0	0	0	0	1	1	3	1	0	0	3	1	×
202104	Annual Quality Statement	Not Rated	0	1	0	0	0	0	0	1	0	0	0	0	1				×
202105	Advanced Practice Framework	Not Rated																	✓
TOTAL			**2**	**10**	**2**	**0**	**2**	**0**	**0**	**1**	**1**	**7**	**3**	**1**	**1**	**2**	**7**	**1**	

2018/19 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Recommendations Not Yet Due	All recommendations implemented
					Priority			Not Yet Prioritised		
					1	2	3			
181951	Structured Assessment 2018	12	8	4	0	2	1	1	0	×
181952	Clinical coding follow-up review	4	4							✓
181953	Audit of Financial Statements Report	4	4							✓
TOTAL		**20**	**16**	**4**	**0**	**2**	**1**	**1**	**0**	

2019/20 External Audits

					Priority			Not Yet Prioritised		
					1	2	3			
192051	Structured Assessment 2019	3	1	1	0	1	1	0	1	×
TOTAL		**3**	**1**	**1**	**0**	**1**	**1**	**0**	**1**	

2020/21 External Audits

					Priority			Not Yet Prioritised		
					1	2	3			
202151	Effectiveness of Counter-Fraud Arrangements	3	0	2	0	0	0	3	1	×
TOTAL		**3**	**0**	**2**	**0**	**0**	**0**	**3**	**1**	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
													Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
192023	Estates Assurance Follow Up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director: Support Services & Facilities	FP2	The proposed fire training needs assessment (TNA) should be reviewed by the Fire Safety Group and implemented accordingly.		sep-20	Overdue	1	Partially complete		The TNA is ready and will go to the Fire Safety Group on the 10 September					3	#REF!	des-20	26.09.2020
192023	Estates Assurance Follow Up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director: Support Services & Facilities	FP3	Site fire drills should be performed on an, at least, annual basis.		sep-20	Overdue	1	Partially complete		We are working with the community services managers to re-fresh the fire drill schedule and updated scheduled will be sent to the FSG.					3	#REF!	des-20	26.09.2020
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Assistant Director of Estates & Property	R1	The Fire Safety Policy should be updated to: a) Demonstrate compliance with the current regulations [WHTM 05-01 (2019)]; b) Reflect the current fire safety management structure within the THB	Should there be substantial changes to legislation, then policy documents would be updated and presented to Board for ratification. Where only minor updates, a decision would be made as to whether they would warrant a full review of the	jan-21	Not yet due	1								#NUM!	#REF!	des-20	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health Services	R2	The current fire safety management structure should be formally clarified, documented and approved at an appropriate forum (e.g. Fire Safety Group), ensuring commitment and support from both Executive Team / Board and Operational Managers	Papers will be presented to the Executive Committee for the escalation of Fire Risk to the Corporate Risk Register. It has been acknowledged that there is a lack of clear site management arrangements and further work is being undertaken by the	jan-21	Not yet due	1								#NUM!	#REF!	des-20	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health Services	R3	Individual fire safety roles and responsibilities should be formally documented (e.g. via terms of reference), assigned and accepted, ensuring appropriate management arrangements within localities	Once the operational site structures have been finalised, a document will be issued to the relevant officers providing clarification on the role.	jan-21	Not yet due	1								#NUM!	#REF!	des-20	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R5	Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed	The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	jul-21	Not yet due	1								#NUM!	#REF!	des-20	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R6	Sample checks should be made during Fire Safety Adviser site visits to ensure folders are being completed as required	A checklist will be added to the folders for officers [either Fire Safety Advisers / Estates Officers / Responsible Persons] to provide a signature to confirm appropriate completion.	jul-21	Not yet due	1								#NUM!	#REF!	des-20	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health (in	R7	Fire Warden and Incident Coordinator roles will be confirmed with immediate effect to ensure there is sufficient coverage in each location in the event of an incident / evacuation	These roles will be allocated upon finalisation of the roles and responsibilities of the Senior Operational Managers (see recommendation 2)	apr-21	Not yet due	1								#NUM!	#REF!	des-20	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R5	Actions from the HSE action plan, the interim health and safety report and other audit / inspection reports, including internal inspections carried out by the health board and from the NWSSP Specialist Estates Services should be collated and reviewed to ensure they are all	To monitor progress of HSE action plan, the interim health and safety report and other audit / inspection reports, including internal inspections carried out by the health board and from the NWSSP Specialist Estates Services through the		Overdue	1								1451	#REF!	des-20	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
															Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	mai-18	des-20	mar-20	Overdue	2	Partially complete			Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	des-20		31	0	des-20	26.02.2019
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	mai-18	des-20	mar-20	Overdue	2	Partially complete			Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	des-20		31	0	des-20	26.02.2019
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	mai-18	des-20	mar-20	Overdue	2	Partially complete			Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	des-20		31	0	des-20	26.02.2019
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed and	apr-18	des-20	mar-20	Overdue	2	Partially complete			Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	31-des.-20		32	0	des-20	26.02.2019
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	mai-18	des-20	mar-20	Overdue	2	Partially complete			Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	des-20		31	0	des-20	26.02.2019
181909	Occupational Therapy Se	Reasonable	Board Secretary		R5	The Records Management Policy, Health Records Procedure and Safe Haven and Information Policies should be reviewed and updated as necessary so that they comply with General Data Protection Regulations (GDPR). A consistent approach to records management	The policies and procedures will be updated to ensure compliance with GDPR. Occupational Therapy Teams will be reminded of the standards for records management to promote a consistent approach.	apr-19	des-20	nov-19	Overdue	2	Partially complete		A revised Records Manegement Framework is being developed.	Impact of COVID-19 on the IG team	IG advice and support is provided to the organisation when requested.	31-des.-20		20	0	des-20	26.02.2019
181927	Engagement with Primary Care Providers Follow-up	Limited	Director of Primary, Community and Mental Health		R1	1. To ensure constructive and continued engagement with the primary care clusters, the health board should move forward with implementation of the Primary Care Transformation Programme. Particular attention should be paid to the establishment of a Primary and Community Care	Agreed. Progress has been made in this area however the formal framework for Cluster Development (note – the term Primary Care Transformation programme is not being used) is due to the Cluster Leads meeting at the end of June 2019.	jul-19	sep-20	jul-20	Overdue	2	Partially complete		Engagement with clusters has remained active during covid 19 albeit with a covid focus. Cluster framework was delayed			sep-20		17		des-20	30.05.2019
192006	Records Management	No Assurance	Board Secretary		R1	The health board should strengthen its leadership arrangements and the coordination of its approach to enable effective records management. Individual roles and responsibilities should be reviewed, defined and documented accordingly, either within the most appropriate policy or a separate roles and	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	feb-20	des-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of RM Improvement Group and approval delayed due to COVID-19.	A Records Management Project Risk Register has been developed. Existing policies and procedures remain	31-des.-20		10	0	des-20	14.11.2019
192006	Records Management	No Assurance	Board Secretary		R2	In order to ensure correct and up to date policies and procedures are accessible to all staff, policies and procedures need to be reviewed and updated to reflect current legislation, All Wales guidance and current working practices. Once updated and approved, the policies and	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	feb-20	des-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed. Existing policies and procedures remain	31-des.-20		10	0	des-20	14.11.2019
192006	Records Management	No Assurance	Board Secretary		R3	The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	mar-20	des-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed.	31-des.-20		9	0	des-20	15.11.2019
192006	Records Management	No Assurance	Board Secretary		R4	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	apr-20	apr-22		Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the RM	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		8	#NUM!	des-20	14.11.2019
192006	Records Management	No Assurance	Board Secretary		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	apr-20	apr-22		Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		8	#NUM!	des-20	14.11.2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R3	The health board should assess the effectiveness of initiatives to reduce stress amongst its employees and where some are considered more effective these could be promoted further and identify whether there are any barriers to accessing initiatives. The health board may wish to undertake	HR Business Partnners and HR advisors using the available reports will monitor where there are high level of stress. These reports will be discussed during their caseload meetings and a targeted approach can be looked at for the areas	mai-20			Overdue	2	Partially complete		We will be monitoring stress levels and discussing it in caseload meetings.The stress management toolkit is part of the absence		work on COVID has prevented progress.	Due to the work on Covid and the OH Manager's secondment to cover the Wellbeing Hub, there is no new update at this time.		7	1451	des-20	14.11.2019
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R1	We recommend that remedial actions are developed for all areas where they are absent.	Red Rated Actions: Going forward the assessment will include the following narrative: "Current status - Working with providers to ensure end to end reporting is in place by the end of the financial year	feb-20	sep-20		Overdue	2	Partially complete		End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept	Reliant on input and agreement from 3rd parties: Advanced, Shropdoc &	Monthly data continued to be recieved from Shropdoc which provides assurance on the 2nd line triage and face to face contact.	sep-20		10	3	des-20	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R3	We recommend that the health board agree a suite of metrics that WAST will submit regularly and that these be reviewed quarterly (see also recommendation 2 which is related).	End to end reporting remains a problem but has progressed. Once this is in place the availability of data will be considered and then debated with WAST/111 for future use and monitoring via the OOH Performance Management Group.	mar-20	sep-20		Overdue	2	Partially complete		End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept	reliant on WAST		sep-20		9	3	des-20	

192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Director of Primary Community Care & Mental Health	R4	We recommend that a process to review patient complaint and feedback received by WAST in relation to the 111 service is implemented.	This will be raised with WAST/111 to seek that such feedback is provided via the National 111 and OOH Implementation Programme Board. A similar request will be made to for the sharing of Powys resident information directly with Powys	jan-20	sep-20		Overdue	2	Partially complete		111 attendance at OOH Performance Mgt meeting. Patient complaints/concerns and compliments reviewed as part of the		Powys representation into national 111 Ops group. Expectation that 111 will proivde local data at future Powys quarterly OOH	sep-20		11	3	des-20	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R5	We recommend that the 111 service activities are reviewed to ensure that all risks have been captured and that the risk scoring of 111 service reporting is reviewed to ensure that residual risk is not understated.	Specific risk relating to general OOH standards will be reviewed. Consideration of a risk around the metric reporting by 111 (bearing in mind this is a national service) will be considered by the OOH Performance Management Group.	feb-20	sep-20		Overdue	2	Partially complete		111 attending OOH Performance Mgt Group meeting. Performance reviewed and exceptions documented. Risks captured on risk			30th September 2020		10	3	des-20	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Primary, Community and Mental	R1	Complex Care Steering Group 1.1 The CCSG should meet bi-monthly, as stated in its terms of reference, and should report back assurance from other key governance forums, for example, the JIMP, S33 JOG, etc. Minutes should clearly evidence	1.1 Meeting schedule to be implemented and monitored. 1.2 Reinstate the Highlight Report which will be adapted to include Care Home Key metrics. 1.3 The Complex Care Steering Group	jan-20			Overdue	2	Partially complete		23.01.20: 1.1 Calendar invites sent to CCSG Group and all meetings for 2020 – 2021 diarised. CHC administrator will					11	1451	des-20	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance and	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review	des-20			Overdue	2	No progress		July 2020 - CL will need speak to Hayley about how the capacity can be made available for the action below – as this was going to be taken					0	1451	des-20	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the	apr-20			Overdue	2	Partially complete		Checklist used for Joint Monitoring Visits updated Revised policy, standard operating procedure expected end July 2020					8	1451	des-20	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices;	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	mar-20			Overdue	2	Partially complete		The CHC policy, standard operating procedure and escalation matrix being revised, expected completion end July					9	1451	des-20	
192015	Primary Care Clusters	Reasonable	Director of Primary, Community and Mental Health	Director of Primary Community Care and Mental Health	R4	We recommend that the health board devise and implement a comprehensive cluster governance framework to strengthen control of cluster operation going forward.	This document is already under revision and will be implemented for 2020/21.	apr-20	sep-20		Overdue	2	Partially complete		Cluster framework was delayed finalisation due to Covid 19 but will now be concluded by end July 2020.			sep-20	jul-20	8	3	des-20	
192026	Risk Management and Board Assurance	Limited	Board Secretary	Head of Risk & Assurance	R1	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	Agreed.	sep-20			Overdue	2	Partially complete							3	1451	des-20	26.09.2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secetary/ Head of Risk & Assurance	R2	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	Agreed.	des-20			Overdue	2	No progress							0	1451	des-20	26.09.2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Head of Risk & Assurance	R3	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.	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.	des-20			Overdue	2	Partially complete		Directors have been written to, to remind them that there is an expectation that Directorates will need to manage their existing					0	1451	des-20	26.09.2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secetary/ Head of Risk & Assurance	R4	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	Agreed	des-20			Overdue	2	Partially complete		Directors have been written to, to remind them that there is an expectation that Directorates will need to manage their existing					0	1451	des-20	26.09.2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secetary/ Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and,	Agreed	mar-21			Not yet due	2	No progress							#NUM!	1451	des-20	26.09.2020
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development & Assistant	R1	The remaining health and safety policies, procedures and guidance should be reviewed to ensure they accurately reflect current working practices and detail roles, responsibilities and reporting structures. Once approved, the policies, procedures and	Analysis to be undertaken on policy review date with any outstanding or due policies to be reviewed. Re-draft and complete sign off of any due policies. Communicate reviewed policies to	mar-21			Not yet due	2								#NUM!	1451	des-20	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R2	The Health and Safety Team should undertake an exercise to provide assurance that appropriate risk assessments are in place across all sites and services throughout the health board and to manage any issues raised. These risk assessments should then inform the	All service leads will be asked to confirm risk assessments, safe systems of work and SOPS that are in place for their service areas. This will be a desk top collation request utilising the key service contacts on each site (22 sites). Once completed a	mai-21			Not yet due	2								#NUM!	1451	des-20	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R4	The health board should review the terms of reference of the Health and Safety Group, including confirming who should be in attendance. Attendance of members at the group should be monitored and where a member of the Group is unable to attend, an alternative representative	Terms of Reference for the Health & Safety Group to be drafted and approved, via the Executive Team and Health & Safety Group. Attendance of members of Health & Safety Group to be tracked and monitored.	sep-21			Not yet due	2								#NUM!	1451	des-20	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	Director of Primary, Community and Mental Health		R4	The Health Board should introduce a formal policy which clearly sets out the process of prescribing medicines. This should include the following: • roles and responsibilities • monitoring and reporting arrangements • processes for processing and approving changes	Concise collation of advice for practitioners from professional guidance, and contractual arrangements that they should already be working to, may be a helpful reminder.	apr-18	sep-20	Overdue	3	Partially complete		Medicines Policy has been delayed until January to be approved by Med Safety and Governance Group. The advice will be attached	Chief Pharmacist new in post and needs time to understand/amend governance arrangements to ensure that when Medicines	Reminder, and links, send to HB employed prescribers on GMC advice	sep-20		32	3	des-20	27.03.2019
192001	Deprivation of Liberty Safeguards	Limited	Director of Nursing & Midwifery		R3	The health board should put in place a formal agreement (for example, a Service Level Agreement) with the LA for the services provided by the Powys DoLS Team. This should include: I. clear details of the service provided, including who is responsible/liable for each aspect of the	Agreed.	okt-19		Overdue	3	Partially complete		**19.9.19:** Meeting with DoLS Team manager in PCC scheduled for **27.9.19**. Draft document has been prepared.			1 month		14	1451	des-20	10.07.2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R1	The health board must approve, promote and publish the new Policy and Toolkit. Line Managers should be provided with adequate training in line with the requirements of the 'Stress Management and Wellbeing in the Workplace Policy' on how to identify, manage and where	The Stress Management Policy and Toolkit was approved on October 23rd 2019. It was agreed that the policy and toolkit will be reviewed in 9 months (July 2020) to ensure approaches are current and fit for purpose.	jul-20	sep-20	Overdue	3	Partially complete			Managers Programme has been placed on hold during COVID-19 operations so the Health and Safety Module has not been		Work to resume in Q2.		5	3	des-20	14.11.2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R2	The Occupational Health service has recently upgraded its case file software 'Cohort' which should provide the service with on demand reporting. This should be used to monitor or identify trends with stress related referrals with appropriate action being taken where trends are	The recently upgraded software is due to be able to interface with ESR; this in turn will provide management reports relating to referrals and absence reasons. A stress steering group will be set up that seeks to monitor information, and data.	apr-20		Overdue	3	Partially complete		Bi-directional ESR/Cohort interface not yet progressed and no date confirmed by Medgate. Rapid access available for managers	Bi-directional interface postponed due to Covid-19 priorities	Clinical psychologist working alongside OH Registered Mental Health Nurse in developing on-line Mental Health	Unable to provide date for bi-directional interface at this stage, the work will resume in Q2.		8	1451	des-20	14.11.2019
192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R2	In order to ensure the effective governance of the service, the health board should continue to hold the monthly Facilities Management Team meetings. The health board should also consider producing a standard agenda and method of recording for the local team meetings to ensure	Agree The Department welcomes and accepts the recommendation. We will implement the recommendation to set agendas and record local team meetings in a format that reflects the Facilities Management Team (FMT) meeting.	feb-20	sep-20	Overdue	3	Partially complete		Regular management teams have been suspended during Covid 19 escaltion, as reported to the Board Secretary in March	Covid 19 escalation.	During Covid 19 Escalation there have been thrice weekly briefings between the Assistant Director and his direct reports. FMT	jul-20	Yes	10	3	des-20	
192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R5	We concur with management intentions, that regular spot checks of PADRs should take place to ensure; • all PADRs are completed to the required standard; • all staff are using the correct form to ensure	Agree. The department welcome's the auditor's confirmation that PADR compliance has been sustained at above the health board's target of 80%. The department is happy to confirm our commitment to sustaining and improving	mar-20	sep-20	Overdue	3	Partially complete		Suspended due to Covid 19 escalation.	Covid 19 escalation.	Action has resumed following Covid 19 escalation.	sep-20	Yes	9	3	des-20	
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R1	(a) That the health board progresses its discussions with Welsh Government to ensure all parties are aware of the practical inconsistencies between the historic Welsh Government Hosting Agreement and the reality of the relationship between CHC and the health board, with the aim of agreeing an accepted	(a) and (b) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to	apr-20		Overdue	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments.Awaiting finalised document from WG.		8	1451	des-20	
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to	apr-20		Overdue	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments.Awaiting finalised document from WG.		8	1451	des-20	
192015	Primary Care Clusters	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R5	We recommend that clusters conduct a review of patient information resources and that up to date cluster newsletters and other documents covering cluster service developments and achievements are provided on cluster and health board web pages.	This will be considered by the clusters and factored into their work programme for 2020/21. Prioritisation of this may vary across the 3 clusters and thus the deadline set allows that local flexibility.	sep-20		Overdue	3	No progress							3	1451	des-20	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and	The Executive Directors will develop detailed objectives and actions that will enable the achievement of each of the key priority deliverables within the Organisational Development Framework. For each action there will be action	mar-20	sep-20	Overdue	3	No progress		Objectives and actions aligned to the Framework have been put on hold due to Covid-19	Covid-19 work superseded this piece of work	This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		9	3	des-20	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R2	We recommend that the health board either seek to incorporate all of the OD Strategic Framework priority themes in the health board's existing performance monitoring framework or consider implementing a dedicated framework to manage the delivery of the OD Strategic Framework priority	Agreed Executive Directors will report progress against actions through the following performance monitoring governance mechanisms: • IPR reporting where appropriate	mai-20	des-20	Overdue	3	No progress		Performance reporting aligned to the OD Framework put on hold due to Covid-19	Covid-19 work superseded this piece of work	This will be reviewed as part of the re-introduction of BAU	end of Qtr 3		7	0	des-20	
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	Director of Planning and Performance	Assistant Director of Estates & Property	R6	A lessons learnt exercise should be undertaken in consultation with appropriate parties and reported to Board. (O)	Accepted. As PTHB develops a major project pipeline, it is important that the organisation employs a lessons learned regime. A review will be undertaken of the project at Machynlleth from inception to the point of the FBC resubmission.	sep-20	okt-20	Overdue	3	Partially complete		Lessons learnt framework currently under development	Delayed due to covid	FBC submission date revised due to covid - currently no risk	okt-20		3	2	des-20	
192020	Welsh Risk Pool Claims Management	Substantial	Director of Nursing & Midwifery	Assistant Director Quality & Safety	R1	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.	The recommendation is accepted. Future claims reports will distinguish between new claims, ongoing claims and closed claims from one period to the next.	okt-20		Overdue	3	No progress		The reports scheduled September 2020 onwards will be set out in the described way. This will then enable readers to distinguish	None	Information relating to claims is categorised and recorded to support differentiation between new, ongoing and closed claims.	okt-20		2	1451	des-20	
192022	Outpatients Planned Activity	Reasonable	Director of Primary, Community and Mental Health		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are	mar-21		Not yet due	3	No progress							#NUM!	1451	des-20	26.09.2020

192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R3	The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This should include	The CAF report sets out the RTT position for Powys patients in each of the different providers attended (due to geography) even though the waiting times are different. The waiting time differences are recorded in the public domain.	mar-21		Not yet due	3	Partially complete						#NUM!	1451	des-20	26.09.2020
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R4	Continue to work with the commissioned health boards and trusts in Wales and England to enhance the reporting of commissioning services data to include Powys outpatient follow-up appointments waiting times and to discuss exceptions with them.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	mar-21		Not yet due	3	No progress						#NUM!	1451	des-20	26.09.2020
192023	Estates Assurance Follow Up	Reasonable	Director of Planning and Performance	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		jan-21		Overdue	3	Partially complete		Management Plan updates complete and for formal review by Asbestos Group in January	COVID-19 delays	Changes to Management Plan are well understood by management team with strengthening of structure in place with	jan-21		#NUM!	1451	des-20	26.09.2020
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: the roll of out awareness sessions, keeping records of attendance; increasing the frequency and content of internal communications; and	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to record staff	mar-21		Not yet due	3	No progress						#NUM!	1451	des-20	26.09.2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R1	The deed of variation to the Overarching Agreement requires completion and signing to demonstrate agreement by both the health board and county council of the amendments proposed during 2019/20. The Reablement agreement needs to be brought	There has been an inevitable impact on the signing of 2020/21 S33 Agreements by April 2020, in light of the COVID-19 Pandemic. 2020/21 Agreements will therefore be signed later in the year. PTHB will therefore work towards ensuring	apr-21		Not yet due	3	No progress						#NUM!	1451	des-20	26.09.2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R2	The health board should continue strengthening the arrangements in place to ensure it receives the assurance it needs over the governance of the Section 33 agreements in place. This could be achieved by: working with the county council to establish the	The remit and constitution of JPB will be revisited and will be articulated through the Overarching Agreement Deed of Variation (linked to Finding 1). S33 Oversight by JPB and Board Committees will continue to be strengthened	apr-21		Not yet due	3	No progress							1451	des-20	26.09.2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R3	There is a need for a further final accuracy check of the Section 33 Agreements before they are signed.	A Quality Check process will be established in advance of the signing of agreements.	apr-21		Not yet due	3	No progress							1451	des-20	26.09.2020
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Health & Safety Team	R3	The health board should resume the roll out of health and safety training sessions once practicable, in particular the programme of accredited IOSH Working Safely courses to ensure managers have a full understanding of their roles and responsibilities and those of their employees.	IOSH working safely one day programme will run in conjunction with managers development programme. Programmes scheduled quarterly. Delivery will be through the Health & Safety Team. First course due to commence in October 2021	okt-21		Not yet due	3							#NUM!	1451	des-20	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
															Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
171802	Clinical Audit Programme Follow-Up	Limited	Medical Director		R3	The Clinical Audit Plan should be developed further to show expected completion dates so that any slippage can be identified promptly and where applicable relevant action taken. A clear audit trail should be maintained to record all changes made to the Clinical Audit Programme, along with the	Improved coordination and operational management of the clinical audit programme will (as described above) be encompassed in the work being taken forward by the Interim Medical Director during 2018/19.	sep-18	mar-20	mar-20	Overdue		Partially complete		Monitor progress / compliance against the expected completion dates - At present services to provide an update on progress	None. Audit plans reviewed for directorates	No evident risk	mar-20		27	9	des-20	27.02.2019
171802	Clinical Audit Programme Follow-Up	Limited	Medical Director		R5	The Clinical Audit Plan should be developed further so that consideration of strategic risks and objectives and findings and issues from recent Health Board and National audits can be clearly demonstrated.	Improved governance, co-ordination and operational management of the clinical audit programme will (as described above) be encompassed in the work being taken forward by the Interim Medical Director during 2018/19. As part of this,	sep-18	mar-20	mar-20	Overdue		Partially complete		Clinical audit is an established as a systematic review process with quality improvement at its core. It is important that	None	No evident risk	mar-20		27	9	des-20	27.02.2019
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R1	ICT should consider undertaking a formal ITIL maturity level assessment. They should assess their current level, and a target level formally agreed, where necessary with a plan to reach the level.	Accept recommendation – A full ITIL maturity level assessment will be conducted to review current status in order to assess and plan future target level and actions with timescales to reach set standards.	sep-20			Overdue		No progress							3	1451	des-20	
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R2	Key date information should be added to the register. As a minimum the following dates should be included: when added; when last reviewed; when next due for review; expected resolution.	Accept recommendation – Key dates will be added to the problem register to ensure adequate management and tracking of problems.	feb-20			Overdue		No progress							10	1451	des-20	
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R3	All subjective terms should be replaced with clearly defined number ranges.	Accept recommendation – A review of incident categorisation terminology to be considered and a framework to support decision making will be agreed and implemented.	jun-20			Overdue		No progress							6	1451	des-20	
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and IT		R2	The health board should investigate options for the implementation of an electronic referral management system as a replacement for the manual activities that currently cover the processes from initial patient referral up to booking of a patient's outpatient appointment into WPAS. This	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. Booking systems are automated and PTHB	mar-21			Not yet due		No progress							#NUM!	1451	des-20	26.09.2020
202104	Annual Quality Statement	Not Rated	Director of Nursing & Midwifery		R1	The Patient Experience Steering Group (or equivalent group focusing on patient experience) should continue to be considered as the editorial forum for the AQS, with AQS being a standing agenda item. It is important that this group receives adequate support to focus on the production of the	1. The AQS will a standing agenda item in the patient experience steering group from this point forward, and continue to be so in any further iteration of the group, for as long as the AQS is required of the health board.	okt-20			Overdue									2	1451	des-20	

PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
181951	Structured Assessment 2018	Board Secretary		R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	okt-19	mar-21		Deadline Revised	2	No progress		To be taken forward in Q2.	Delayed in light of COVID-19	Clinical and Stakeholder engagement is undertaken via other means	31-mar.-21	
181951	Structured Assessment 2018	Board Secretary		R4	The Health Board's internet pages do not provide access to current policies such as the counter fraud policy. The Health Board should update its internet site to provide easy access to current policies and strategies.	The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	okt-19	mar-21		Deadline Revised	2	Partially complete		The Policy Management Framework is under development	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	31-mar.-21	
192051	Structured Assessment 2019	Board Secretary		R2	Board committees were restructured and streamlined in 2019. The Health Board should evaluate the whole of the new committee structure to ensure that decision making, assurance and scrutiny are appropriate and that mental health, information governance and workforce have sufficient coverage in the new committees.	The Board will undertake a self-assessment of its effectiveness at a development session in February 2020. In addition, the Board's Committees will undertake a self-assessment of effectiveness, respectively, during Q4 of 2019/20. This work will inform the annual review of Terms of Reference and	apr-20	mar-21		Deadline Revised	2	Partially complete		The Board had scheduled its annual self-assessment and reflection to take place in April 2020 (to include consideration of the	COVID-19	In its absence, implementation of the Board Development Plan will continue into its second year to support improved	mar-21	
202152	Structured Assessment 2020	Board Secretary		17	The Health Board's legacy website had a form to enable members of the public to raise questions of the Board in advance of board meetings. This form is no longer available on the new website. Given little use was made of the facility, the Health Board is considering how to improve its engagement with the public in its Board meetings in future.	To be considered in-line with the roll out of live streaming of board and committee meetings.					2							
202152	Structured Assessment 2020	Board Secretary		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	• Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.					2							
202152	Structured Assessment 2020	Board Secretary		31	The Board is under pressure because it holds two Independent Member vacancies, while the Chair and five experienced Independent Members are due to step down during the next two years. The Public Appointments process was suspended during the pandemic but is scheduled to resume in October. To support the Board during this period of transition, one	• 2 x Independent Member Vacancies out to advert, via public Appointments. Interviews scheduled for January 2020. • Induction Programme to be developed, linked with National Programme (via Public Bodies Unit)					2							
202152	Structured Assessment 2020	Board Secretary		46	In 2019, we reported that the Performance and Resources Committee was unable to provide detailed scrutiny of the most up-to-date financial position prior to board meetings and recommended the schedule of meetings was reviewed to ensure the timing of meetings supports effective detailed scrutiny. While the Health Board's aspiration is for the	• Linked to 2019 Structured Assessment Actions and Update. Business Cycle to be reviewed, recognising the impact of COVID-19 during 2020.					2							

No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
14	#NUM!	des-20	
14	#NUM!	des-20	
8	#NUM!	des-20	

PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
181951	Structured Assessment 2018	Board Secretary		R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	jun-19	mar-21		Deadline Revised	3	Partially complete		Report templates and masterclasses for senior managers will be delivered in Q2.	COVID-19 arrangements have taken priority over this work.		31-mar.-21	
192051	Structured Assessment 2019	Director of Workforce & OD and Support Services		R3	The All Wales Attendance at Work Policy was recently implemented with the delivery plan developed in partnership with Trade Unions. The Health Board should evaluate and report on how the change in approach is working in practice for staff and managers.	A review will be undertaken in partnership with Trade Unions to assess the impact of the All Wales Policy in its implementation.	sep-20			Not yet due	3	Partially complete		Union representative has been identified to work on PULSE survey.	COVID-19 work took priority.	WOD and Trade Unions held regular meetings during COVID-19 to discuss workforce issues.	The work will re-assume in Q2.	
202152	Structured Assessment 2020	Director of Workforce & OD and Support Services		30	The Medical Director retired after the first phase of the pandemic with appropriate interim arrangements secured until a permanent successor can be recruited.	• Recruitment process underway.					3							
202152	Structured Assessment 2020	Director of Therapies & Health Sciences		44	The Health Board is undertaking a programme of work to refresh its patient experience framework as part of the improving clinical quality assurance framework.	• Linked to 2019 Structured Assessment actions. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.				Overdue	3	No progress						

No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
18	#NUM!	des-20	
3	1451	des-20	

PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
181951	Structured Assessment 2018	Director of Finance, Information and IT		R7	The Health Board should review and update the Standing Financial Instructions given that the last update was in 2016.	The Standing Financial Instructions will be reviewed and approved during 2019/20	nov-19	okt-20	nov-19	Deadline Revised		Partially complete		This is currently being undertaken on a national basis. The Head of Financial Services is part of this review. The initial	Awaiting work from All wales Group.	Existing SFIs in place remain fit for purpose until reviewsed documentation issued.	Dependent on All Wales nature of review. Estimated date of Oct '20 included pending further updates from All Wales project.	
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT		I1	Implement mandatory counter-fraud training for some or all staff groups.	Implementation of mandatory counter fraud training would be seen as gold standard in terms of assisting to develop a counter fraud culture within the Health Board. There are a range of options from face to face delivery of training to mandatory counter fraud e-learning. Mandatory learning could apply for all or	mar-21											
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT		I2	Consider the Local Counter-Fraud Specialist capacity required to resource required levels of proactive and investigative work, including staff training, and build in resilience to the team.	Whilst increased capacity is accepted to lead to greater impact and return within Counter Fraud work, economies of scale have yet to be explored in detail. A more dynamic, joined up approach to counter fraud work across Health Boards could lead to better resilience and improved preventative												
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT		I3	Implement consistency in the recording and monitoring of economic fraud risk in line with the Health Board's risk management policy and strategy.	Fraud risk will be managed in line with the Health Board's risk management framework; utilising established policy, procedure and systems. This will enable effective management of risk by the risk owners with specialist support from the Counter Fraud Team.	aug-20											
202152	Structured Assessment 2020	Director of Nursing & Midwifery		41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received six formal	• Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.												
202152	Structured Assessment 2020	Medical Director		42	Progress has been slow in addressing weaknesses for both clinical audit and mortality reviews, although these areas are currently the focus of attention.	• Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.												
202152	Structured Assessment 2020	Director of Nursing & Midwifery		43	The Health Board has a process for responding to national Patient Safety Alerts and Notices. A review of the system for implementation is underway and will be revised as necessary.	• Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.												
202152	Structured Assessment 2020	Director of Finance & IT		52	At month 5, it estimated a shortfall in savings of around £3.9 million because of the ongoing response to COVID-19 and has revised its savings target down to £1.8 million. The Health Board indicates that this figure could reduce further depending on the outcome of subsequent reviews. By the end of August, it had delivered £55,000 of savings with more than £1.2 million	• Efficiency Framework to be implemented • Routine reported to Performance & Resources Committee and Board												
202152	Structured Assessment 2020	Director of Finance & IT		58	The Health Board updated its Budgetary Control Procedure in line with Internal Audit recommendations. One of the key changes included clarifying timescales on the publication of the annual letter of accountability to principle budget holders given problems with timely sign off by executive officers in recent years. The 2020- 21 accountability letters were ready in	• Linked to 2019 Structured Assessment actions and update. • To be progressed in Q3/4, 2020/21, recognising the impact of COVID-19.												

No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
13	2	des-20	
		des-20	
		des-20	
		des-20	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

Audit, Risk and Assurance Committee	**Date of Meeting: 26 January 2021**
Subject :	**Final Report for Losses and Special Payments for the period 1st April 2020 to 31st October 2020**
Approved and Presented by:	Director of Finance & ICT
Prepared by:	Head of Financial Services and Assistant Director, Quality and Safety
Other Committees and meetings considered at:	None

PURPOSE:

To NOTE the Interim Report of Losses and Special Payments for the period 1st April 2020 to 31st October 2020.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

It is recommended that the Audit, Risk and Assurance Committee NOTE this Interim Report on Losses and Special payments covering the period 1st April 2020 to 31st October 2020.

Ratification	Discussion	Information
	✓	

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

EXECUTIVE SUMMARY:

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

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

DETAILED BACKGROUND AND ASSESSMENT:

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

The Audit Risk and Assurance Committee received an Annual report at its 8th September 2020 meeting documenting Losses and Special payments made between the period 1st April 2019 to 31st March 2020.

This paper provides an interim report for the period 1st April 2020 to 31st October 2020.

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

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

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery (the Chief Executive prior to the appointment of the substantive Executive Director of Nursing). All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. The Executive Team received an update on a case by case basis for the period October 2019 – March 2020 and April 2020 – July 2020 at the Executive Committee on 9th September 2020. A summary position on overall open cases was provided to Quality Governance Committee and Experience, Quality & Safety Committee in November/ December 2020.
- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2020 to 31 October 2020, the THB made payments in respect of 4 cases totalling £155,570.00 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year the THB received no reimbursements in respect of cases that exceeded the £25,000 THB liability.

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

	No. of payments/Receipts	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	9	5	£155,570.00
Total	**9**	**5**	**£155,570.00**

There were no receipts from Welsh Risk Pool in respect of Clinical Negligence and Personal Injury cases over 25k during 1st April 2020 to 31st October 2020.

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 15 open which are inclusive of clinical negligence and personal injury claims with one case transferring from a potential claim during quarter 3, with NWSSP Legal and Risk Services instructed to act on behalf of the health board. The health board currently have less than 5 personal injury cases being managed by NWSSP Legal and Risk Services.

Redress (Putting Things Right)

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

Details of the payments made during 1st April 2020 to 31st October 2020 are included in **Appendix Aii.**

	No. of payments/receipts	No. of cases	£
Redress Payments	9	6	£6,670.00
Total	**9**	**6**	**£6,670.00**

Details of the receipts in 2020/21 from Welsh Risk Pool in respect of reimbursements for Redress are included in **Appendix Aii.**

There are currently 20 open redress cases at variable stages, namely:

- 2 cases submitted to the Welsh Risk Pool for reimbursement of finance
- 5 cases discussed at November redress panel and actions progressing
- 4 cases awaiting expert reports
- 3 cases avoidable pressure damage, with one report scheduled for the next redress panel
- 6 cases at various stages of review

There have been no reimbursements to date during 2020/21, but the outcome is awaited of the two cases submitted for consideration in quarter 3, December 2020.

Other Special Payments

Details of the payments are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
Other Special Payments	2	2	£727.92
Total	**2**	**2**	**£727.92**

Benchmarking of cases

The Committee at a previous meeting requested that there is a benchmark of Powys Cases against other health boards.

NWSSP Legal and Risk Services have completed an impact and reach report to give an update on the services they provide, which includes All Wales data regards an analysis of caseload activity for clinical negligence matters by Health Board & Trust at February 2020 (page 29) which is extracted for reference in Attachment B. The report can be found at 2.8c Impact and Reach Report 2020 final QSC 18 November 2020.pdf (cwmtafmorgannwg.wales)
At the health board's quarterly clinical negligence case review meeting 17 November 2020, a request was made for benchmarking data going forward.

Following feedback from the previous Audit, Risk and Assurance Committee meeting discussion took place with Legal & Risk Services in November 2020 regards costs paid out in respect of clinical negligence claims. Legal and Risk Services review,

negotiate and advise on costs on a regular basis with the aim of reducing costs wherever they can to reduce the financial impact on the NHS, and use costs draftsman to provide advice on cases as necessary. Where fixed costs are in place for redress cases, these are non-negotiable and have been agreed at an All Wales level. Whereas clinical negligence compensation claims related costs can be negotiated, this is more challenging where costs are reasonable and also where a patient/ claimant has taken out an insurance policy which attracts a fixed premium. Mediation is used where appropriate to come to an early settlement on claims.

Conclusion

The Audit, Risk and Assurance Committee is asked to note the above interim report for 2020/21 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiii
Benchmarking data regarding NHS Wales organisations is attached at Appendix B

NEXT STEPS:

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

Appendix Ai

Losses And Special Payments for 2020-21 Financial Year					Appendix Ai	
1st April 2020 to 31st October 2020						
Claim Type	Payment Type	Laspar Reference	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Damages	176C4MN0001	Apr-20	£117,477.00		Damages in full and final settlement of claim.
Clinical Negligence	Claimant Costs	176C4MN0001	May-20	£20,000.00	£137,477.00	Payment on account of costs. Work progressing to settle costs.
Clinical Negligence	Defence Costs	176C4MN0002	May-20	£255.00	£255.00	Witness summons fee. Claim since struck out.
Clinical Negligence	CRU	206C4MN0003	Jul-20	£4,998.00		
Clinical Negligence	Claimant Costs	206C4MN0003	Jul-20	£5,425.00		
Clinical Negligence	CRU	206C4MN0003	Sep-20	£4,165.00	£14,588.00	Matter progressing to closure.
Clinical Negligence	Claimant Costs	206C4MN0005	Jul-20	£2,500.00		
Clinical Negligence	Damages	206C4MN0005	Jul-20	£750.00	£3,250.00	Matter progressing to closure
		TOTAL		£155,570.00	£155,570.00	

Appendix Aii

Redress Losses And Special Payments for 2020-21 Financial Year

Appendix Aii

1st April 2020 to 31st October 2020

Payment Date	Redress Reference	Laspar Reference	Nature of Payment	Amount
Aug-20	3940	216C4MN0002	Defence Costs	£300.00
Jul-20	3925	206C4MN0007	Defence Costs	£1,050.00
Oct-20	3154	196C4MN0003	Defence Costs	£150.00
Jul-20	3154	196C4MN0003	Claimant Costs	£1,600.00
Jul-20	3154	196C4MN0003	Damages	£1,500.00
Jun-20	3492	196C4MN0012	Defence Costs	£360.00
Oct-20	3492	196C4MN0012	Defence Costs	£360.00
Jun-20	4083	216C4MN0001	Damages	£750.00
Oct-20	4165	216C4MN0010	Damages	£600.00
			Total	**£6,670.00**

Reimbursements from Welsh Risk Pool

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

Appendix Aiii

Other Losses And Special Payments for 2020-21 Financial Year

1st April 2020 to 31st October 2020

Appendix Aiii

Payment Date	Laspar Reference	Nature of Reimbursement	Amount
Apr-20	216C4EG0001	Payment in response to Ombudsman Complaint	£250.00
Sep-20	216C4EG0002	Payment to Staff Member in respect of costs incurred	£477.92
		Total	**£727.92**

Appendix B

Analysis of caseload activity for clinical negligence matters by Health Board & Trust at February 2020

2019/20	SBU	BCU	AB	CTM	HD	C&V	Powys	WAST	Velindre	PHW	Grand Total
Opening Month 1	360	342	318	215	265	239	13	27	4	10	**1793**
Closing Mth 12	311	318	297	229	212	246	12	29	7	13	1674
Movement	**-49**	**-24**	**-21**	**14**	**-53**	**7**	**-1**	**2**	**3**	**3**	**119**
Total opened 2019/2020	75	107	89	76	41	109	5	13	3	6	**524**
Total closed 2019/2020	-124	-131	-110	-62	-94	-102	-6	-11	0	-3	**-643**

2018/19	ABMU	BCU	AB	CTM	HD	C&V	Powys	WAST	Velindre	PHW	Grand Total
Opening Month 1	423	397	331	255	297	286	16	22	8	13	2048
Closing Month 12	360	342	318	215	265	239	13	27	4	10	1793
Movement	**-63**	**-55**	**-13**	**-40**	**-32**	**-47**	**-3**	**5**	**-4**	**-3**	**-255**
Total opened 2018/2019	104	67	83	37	55	74	3	8	2	3	436
Total closed 2018/2019	-167	-122	-96	-77	-87	-121	-6	-3	-6	-6	-691

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

INTERNAL AUDIT PROGRESS REPORT 2020/21

Powys Teaching Health Board

January Audit Committee

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents

1. INTRODUCTION

1.1 The purpose of this report is to inform the Committee of progress with the 2020/21 Internal Audit Plan as recorded at January 2021.

1.2 Appendix A details the 2020/21 Audit plan and shows the status of work to date. At the time of this report, progress against the Plan is as follows:

Number of audits finalised	10
Number of audits issued at draft	1
Number of audits in progress	5
Number of audits not started	4
Year-end reporting	2
Total number of audits in 2020/21 plan	**22**

2. OUTCOMES FROM COMPLETED REVIEWS

2.1 Since the November meeting of the Committee, three reviews have been finalised. These are included in the table below along with the allocated assurance rating where applicable. The full versions of these reports are included in the committee's papers as separate items.

Review	Assurance rating
Partnership governance – programmes interface	Limited
Access to primary care – GP contract monitoring	Substantial
Capital systems	Substantial

3. DELIVERY OF THE 2020/21 AUDIT PLAN

Full details are available at Appendix A.

3.1 The following report has been issued as draft and awaiting management response.

Review
IM&T control and risk assessment

3.2 The following audit reviews are currently in progress:

Audit Review	Objective overview
Progress against regional plans - Clinical Futures	The overall objective of this review is to carry out an assessment of the health board's engagement with and contribution to progressing the Clinical Futures initiative.
Cancer services	The review will assess the effectiveness of the structure in place to provide an assurance that cancer patients are receiving the best possible service. We will include both provider and commissioned cancer services.
Safeguarding during Covid-19	An assessment of the THB's safeguarding processes during the Covid period and lessons learned.
Winter pressures and flow management	The review will assess the winter 2020/21 planning process with regard to patient flow; and provide assurance over the management of patient flow in provided and commissioned services over the winter 2020/21 period.
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.

4. PROPOSED CHANGES TO REVISED 2020/21 PLAN

4.1 Due to the impact of the pandemic, management has requested that the following reviews are deferred to 2021/22:

- Concerns tracking/monitoring assurance
- Breathe well programme
- Theatres utilisation

4.2 In discussion with management, we have agreed to include the following reviews in quarter 4 of our 2020/21 plan. These are in addition to the current revised approved plan:

- Safeguarding during Covid-19
- Digital solutions

4.3 Further to discussion with management, we are proposing to shift the emphasis of the 'delayed transfers of care' review to focus on 'winter pressures and flow management'.

5. ENGAGEMENT

5.1 Board and sub committees attended and meetings held during the reporting period:

Board/Sub Committee:

- N/A

5.2 Health board internal meetings:

- Carol Shillabeer, CEO – 26 January
- Vivienne Harpwood, Chair – 7 December
- Rani Mallison, Board Secretary – 14 January

5.3 Wales Audit Office Meetings:

- Dave Thomas / Elaine Matthews – N/A

5.4 Health Inspectorate Wales Meetings:

- Rebecca Collier – N/A

In addition to the above, the usual meetings with Executive Directors to discuss individual audit reviews.

6. POST AUDIT SURVEYS

6.1 Following the completion of each audit report, we issue a feedback survey to the Executive lead/key contact. Feedback is important as it helps us to improve our service and allows us to deal with any issues. We have issued six feedback forms recently and received three responses.

6.2 We encourage auditees to take the opportunity to feedback on their experience, as this will allow us to consider improvements to the way we work.

7. PLANNING 2021/2022

7.1 Discussions are being held with the Accountable Officer, Executive Directors and the Board Secretary to inform a draft of the 2021/2022 Audit Plan. We have arranged to discuss the draft with Independent Members prior to finalisation. The plan will be presented to the March Audit Committee meeting for approval.

8. RECOMMENDATION

8.1 The Audit Committee is invited to:

- agree the proposals at section 4 above; and
- note progress with the 2020/21 plan.

Planned output	Outline timing	Start of field work	End of field work	Draft report issued	Mgt response received	Final report issued	Assurance	Planned Audit Committee	Status
Corporate governance, risk management and regulatory compliance									
Head of Internal Audit Opinion & Annual Report	Q4								Year end
Annual Governance Statement	Q4								Year end
Health & Safety follow up	Q4	09/06	07/08	20/08	15/09	17/09	Reasonable	November	Final
Generic follow up of 'limited' assurance reports (Risk Management and Board Assurance, Welsh Language Standards Implementation, Care and Nursing Homes governance, DoLS / Best Interest Assessments and Freedom of Information.)	Q4								
Strategic planning, performance management and reporting									
Progress against regional plans • Future fit • Clinical futures – effect on South Powys	Q3								In progress
Partnership governance – programmes interface	Q2	2/11	11/12	16/12			Limited	January	Final
Section 33 governance arrangements follow up	Q1	08/06	09/06	17/06	18/06	18/06	Reasonable	June	Final
Financial governance and management									
Covid-19 governance review	Q2	22/06	30/07	06/08	N/A	01/09	N/A	September	Final
Clinical governance, quality and safety									

Planned output	Outline timing	Start of field work	End of field work	Draft report issued	Mgt response received	Final report issued	Assurance	Planned Audit Committee	Status
Annual Quality Statement	Q1	07/09	22/09	23/09	28/09	05/10	N/A	November	Final
Concerns tracking/monitoring assurance	Q4								Proposal to defer to 21/22
Breathe well programme (appropriate use of oxygen)	Q2								Proposal to defer to 21/22
Cancer services	Q3								In progress
Safeguarding during Covid-19	Q4								
Information governance and I.T. security									
IM&T control and risk assessment	Q2							March	Draft issued
Records management follow up	Q4								
Digital solutions	Q4								
Operational service and functional management									
Winter pressures and flow management	Q4								In progress
Access to primary care – GP contract	Q3	08/10	02/12	15/12	18/12	18/12	Substantial	January	Final
Theatres utilisation	Q2								Proposal to defer to 21/22
Workforce management									
Grievance policy	Q4								

Planned output	Outline timing	Start of field work	End of field work	Draft report issued	Mgt response received	Final report issued	Assurance	Planned Audit Committee	Status
Advanced Practice Framework	Q2	09/09	25/09	02/10	19/10	20/10	N/A	November	Briefing paper issued
Capital and estates management									
Environmental sustainability	Q2	18/05	01/09	18/08	28/08	01/09	N/A	September	Final
Fire safety	Q3	13/08	02/10	06/10	21/10	23/10	Limited	November	Final
Machynlleth Hospital, Primary & Community Care Project	Q3	N/A	N/A	N/A	N/A	N/A	N/A		Approval to defer to 2021/22 plan
Capital Systems	Q3	12/11	04/01	04/01	13/01	13/01	Substantial	January	Final issued
Control of contractors	Q2								Approval to defer to 2021/22 plan
Llandrindod Wells	Q1-Q4								In progress

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	7 out of 7	80%	v>20%	10%<v< 20%	v<10%
*Report turnaround: time taken for management response to draft report [15 days]	●	5 out of 6	80%	v>20%	10%<v< 20%	v<10%
*Report turnaround: time from management response to issue of final report [10 days]	●	6 out of 6	80%	v>20%	10%<v< 20%	v<10%

Correct at 31/12/21

*

■ Within agreed timescales ■ Less than 5 days over agreed timescale ■ More than 5 days over agreed timescale

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.

Office details:

Audit and Assurance,
Cwmbran House,
Mamhilad Park Estate,
Pontypool,
NP4 0XS

Audit & Assurance,
Hafren Ward,
Bronllys,
Powys,
LD3 0LS

Contact details

Helen Higgs (Head of Internal Audit) – helen.higgs@wales.nhs.uk
01495 300846

Capital Systems

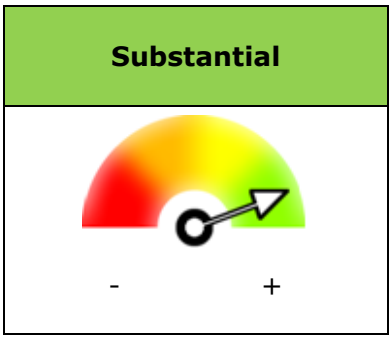
Final Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services



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Review reference:	SSU_PTHB_2021_01
Report status:	Final
Fieldwork commencement:	12 November 2020
Fieldwork completion:	4 January 2021
Draft report issued:	9 December 2020
Draft report meeting:	10 December 2020
Updated draft report issued:	4 January 2021
Proposed final report issued:	11 January 2021
Management response received:	13 January 2021
Final report issued:	13 January 2021
Auditor/s:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign off	Hayley Thomas, Director of Planning & Performance
Distribution	Wayne Tannahill, Associate Director of Estates & Property Louise Morris, Head of Capital Rani Mallinson, Board Secretary
Committee	Audit, Risk & Assurance Committee

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.

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.

1. Introduction and Background

This audit was commissioned in order to evaluate the processes and procedures operating within Powys Teaching Health Board (the THB) that support the management and control of capital projects.

The capital systems review applies a cyclical audit approach, assessing different stages of the project lifecycle annually, against both national and local guidance (see **Appendix B**). The focus during 2020/21 was on project feasibility, initiation, project management controls and the appointment of external advisers.

The projects reviewed as a part of the audit testing were selected from the 2019/20 and 2020/21 capital programmes, with agreement by management, included:

- Ynys y Plant, Newtown;
- Montgomery County Infirmary (MCI), Windows;
- Machynlleth Hospital, Ward Improvements;
- Pan-Powys, Building Management System (BMS);
- Bronllys Hospital, L Ward Palliative Care Suite; and
- Brecon War Memorial (BWM) Hospital, Gardens.

Noting the impact of Covid-19, the delivery of this assignment included an increased element of remote working.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the THB's systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

An objective of the audit was to evaluate the systems and controls in place within the THB, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage were appropriately managed.

Accordingly, the scope and remit of the audit included the following (as relevant to the size/complexity of the sampled projects):

- **Project Feasibility and Approval:** appropriate preparation, scrutiny and approval of the required business case/approval documentation;
- **Project Initiation –** development of the project brief, governance arrangements, including key roles and responsibilities and formulation of project groups;

- **Scheme Management:** preparation of appropriate project management tools, including the project execution plan, programme, management control plan, reporting mechanisms etc.
- **Appointments:** appropriate selection and appointment of the appropriate advisers.

3. Associated Risks

The potential risks considered in the review were as follows:

- Inappropriate planning and approval processes result in a lack of adequate control;
- Poor project governance and management arrangements put the objectives of the project at risk;
- Poor procurement approaches result in poor value for money and potentially put the interests of the THB at risk.

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 THB has developed comprehensive Capital Procedures, supported by a Capital Booklet ('the Booklet') containing relevant forms to be completed when managing projects. The Capital Procedures and the Booklet had been utilised as key reference points at each of the projects reviewed, and were clearly embedded within the day-to-day project management function.

The majority of key project controls had been applied at the sample reviewed, however the following issues were noted:

- The change control procedure established within the Capital Procedures requires review and updating to provide clarity on its application, improved controls and delegated authorities; and
- An appropriate audit trail needs to be maintained, at the individual project files, to demonstrate the appointment of advisers.

Additional areas for enhancement have been recommended in respect of:

- The completion of Management Control Plans at all projects; and

- The inclusion of Professional Indemnity Insurance within the required suite of advisor insurances defined in the Fee Bid document.

Against the context of the matters detailed above, the overall level of assurance has been determined as **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	Feasibility & Approval				✓
2	Project Initiation				✓
3	Scheme Management				✓
4	Appointments				✓

** 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 **1** issue that is classified as weaknesses in the system control/design for capital systems.

Operation of System/Controls

The findings from the audit have highlighted **3** issues that are classified as weaknesses in the operation of the designed system/control for capital systems.

6. Summary of Audit Findings

The key audit findings are reported within the Management Action Plan (**Appendix A**); with full audit findings, specific to each project reviewed, reported in **Appendix C**.

In summary, six projects were reviewed at this audit, as follows:

- Discretionary capital: 4 projects, ranging in value from £47k to £147k;
- Estates compliance: 1 project, £145k in value; and
- Charitable funding: 1 project, initially £53k in value, rising to £88k.

The Capital Procedures are relevant to all THB staff involved in the planning, procurement and delivery of projects or equipment with a value over £5k. Project controls are defined for major (above £500k), capital (£50k and £500k) and minor (£5k to £50k) schemes. Application of the procedures for both minor and capital schemes has been considered at this review.

Project Feasibility & Approval

That there was appropriate preparation, scrutiny and approval of the required business case/approval documentation.

The Capital Procedures define the approval routes for the various project types, including (with relevance to this review) discretionary capital, estates compliance and charitable funding.

Recognising the low value of the projects reviewed, i.e. under £500k, formal business cases were not required.

At discretionary capital projects, below the threshold of £500k, Capital Procedures require completion of a Project Request Form (PRF). These had been correctly prepared at the four discretionary capital projects reviewed, with scrutiny and approval, including increases to initial estimates, appropriately demonstrated at the Capital Control Group (CCG).

Estates compliance projects do not require PRFs. Instead, funding is prioritised from Highlight Reports submitted by each compliance specialism, demonstrating the risks faced at each compliance area, with prioritisation and funding approval discussed and agreed at the Estates Compliance Group. Whilst noting that minutes had not been retained to document issues discussed at this forum, an appropriate audit trail setting out the subsequent agreed funding allocations has been evidenced.

At the date of the initiation of the Charitable Funded project reviewed (July 2018), such capital projects were approved by the Charitable Funds Committee rather than the CCG. Management advised that a lessons learned exercise undertaken post completion of the sampled project has led to initial scrutiny and approval at CCG of Charitable Funded projects, to enable consistency in management across the capital programme.

All projects reviewed had received overall scrutiny and approval at relevant committee / group level (e.g. Finance, Planning & Performance Committee / Innovative Environment Group), with ratification at Board level, via the annual approval process of the Capital Programme.

Recognising that appropriate controls are operating within the requirements of the Capital Procedures, **substantial assurance** has been determined in this area.

Project Initiation

That an appropriate project brief was developed; and appropriate governance arrangements were established including key roles and responsibilities and project groups.

The Outline Approval form (CP1.0) provides confirmation that the project has been fully approved to proceed to design, and incorporates acceptance by the key officers assigned to the project (Senior Responsible Officer (SRO), Project Director (PD) and Internal Project Manager (IPM)). The form was appropriately applied and signed at each project examined.

Recognising the value of the projects reviewed formal project boards were not required. Liaison between the PD and IPM was appropriately demonstrated via fortnightly Capital Team meetings, at which IPMs presented progress updates to the PD, and with key risks/issues formally recorded. Output from these meetings was reported to the CCG.

The Initial Brief (CP1.1) is required at all projects to define project requirements and form the basis of cost estimates for subsequent design development, and should be agreed by the client to confirm it meets their service requirements as defined in the PRF. The form had been completed at all projects reviewed.

Noting the sound controls operating, **substantial assurance** has been determined in this area.

Scheme Management

That appropriate project management tools have been prepared, including the project execution plan, programme, management control plan, reporting mechanisms etc.

The Capital Procedures define the requirements for the application of project management tools (subject to project financial thresholds).

Inconsistencies were observed in the application of procedural requirements (ref **Appendix C**) i.e. some forms had been completed even where not required by the Capital Procedures. Recognising this does not pose an issue of non-compliance, a recommendation has not been raised. Discussions with management have, however, highlighted the need to review the stages of scheme management, as subsequent projects progress, and consider any inconsistencies / inefficiencies in the current approach.

The Capital Procedures require a Management Control Plan to be in place at every project. However, this was not in place at one of the six projects reviewed (BWM Gardens). Delays in obtaining client decisions at this project may have benefited from the earlier agreement of key project timescales/deadlines (**recommendation 1**).

The change control processes required by the Capital Procedures lacked clarity; and inconsistent application at the sampled projects was observed e.g. at changes which take the project over budget and changes within the project budget.

Best practice noted at other Health Boards includes the use of change control forms at all changes (within or outside of original budget allocations) which enables the effective monitoring of project contingency and control of project scope/objectives (**recommendation 2**).

Recognising the need for clarification and improved consistency in this area, **substantial assurance** has been determined.

Appointments

That there has been appropriate selection and appointment of the advisers.

The Capital Procedures do not specify the requirements for adviser appointments, other than to confirm that all procurements must be made in line with the THB's Standing Financial Instructions (SFIs).

The review of sampled project files, demonstrated a lack of audit trail at the selection and appointment of external advisers. Management subsequently confirmed the appointment processes; demonstrating SFI compliance. A recommendation has been made aimed at improving record retention and demonstrating how respective appointments had been enacted (**recommendation 3**).

The Capital team issue Fee Bid documents to advisers at the initial communication stage. Included in the document is the statement that, if successful, a minimum level of in-date insurance will need to be demonstrated, prior to appointment. Not all insurance documents were available for review with some being at the date of the audit rather than date of appointment; also, Professional Indemnity Insurance is not a stated requirement in the Fee Bid document **(recommendation 4)**

Recognising the improvements required in centralised record keeping, by project, of adviser appointments, **substantial assurance** has been determined.

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
Number of recommendations raised	-	-	4	**4**

Finding 1: Scheme Management – Management Control Plan	Risk
The Capital Procedures require that: *"The Internal Project Manager/ Design and Construction Project Manager will produce a Management Control Plan in the form of a Gantt Chart for construction based schemes subject to the complexity. These will be updated at each stage of the project process."* Management Control Plans were in place at five of the six projects reviewed; the exception being the BWM Gardens project where only a construction programme was in place. Noting the low value of this project (initially £53k), and that the scope and value of the project only increased following the securing of additional funding, coupled with the existence of the construction programme, this appears to be an exception to otherwise robust practice. However, delays experienced at this project in terms of client decision making, may have been better controlled with agreed deadlines in place, and such a plan would also be a useful tool when assessing lessons learnt.	Lack of clarity over key project milestones / deadlines, may risk delays in the achievement of project objectives.
Recommendation 1	**Priority level**
Management Control Plans should be prepared for all projects, in accordance with the Capital Procedures and shared with relevant parties (e.g. the client) to enable cooperation towards achieving set deadlines (**O**).	**Low**

Management Response	Responsible Officer/ Deadline
Agreed. Whilst the aforementioned project commenced outside of the management of the Capital Team, it is acknowledged that all capital projects require a Management Control Plan.	Head of Capital With immediate effect

Finding 2: Scheme Management – Change Control	Risk
Section 2.6 of the Capital Procedures state that: *Where a change has a financial impact a change control form (CP2.5A) needs to be completed.* *If an additional expenditure of <10%, up to a maximum of £25,000, is required then the approval of the Senior Responsible Owner (SRO) is a mandatory requirement. Above these limits formal CCG sign off must be obtained."* Review of the Capital Booklets for the projects sampled identified the following financial changes:	Project changes may not be appropriately scrutinised and approved. Risk of projects exceeding their allocated budget if changes are not managed effectively.

Project	Number of financial changes (and value)		CP2.5A completed?
Ynys Y Plant	1	£3.6k	No
MCI Windows	2	£2.8k; £220	No
Machynlleth Ward Improvements	-	-	-
BMS	4	£69k; £18k; £15k; £3k	Yes; but only for £69k and £15k
BWM Gardens	2	£35k; £6k	Yes

However, for the nine changes identified, only three CP2.5A forms had been completed. These forms were for changes which would take the projects over budget; and each had been appropriately approved by the SRO and CCG [and the Charitable Funds Committee in the case of BWM Gardens]

Management confirmed that they viewed the purpose of the change control form only for changes that take projects over budget. Any changes which could be managed within budget did not need to be recorded in this manner, and were to be managed by the Internal Project Manager (as also set out in their respective job descriptions). The narrative of the Capital Procedures [Change Control] does not support this view; and it also does not provide any guidance on the responsibility/delegated authority of the Internal Project Manager.	
Recommendation 2	**Priority level**
The change control process defined within the Capital Procedures should be reviewed and clarified to ensure it reflects actual process and is not left open to interpretation (**D**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Associate Director of Estates & Property June 2021

Finding 3: Adviser Appointments	Risk
The Capital Procedures do not specify the requirements for adviser appointments, other than to confirm that all procurement exercises must comply with the THB's Standing Financial Instructions (SFIs). On review of sampled project files, there was a lack of audit trail demonstrating the selection and appointment of advisers. Management subsequently confirmed the appointment processes, including appointment letters; demonstrating SFI compliance. All appointments made at the projects reviewed were below the £5k competitive quotation threshold required by the SFIs. The Capital Booklet form CP4.2 (Approval to Award Contract), had only been completed for the main construction contracts (excepting the L Ward Palliative Care project, where the Approval to Award Contract form was completed for the adviser appointments also). The Capital team issue a 'fee bid' document to prospective advisers setting out key information i.e. project background, proposed consultant appointments, scope of quotation/fee bid and outline proposals/specification information. Included in the narrative is the statement: *"Please be advised that if successful, the following minimum levels of insurance will be required for the duration of the commission - not less than £5m Public Liability Insurance and not less than £10m Employers Liability Insurance. A copy*	Lack of audit trail to support compliance with SFIs.

of your in-date insurances will be required prior to any commission appointment being progressed." Of the projects sampled, most insurance documents were made available (ref ***Appendix C*** for full audit findings); however, some were at the current date rather than the date of appointment. Further, some advisers provided details of their Professional Indemnity Insurance. It is therefore recommended that the fee-bid document is updated accordingly.	
Recommendations 3 & 4	**Priority level**
3. Project files should include a clear audit trail of all adviser appointments, including: • how the advisers had been selected (e.g. from a 'select list' or via competitive quotation exercise); • requests for quotations etc.; • quotations received (where applicable); • copies of insurance certificates obtained at the date of appointment; and • appointment letters / purchase orders. Form CP4.2, or similar, could be used to summarise each appointment (**O**).	**Low**
4. The 'fee-bid' document should be updated to include Professional Indemnity Insurance for submission prior to appointment (**O**).	**Low**

Management Response		Responsible Officer/ Deadline
3.	Agreed. A summary of the information will be included in the respective capital files. However, it is recognised that the Capital team have mitigating controls in place for review of appointments through the monthly meetings held with NWSSP: Procurement; quarterly reports regarding use of individual contractors; and the annual Procurement report.	Head of Capital February 2021
4.	Agreed. The fee-bid document will be updated accordingly.	Head of Capital February 2021

Proposed Cyclical Approach (Indicative):

Financial Year	Proposed Capital Systems Coverage
2020/21	**Feasibility / Approval stage** Areas of coverage may include: • Use of the appropriate bid proforma / business case dependent on funding stream required • Appropriate scrutiny and approval arrangements based on the above routes **Initiation Phase** • Allocation of reference numbers and completion of Outline Approval Form • Initiation of project governance arrangements, including key appointments and establishment of the project board • Development of the initial/outline brief **Scheme Management** • Project Execution Plan • Cost control forms • Risk management arrangements • Management control plan • Issues log • Change control arrangements **Advisers** • Appointment of appropriate advisers • Use of frameworks, local tender arrangements, call of contracts as appropriate • Formalisation of appointments
2021/22	**Scheme Development stage** Areas of coverage may include: • Development of the design brief. The requirements of the end user are developed by consultation and reviewed by the User Representatives to confirm that the design brief accurately reflects their needs. They will be asked to sign off the design brief along with any documented changes. As the design brief is developed, the Project Director must be fully aware of the developing cost estimate and any possible trade-offs which may have to be made between quality, capital costs and future running costs, all of which may affect the viability of the project. • Detailed design and pre-tender estimate. At the end of the Detailed Design stage the design proposals will be reviewed by the User Representatives and assigned specialist champions and signed-off once agreed. Once the final design has been completed and signed off (using CP3.2 Pre-Tender

Financial Year	Proposed Capital Systems Coverage
	Scheme Sign Off) and the Cost Manager has produced the pre-tender estimate, the Scheme can proceed to Tender stage. If at any time the pre-tender estimated cost should exceed the existing approved budget then the design must be revised to identify savings and modified accordingly. If savings can only be achieved by affecting quality and/or delivery of the project outside of the agreed timescale then the Senior Responsible Owner should be informed immediately. If it is not possible to make savings, then the Senior Responsible Owner must either: • Seek the re-approval for the outline approval form business case and secure additional funds, or • Close the scheme.

2022/23	**Procurement**
	
	Areas of coverage may include:
	
	• A procurement strategy has been considered at the inception of the scheme
	• Compliance with the stated rules in respect of contracts under £25,000, over £25,000 and over the OJEU threshold
	• Compliance with the stated rules in respect of procurement of equipment
	• Single Tender Action/Waivers
	• All staff involved in the evaluation of tenders to complete a Declaration of Interest
	• Financial vetting to be undertaken by NWSSP Procurement on request from Estates.
	• Technical vetting to be undertaken by Estates where necessary
	• Recommendation to the Project Director to award the contract
	• Notification letters issued to successful/unsuccessful tenderers
	• Full cost of scheme updated in the Outline Approval Form / Business Case
	• If tender is over the allocated budget, the SRO must either
	  • Seek the re-approval for the Outline Approval form or Business Case and secure additional fund via the change control process (form CP2.5A),
	  • Close the scheme.

2023/24	**Construction Phase & Completion** Areas of coverage may include: • Pre-start meeting held • Changes pre-start to be approved • Cost Control spreadsheet prepared and maintained

Financial Year	Proposed Capital Systems Coverage
	• Processing of capital payments: contract payment certificates, final account certificates, fee account invoices, equipment invoices • Practical completion process including snagging/defects schedule, agreement of defects period, dates for handover of O&M manuals, H&S File etc. • Completion of Estates Handover Form • Final account produced and agreed, including deductions for liquidated damages • Release of retention monies • End of defects period certification • Post project evaluation and reviews completed
2024/25	**Operational Commissioning** Areas of coverage may include: • The Project Director through the Internal Project Manager shall ensure that appropriate commissioning plans are developed and enacted as required for the type and scale of the Project. • Proposals may be required for the transfer of staff, possible redeployment of staff and also a recruitment strategy. • The Project Director, will consider, in conjunction with the Service Liaison or Communications Officer, the mechanism to obtain appropriate publicity. Staff must be kept informed about and involved in the development of the new facility. • Equipping strategy should be in place – specification and timely procurement of equipment is critical to the successful implementation of a capital project • Completion of Estates Handover Form • It is vital at this stage that all relevant information such as drawings, schematics, assets, risk assessments, maintenance contracts etc. are updated to ensure that the new facility can be maintained correctly to ensure that the design lifespan and statutory compliance is achieved. **Post Project Evaluation & Benefits** • For schemes under £500k, a Contractor Evaluation will be carried out within 1 month of scheme completion after end of defects period; • For schemes over £500k, a more in depth post project evaluation 4-6 months after the new facility has been commissioned.

Summary of audit findings

The information below represents an overall summary of key areas reviewed – supporting documentation in each category was also checked, with issues noted in the main body of the report where applicable.

Project	Project Type	Value	Feasibility/Approval		Initiation			Scheme Management				Adviser Appointment	
			Project request[1]	Approval[3]	Roles	Project Board[4]	Initial Brief[5]	Risk Register[6]	MCP[7]	Issues Log [8]	Change Control	SFI Compliance	Insurance[10]
C002 Ynys Y Plant	Discretionary	£116k	Y	Y	Y	Y	Y	n/a	Y	Y	See [9]	Y	N: current documents rather than date of appointment
C007 MCI Windows	Discretionary	£66k	Y	Y	Y	Y	Y	n/a	Y	Y	See [9]	Y	-
C113 Machynlleth Ward Improvements	Discretionary	£47k	Y	Y	Y	Y	Y	n/a	Y	Y	See [9]	Y	N: current documents rather than date of appointment
C902 L Ward Palliative Care	Discretionary	£147k	Y	Y	Y	Y	Y	n/a	Y	Y	See [9]	Y	Y
C756a BMS (Phase 1)	Compliance	£145k	Y	**N**	Y	Y	Y	n/a	Y	Y	See [9]	Y	Y
C909 BWM Gardens	Charitable	£53k + £35k	Part[2]	Y	Y	Y	Y	n/a	**N**	Y	See [9]	Y	Y

Notes

[1] At Discretionary Schemes, to be demonstrated via submission of a Project Request Form. At Compliance schemes, by completion of a Highlight Report.

[2] A PRF was completed for one element of the scheme, but not the other.

[3] To be demonstrated as follows:

- Initial scrutiny/approval at Capital Control Group (Discretionary Schemes), at Compliance Group (Compliance Schemes) or approval at the Charitable Funds Committee (for charitable funded schemes).
- Annual capital programme sign-off at Board level.

[4] There was no requirement for a formal project board at any of the projects reviewed. Evidence of regular liaison between the Project Director and Internal Project Managers was demonstrated in each case.

[5] Project Initiation Documents are required at projects over £50k, with a generic PID acceptable up to £500k. Whilst not required by the Capital Procedures, based on the values, project specific PIDs were evidenced at all of the projects reviewed.

[6] Whilst there was no requirement for risk registers to be completed at any of the schemes, based on their value, registers were in fact in place at 5 of the schemes.

[7] As per the Capital Procedures, Management Control Plans are required at all projects.

[8] Any changes / issues should be identified by the Internal Project Manager who can then report it to the appropriate stakeholder or Project Director for approval (using CP2.5). This is achieved through discussion with the Project Director at the fortnightly Capital Team meetings.

[9] There is a lack of clarity at the Capital Procedures as to the requirement for internal change control sign-off. Management are operating on the basis that this process is only required where changes take the project outside its approved budget. Where this was the case at the sample reviewed, forms had been appropriately completed and approved at CCG. However, forms had not been completed for lower value changes, which may still require formal review. A recommendation has been raised that the position be reviewed.

[10] The THB's Fee Bid document sets out the requirement for return of insurance certificates prior to appointment.

Appendix D: 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

GP Access Standards

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership
Audit and Assurance Services

CONTENTS

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Executive sign off:	Jamie Marchant, Director of Primary, Community & Mental Health Services
Distribution:	Jayne Lawrence, Assistant Director of Primary Care
Committee:	Audit, Risk & Assurance Committee Performance & Resources Committee

ACKNOWLEDGEMENT

Thank you to management and staff for the time given to us and for their cooperation while we carried out this review.

We conform to all Public Sector Internal Audit Standards.

Validated through an external quality assessment undertaken by the Institute of Internal Auditors.

Please note:

We have prepared this audit report in line with the Service Strategy and Terms of Reference approved by the Audit Committee. It is for internal use only.

We address our reports to the Independent Members or officers, including those designated as Accountable Officer, for the use of Powys Teaching Health Board only. Our staff members have no responsibility to any director, officer or third party in their individual capacity.

Executive Summary

Purpose

To provide assurance that Powys Teaching Health Board (the health board) is progressing work to support GP practices to comply with the Access Standards (the Standards).

Our assessment considers the impact of Covid-19 on the arrangements in place.

Limitation of scope

The assurance provided is over the health board's work around the Standards, which do not fully address all issues relating to GP access.

Overview of findings

The health board has:

- engaged well with its GP practices;
- provided support to enable them to identify and implement access improvements in line with the Standards; and
- enabled their practices to achieve a high level of compliance with the Standards in advance of the March 2021 deadline.

No significant issues for reporting were identified in our review.

Matters arising concern areas for refinement and further development.

Report classification

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low** impact on residual risk exposure.	N/a – area not audited previously

Summary of matters arising

	High	Medium	Low
Control design	-	-	1
Operation	-	-	-
Total	**-**	**-**	**1**

Matters arising

1	GP access reporting	Design	Low

Assurance summary

Objectives		Assurance
1	The health board has an appropriate governance and reporting structure over the monitoring of GMS contract performance, in particular with regard to the Access Standards	Substantial
2	The health board has engaged and supported GP practices in identifying and implementing improvements required to meet the Standards, as per the health board's 2020/21-2022/23 IMTP	Substantial
3	The health board monitors progress against implementing the above improvements and compliance with the Standards. There is escalation of issues to highlight non-compliance and identify areas of support to assist GP practices to address these issues where necessary	Substantial

Limitations of scope

This review covered the Access Standards for 'in hours' GP services only. The following areas were excluded from the scope:

- wider GP practice performance monitoring, including further aspects of GP access usually monitored through the Annual Returns and the Quality Assurance and Improvement Framework (all stood down due to the Covid-19 pandemic);
- Out of Hours GP services; and
- other aspects of primary care, including prescribing and mental health services.

Note: The GP Access Standards do not currently address all issues relating to GP access. Therefore, the substantial assurance given over the health board's work with regard to the GP Access Standards does not translate to substantial assurance over GP access within Powys, which was out of scope for this review.

Risks

The key risks considered in the review were potential patient harm or poor patient experience arising from non-compliance with the Access Standards.

1. Background

1.1 Audit Wales undertook a review of primary care across all Welsh health boards, publishing the health board's individual report in December 2018 and a national report in October 2019. This identified that steps were being taken to improve and strengthen primary care, but that change needed to happen at a greater pace and scale to ensure services are future fit.

1.2 In March 2019, the Minister for Health & Social Care announced a set of Access Standards aligned with the 2019/20 General Medical Services (GMS) Contract Wales. Detailed guidance was released in September 2019. Supported by health boards, Welsh Government expect all GP practices across Wales to meet these Standards by March 2021 – this requirement remains in place in spite of Covid-19. Practice participation in meeting the Standards is not a contractual requirement, although all Powys GP practices are committed to achieving them.

1.3 Whilst GP contract performance monitoring and reporting was relaxed by Welsh Government during March-September 2020 to support the Covid-19 pandemic response, improvement work and monitoring around the Access Standards was still required.

1.4 The Standards provide requirements for GP practices in terms of minimum expectations relating to access, including an increased digital offering. They focus predominantly on phone systems, information sharing and appointment systems. As stated in its 2020/21-23 Integrated Medium Term Plan, the health board is also engaged in wider initiatives (which are out of scope for this audit) that will have an impact on GP access such as:

- plans for the development of primary care base on 'A Healthier Wales' and the National Primary Care Model for Wales;
- the Pacesetter programme. involving work around multi-disciplinary teams working at a cluster level;
- working with partners across primary, community health and social care to identify improvement and design/test care pathways;
- monitoring of practice sustainability through the health board's Sustainability Toolkit; and
- addressing issues around recruitment of GPs through the establishment of a Primary Care Workforce Group and plans to attract more GPs to the county.

1.5 The current Access Standards only partially cover matters relating to access to GP practices and, therefore, the related improvements implemented by practices will not fully address the wider access picture. Our review of concerns and complaints about GP access showed that the number received remained consistent before and after the practices had implemented the identified improvements.

1.6 Our audit focused on the health board's work to support GP practices to comply with the Standards. As such, the assurance provided can only be taken in the context of the areas covered by the Access Standards and cannot be applied to the wider work around GP access.

1.7 Welsh Government's approach to the Standards is incremental and work is currently ongoing to further develop and expand the Standards for 2021-2023. To achieve this, Welsh Government has engaged the health boards and practices across Wales and Powys Teaching Health Board is seeking to use this opportunity to ensure the Standards appropriately address wider access issues. To this end, the health board is refining its GP Access Patient Survey in conjunction with its GP practices (through the Access Forum – see paragraph 2.4) to help gain further insight into access issues within Powys and identify areas to incorporate into the updated Standards.

1.8 As with most organisations, Covid-19 has changed the way in which GP practices operate, with triage systems and virtual services being put in place. We understand that the practices are feeling the benefits of these new processes. However, the Community Health Council has stressed the importance of public consultation if these processes are to be implemented on a permanent basis.

2. Detailed Audit Findings

2.1 We identified one **low** priority matter arising. This is highlighted further in paragraphs 2.21 and 2.22 and fully detailed in Appendix A.

Governance & reporting structure over GMS contract performance

2.2 The governance and reporting structure over the monitoring of GMS contract performance, including the Access Standards, is clearly documented in the GMS Commissioning Assurance Framework (CAF), which was approved by the Executive Strategic Planning & Commissioning Committee (a subgroup of the Executive Committee) in May 2019. As a new CAF for the health board, the GMS CAF is subject to refinement and development as it is implemented.

2.3 Covering five key areas (access to care, quality & safety, finance & activity, patient experience and governance & strategic change), the GMS CAF includes frequent monitoring of GMS contract performance at bi-monthly GMS Contract Monitoring meetings and with individual GP practices (triennial meetings as standard, more frequently if performance issues are identified). As the GMS CAF and Access Standards are focused on GP practice performance, they not routinely discussed at Cluster meetings, although significant issues or items of interest may be raised.

2.4 The GMS CAF has clear lines of escalation up to Board level, ultimately reporting by exception to the Performance & Resources Committee via the Executive Delivery & Performance Group (DPG, a subgroup of the Executive Committee) if significant issues are identified.

2.5 In line with the Standards, the health board established an Access Forum in December 2019. The purpose of the Access Forum is to:

- oversee the improvement work related to the Standards;
- provide engagement with, and support for, its GP practices; and
- monitor compliance with the Standards.

2.6 The Standards also require the Access Forum to report quarterly to the health board on its work. Whilst this requirement was stood down by Welsh Government during the initial Covid-19 response, the Assistant Director of Primary Care continued to provide updates to the DPG and PRC (see paragraphs 2.19-2.20).

2.7 The health board commenced collection of data for the GMS CAF for the first time in late 2019. However, due to the Covid-19 pandemic and standing down of GP contract performance monitoring and reporting, no formal reporting has taken place. Additionally, the health board has been unable to take forward the planned development and refinement of the GMS CAF. We understand that performance monitoring and, therefore, the GMS CAF have been stood back up from October 2020 and that the Primary Care team is continuing to develop and refine the process.

2.8 During this period, the Access Forum continued to meet virtually and to fulfil its duties as described above (see also paragraphs 2.10-2.11), providing an appropriate mechanism for monitoring and reporting on the Standards despite other performance mechanisms being stood down.

Matters arising:

2.9 No matters were identified for reporting under this objective.

Engaging and supporting GP practices around the Standards

2.10 The health board engaged with its GP practices on the Access Standards. This was achieved through the Access Forum meetings, attendance at the Powys Practice Managers' Forum (owned and run by the Practice Managers) and through discussions with individual practices where necessary.

2.11 Membership of the Access Forum includes representation from the health board, clusters, GP Practice Managers, Community Health Council and Local Medical Council.

2.12 As the Standards are not enforceable (see paragraph 1.2), each GP practice was individually responsible for developing their own improvement plans in line with the Standards, with the health board required to undertake a supportive role. The health board provided this support through:

- undertaking a baseline assessment for each GP practice against the Standards to assist with identifying areas for improvement;
- the Access Forum, which, in particular, was used to discuss the baseline assessment, develop a consistent pan-Powys GP access survey and discuss and help resolve issues, including around the bilingual phone message; and
- direct contact with individual GP practices where needed.

2.13 As part of our review, we met with the three Practice Manager Cluster Representatives from the Access Forum to discuss their views on the engagement and support from the health board around the Standards. They were unanimous in confirming:

- the health board has provided good engagement and support its GP practices;
- the Access Forum has been an effective part of this process;
- the Powys GP practices have a good, two-way relationship with the health board's Primary Care team; and
- GP practices are able to have constructive conversations with the Assistant Director of Primary Care – they felt listened to and that the differences between the Powys practices are understood.

Matters arising:

2.14 No matters were identified for reporting under this objective.

Monitoring progress against, and compliance with, the Standards

2.15 NWIS has developed a National Access Standards Portal (the Portal), allowing GP practices to submit their compliance information on a quarterly basis. The Portal went live for the first required submission in September 2020 (this element of monitoring was also stood down during the initial Covid-19 response).

2.16 For quarters 1-3, practices are only required to identify whether they have or haven't complied with each element of each standard. For the quarter 4 submission, they are required to provide evidence to support their assertions and the health board is required to provide assurance over compliance through validating the evidence provided.

2.17 To support the quarter 4 evidence submission and assurance process, we understand that:

- the National Access Standards Group (upon which the health boards Assistant Director of Primary Care sits) will develop an All Wales approach to the evidence required and the assurance process (this was delayed by the Covid-19 pandemic but work is now starting again); and
- NWIS is further developing the Portal to allow practices to upload the required evidence.

2.18 The Access Forum continued to meet virtually throughout the Covid-19 pandemic. It discussed compliance with the Standards as reported at March 2020 and was due to discuss the September 2020 submissions in its next meeting.

2.19 The requirement for quarterly reporting on the Standards was stood down in the initial pandemic response, restarting from October 2020 onwards. In spite of this, the Assistant Director of Primary Care continued to provide update and monitoring reports to the DPG and PRC.

2.20 The October 2020 PRC report on the Access Standards identified significant improvements in practice compliance at March 2020 compared to the October 2019 baseline assessment (see table below) and highlighted the remaining areas of non-compliance, outlining the reasons behind them.

Standard	October 2019	March 2020
Group 1		
1. Phone system capability	38%	88%
2. 90% of calls answered within 2 minutes	44%	94%
3. Bilingual telephone message	25%	100%
4. Use of My Health Online for appointments and repeat prescriptions	19%	100%
5. Email facility for patients to make appointments	25%	75%
Group 2		
6. Information sharing on practice processes	6%	100%
7. Appointment systems (triage, same day, pre-bookable)	75%	100%
8. Patient survey and demand & capacity audit	0%	100%

Note: March 2020 compliance was based upon assertions made by GP practices which, due to Covid-19, were not validated by the health board in line with Welsh Government guidance.

Matters arising:

Full details of the below matters can be seen in the related matters arising in Appendix A.

2.21 Due to the standing down of GP contract performance monitoring and reporting, the health board was not in a position to tangibly demonstrate how the Access Standards fit in to the access to care element of the GMS CAF. As noted in paragraphs 1.4-1.6, the current Access Standards do not fully cover all GP access related issues. The health board should ensure that its GMS CAF covers those issues not directly addressed by the Standards (MA1).

2.22 The health board's reporting and monitoring of the Access Standards to date has been proportionate to the requirements of the Standards and has ensured a good position to demonstrate compliance by March 2021. Going forward, the health board may be able to improve efficiency in the reporting process by incorporating it into existing mechanisms, for example, the Integrated Performance Report (MA1).

Appendix A: Matters Arising and Management Action Plan

Matter Arising 1: GP access reporting (Design)	Low priority
The health board commenced collection of data for the GMS CAF for the first time in late 2019, following its approval earlier in the year. However, due to the Covid-19 pandemic and standing down of GP contract performance monitoring and reporting, no formal reporting has taken place. As a result, the health board was not in a position to tangibly demonstrate how the Access Standards fit into the access to care element of the GMS CAF. The Access Standards do not fully cover all GP access related issues. Whilst the health board is seeking to influence the development of the Standards for 2021-2023, it is possible that there may be access issues that remain unaddressed in the updated Standards. The health board's reporting on the Access Standards to date has been proportionate to the requirements of the Standards. Regular monitoring through the Access Forum has ensured the health board and its GP practices are in a strong position to demonstrate compliance by March 2021. Going forward, the health board could improve efficiency in the Access Standards reporting process by incorporating this reporting into its business as usual reporting mechanisms, for example, the Integrated Performance Report, rather than producing standalone reports. *Note: the priority rating of this finding is considered low in the context of the scope of this report, which concerns the health board's work around the Access Standards. This does not reflect the importance of this finding in the monitoring of wider GP access issues and GMS contract performance.*	Potential risk of: • GP access issues not being identified and addressed on a timely basis; and • patient harm or poor patient experience; and • inefficiencies within the reporting process.

Recommendations
1.1 The health board should ensure that its GMS CAF covers GP access issues that are not addressed by the current and updated Access Standards.
1.2 From March 2021 onwards, the health board should consider incorporating reporting on the Access Standards into its business as usual reporting mechanisms.

Management response	Responsible individual	Target date
1.1 The GMS CAF incorporates wider assurance on Access and pulls together various strands to provide holistic access assurance. The CAF includes the Access Standards, practice opening	Assistant Director of Primary Care	March 2021

Matter Arising 1: GP access reporting (Design)		Low priority
hours, appointment availability and times, open/closed lists and practice recruitment issues. Reporting on these areas within the GMS CAF will be in place by March 2021.		
1.2 Annual reporting against the Access Standards and their achievement will continue as a defined standalone report, reported to the appropriate PTHB Executive Committee. Consideration of the mechanism for quarterly reporting within usual PTHB reporting mechanisms such as the Integrated Performance Report will be progressed in readiness for reporting from April 2021.	Assistant Director of Primary Care	March 2021

Appendix B: Audit Opinion and Priority Ratings

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitably designed and applied effectively:

 **Substantial assurance** – Few matters require attention and are compliance or advisory in nature. **Low** impact on residual risk exposure.

 **Reasonable assurance** – Some matters require management attention in control design or compliance. **Low to moderate** impact on residual risk exposure until resolved.

 **Limited assurance** – Significant matters require management attention. **Moderate** impact on residual risk exposure until resolved.

 **No assurance** – Action is required to address the whole control framework in this area. **High** impact on residual risk exposure until resolved.

McLellan,Holly
01/22/2021 14:57:06

Prioritisation of Recommendations

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

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

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Office details

Mamhilad Office
Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS

Swansea Office
Audit and Assurance
Matrix House
Northern Boulevard, Matrix Park
Swansea Enterprise Park
Swansea
SA6 8BX

Contact details

Helen Higgs (Head of Internal Audit) – 01495 300846 / helen.higgs@wales.nhs.uk
Osian Lloyd (Deputy Head of Internal Audit) – 01495 300843 / osian.lloyd@wales.nhs.uk
Emma Rees (Audit Manager) – 01495 300845 / emma.rees13@wales.nhs.uk

Partnership Governance – Programmes Interface

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Rani Mallison, Board Secretary Hayley Thomas, Director of Planning & Performance Jamie Marchant, Director of Primary, Community & Mental Health Services
Distribution:	Joy Garfitt, Assistant Director for Mental Health Services

	Louisa Kerr, Head of Mental Health Operations Freda Lacey, Partnership Manager
Committee:	Audit Committee Mental Health Planning & Delivery Partnership Board Regional Partnership Board Experience, Quality & 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

The Social Services and Well-being (Wales) Act 2014 makes provision for partnership arrangements between local authorities and local health boards to carry out identified specified health and social services functions, and will be managed through the establishment of regional partnership boards (RPBs) as set out in the Partnership Arrangements (Wales) Regulations 2015.

Effective partnership working arrangements requires strong governance and performance management. There should be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population.

We have focused on the *Live Well: Mental Health* partnership as a tracer for the review. The partnership is in place to drive forward the implementation of the *Hearts and Minds: Together for Mental Health* strategy for improving the mental health and emotional wellbeing of the people of Powys.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Weaknesses were brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The review has considered how Powys Teaching Health Board ('the health board') ensures effective interface of partnership programmes through the RPB and sought to provide assurance that:

- there is a robust partnership governance framework in place which is aligned to the health board's strategic aims;
- roles, responsibilities and statutory obligations are clearly defined, monitored and complied with;
- arrangements are in place to ensure the effective management of funding allocation;
- performance measures are in place to ensure delivery of the scheme and are monitored and reported to the Regional Partnership Board; and
- the health board is provided with assurance that the partnership is operating effectively to achieve the objectives set out within the framework.

The impact of the Covid-19 pandemic has been taken into consideration in our assessment of the appropriateness of the arrangements in place.

3. Associated Risks

The key risk considered in the review is that partnerships are ineffective resulting in wasted resources and failure to deliver strategic objectives.

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.

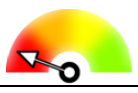
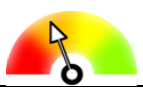
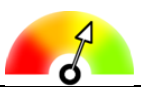
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Partnership Governance is **Limited** assurance.

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	Partnership Governance Framework		✓		
2	Roles & Responsibilities		✓		

					
3	Management of ICF			✓	
4	Performance Monitoring & Reporting		✓		
5	Assurance Reporting		✓		

** 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 five issues that are classified as weakness in the system control/design for Partnership Governance.

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 Partnership Governance.

6. Summary of Audit Findings

Our review has focused on the partnership governance arrangements in place within the Live Well: Mental Health partnership and is not an assessment of the effectiveness of the partnership or the performance of the Mental Health service.

Terms of reference for the Powys RPB state that it is supported by a series of Partnership Groups responsible for the delivery of the Health & Care Strategy and addressing RPB priorities. However, there is no partnership governance framework in place setting out the arrangements for monitoring partnership activity within the health board, and a central record of partnerships is not maintained.

The purpose and overall responsibility of the Live Well: Mental Health partnership is set out within the terms of reference for the Mental Health Planning & Delivery Partnership (MHPDP) Board. However, the specific responsibilities of partner organisations in the delivery of the Hearts & Minds: Together for Mental Health delivery plan are not clear. Furthermore, the arrangements for monitoring implementation of the delivery plan and reporting assurance to the MHPDP Board and subsequently the RPB are not

documented, and there is no evidence that monitoring and reporting is taking place in practice.

Reports reviewed provide a narrative summary of activity in relation to the Live Well: Mental Health partnership, but no indication of progress in implementing the delivery plan. Performance of the Mental Health service as a whole is reported to the health board via the integrated performance report. The measures for Mental Health services are all RAG rated green, although it is difficult to assess the extent to which the Live Well: Mental Health partnership has contributed to this.

7. Detailed Audit findings

Objective 1: there is a robust partnership governance framework in place which is aligned to the health board's strategic aims

Partnership Governance Framework

A partnership governance framework is designed to assist organisations in determining:

- when a partnership is appropriate
- the arrangements for entering a partnership
- appropriate governance arrangements for a partnership
- the arrangements for review and evaluation of partnership activity to ensure that performance is monitored and intended outcomes are achieved

Frameworks for specific partnerships should set out the governance arrangements, define the roles and responsibilities of partner organisations, set out the arrangements for decision making, dispute resolution, managing risk and reporting on activity of the partnership. We have seen examples of such frameworks in other NHS bodies. Previous internal audit reviews also note that the health board operates an equivalent framework for Section 33 agreements.

Terms of reference for the RPB state that it is supported by a series of Partnership Groups responsible for the delivery of the Health & Care Strategy and addressing RPB priorities. However, there is no partnership governance framework in place within the health board, either as an overarching general guidance document or specifically in relation to the Live Well: Mental Health Partnership.

Furthermore, a central record of partnerships is not maintained. This would ensure that the health board maintains oversight of all partnerships in which

it is engaged, and facilitate monitoring and reporting arrangements in respect of partnership activity.

The Board Secretary advised that the Board recognises the need for the development of a partnership governance strategy and central register of partnerships, but the impact of Covid-19 has delayed progress.

See Finding 1 at Appendix A

Live Well: Mental Health Partnership - Alignment to the Integrated Medium Term Plan (IMTP)

The ten-year vision for health and care in Powys is set out in the Health & Care Strategy for Powys, published in March 2017. The strategy seeks to enable children and young people to 'Start Well', for people to 'Live Well' and for older people to 'Age Well' through focus on well-being, early help and support, the big four health challenges and joined up care.

The Powys Wellbeing Assessment identified mental health as one of four main causes (referred to as 'The Big Four') of ill health and premature mortality in Powys. Tackling 'The Big Four' is one of eight wellbeing objectives defined in the Health Board's 2020-23 IMTP 'A Healthy Caring Powys'.

Hearts and Minds: Together for Mental Health is the strategy for improving mental health and emotional wellbeing of the people of Powys. The *Live Well: Mental Health* partnership is responsible for the implementation of the strategy through a detailed delivery plan.

The mental health priorities set out within the IMTP include delivery of the *Together for Mental Health* Strategy and engagement with stakeholders to develop sustainable models of care.

Objective 2: roles, responsibilities and statutory obligations are clearly defined, monitored and complied with

In the absence of a partnership governance framework document, the Assistant Director for Mental Health Services advised that the roles and responsibilities are embedded within the RPB governance structure. Partner organisations are not delivering anything over and above their existing statutory duties, but engage on how these will be delivered. Additional, joint activities are funded through the Integrated Care Fund (ICF) – this is covered in more detail under Objective 3 below.

The RPB is supported by a series of partnership groups responsible for the delivery of the Health & Care Strategy and addressing RPB priorities. These groups report progress to the RPB on a regular basis to highlight achievements or escalate issues of risk or concern. For mental health this

is the *Live Well: Mental Health* partnership, also known as the Mental Health Planning & Delivery Partnership Board (MHPDP Board).

The purpose of the *Live Well: Mental Health* partnership is to deliver the Powys *Hearts and Minds: Together for Mental Health* strategy and supporting delivery plan, developed in response to the Welsh Government's *Together for Mental Health* strategy and delivery plan. Responsibilities of the partnership as a whole are set out within the terms of reference for the MHPDP Board and include reviewing the progress of specific plans contained within the Together for Mental Health strategy.

The most recent delivery plan (dated 2017) covers the period 2016-2019. Publication of the Welsh Government delivery plan for 2020 was delayed from February to October 2020 due to Covid-19 and the next local delivery plan is expected to be in place by March 2021.

The 2017 delivery plan follows a standard Welsh Government template and categorises actions according to responsible partners:

- Health board and partner actions
- Health board specific actions
- Local authority specific actions
- Local Partnership Board actions
- Public Health Wales actions

Actions are high level and linked to other projects, plans and schemes. We were advised that further detail is included within the specific projects/plans/schemes that support the delivery plan actions, and relevant individuals would be able to answer queries and provide explanations needed. However, there is no central coordinated oversight of these. The delivery plan does not clearly or consistently identify the lead officer(s) responsible for delivery, the arrangements for monitoring implementation or reporting assurance on progress.

An example to illustrate this point is section 1.2 of the delivery plan *("to prevent and reduce suicide and self harm in Wales"*) which has the following health board and partner action: *"working with PHW, local authorities and third sector, implement the Talk to Me 2 action plan by March 2019"*. It is not clear from the delivery plan which departments/officers within each partner organisation are responsible for implementation of the *Talk to Me 2* action plan or how and where progress will be monitored and reported. The Head of Mental Health Operations assured that relevant individuals involved in the partnership and supporting projects/plans/schemes are aware of these arrangements, but acknowledged that there is lack of central oversight.

See Finding 2 in Appendix A

Escalation Arrangements

Review of the terms of reference for the MHPDP Board confirm that the partnership is a co-operative arrangement ensuring the effectiveness of joint planning and working arrangements. Each partner retains their existing accountability and the partnership does not have the power to direct partner organisations. Should any substantial area of difference arise between the partners, the joint Chairs (the Director of Primary, Community & Mental Health Services for PTHB and Director of Social Services for Powys County Council (PCC)) will attempt to reach a solution, with escalation to the Chief Executives of the lead partners where necessary. Members are responsible for appropriate participation in prioritisation and resource allocation processes within each agency, including corporate planning processes.

The Assistant Director for Mental Health Services advised that there have been no instances of partners not delivering their roles and responsibilities under the partnership, but if this did occur it would be resolved and escalated where appropriate in accordance with the arrangements set out within the terms of reference.

Audit Wales also reported generally good partnership working between the health board, council and third sector in their 2018/19 review of the Integrated Care Fund. This involved a survey of RPB members which received very positive responses in terms of whether partner organisations demonstrate a commitment to partnership working.

Objective 3: arrangements are in place to ensure the effective management of funding allocations

There is no dedicated budget for the Live Well: Mental Health partnership. Integrated Care Fund (ICF) monies are allocated to each RPB by Welsh Government. The Cross Cutting & Resource Overview Group (CCROG) is a subgroup of the RPB responsible for allocating funds to each scheme which are then approved by the RPB.

There is one scheme under the Live Well: Mental Health partnership – South Powys Dementia Home Treatment Team (DHTT) being delivered by the health board and Powys Association of Voluntary Organisations (PAVO). The funding allocation for 2020/21 is £267,000 – a £6,000 shortfall from the revenue requirement identified in the project proposal document. The Finance Business Partner advised that project overspends have to be absorbed by the lead partner organisation – in this case the health board - if ICF slippage monies don't become available at year end.

ICF funds are managed by the health board. The scheme has its own cost centre and budget holder, with a budget aligned to the project proposal document. Expenditure is recharged to the central ICF cost centre managed by the Finance Business Partner. We were advised that the majority of expenditure is pay-related, with a small amount of non-pay spend for PPE and office equipment.

Budget Monitoring & Reporting

Budget monitoring is in line with health board processes - budget holders have access to budget reports via QlikView, which enables drilldown to the granular income and expenditure detail.

Bi-monthly ICF revenue updates are prepared and presented to CCROG by the RPB Co-ordinator (PCC). At the last meeting in November 2020 it was reported that cumulative Q1 & Q2 spend for the DHTT scheme was £133,902 (50% spend against budget) and the DHTT scheme is on track and RAG rated green: "*admissions into the inpatient wards have reduced along with some length of stays due to the DHTT interventions in supporting earlier discharges*".

CCROG reports to the RPB by the RPB Co-ordinator (PCC) on the use of ICF funds in the form of a narrative update on ICF as a whole rather than broken down by scheme. Quarterly reports are also submitted to Welsh Government providing a breakdown of spend by scheme.

ICF Project Evaluative Review

In August 2020 the RPB requested an evaluative review of ICF projects be undertaken. The initial phase of the review was due for completion in late October to provide context to inform decision making on ICF funding in 2021/22. A second piece of work will be undertaken in January 2021 to identify learning from the initial evaluative review, and a final phase to develop a report identifying the evaluation requirements that would be expected for the future commissioning of similar services or funding of ICF projects.

A report was presented to CCROG in November 2020 outlining the evaluative reviews that had taken place and where possible, the extent to which projects delivered against their objectives. The impact of COVID has been considered and reflected in the evaluative reviews. A questionnaire was developed and uploaded to an online platform for project leads to complete. However, the report notes that the DHTT response as pending.

Audit Wales Review of the Integrated Care Fund

In July 2019 Audit Wales published the national report Integrated Care Fund. A supplementary report for Powys Regional Partnership Board followed in September 2019, which identified a number of areas where Powys RPB could improve upon at a regional level, including:

- ensure there is no unallocated funding within future revenue investment plans;
- ensure underspends are allocated efficiently and effectively in-year; and
- develop mechanisms for reporting back to individual organisations in a more consistent way.

We have not sought to assess progress in addressing the areas for improvement.

Objective 4: arrangements are in place to ensure delivery of the scheme is monitored and reported to the Regional Partnership Board

Mental Health Planning & Delivery Partnership Board and Performance Subgroup

The purpose of the Live Well: Mental Health partnership, as set out within the terms of reference for the MHPDP, is to support and review progress in implementing the agreed outcomes within the *Health & Care Strategy* for mental health, and the local delivery plan for the *Powys Hearts & Minds: Together for Mental Health* strategy. The MHPDP Board reports directly to the RPB.

Minutes of the MHPDP Board were reviewed to establish whether there is good representation and attendance by the key partner organisations including the health board, Powys County Council, Powys Association of Voluntary Organisations and Dyfed Powys Police.

Meetings are jointly chaired by the Director of Primary, Community & Mental Health Services (PTHB) and Director of Social Services (PCC). We identified some issues with attendance by members (as per the Terms of Reference) – details are provided in Appendix A.

However, the Director of Primary, Community & Mental Health Services is confident that the right representatives are attending and attendance is good, which suggests that the Terms of Reference for the partnership board require updating.

See Finding 4 in Appendix A

Minutes and papers of the MHPDP Board were reviewed. There is evidence of discussion around the preparation and submission of the annual report to Welsh Government. The final submissions and positive, constructive feedback from Welsh Government have been reported to the Partnership Board. However, there is no evidence of monitoring progress against the *Hearts & Minds: Together for Mental Health* delivery plan. The MHPDP Board

is supported by a Performance Subgroup. The Head of Mental Health Operations advised that the subgroup was amalgamated with the Mental Health Officers Group and was responsible for monitoring performance against the 2016-19 delivery plan. This is not reflected in the terms of reference, which are yet to be updated to reflect the revised structure and responsibility arrangements. The subgroup has not met within the last 12 months as the previous delivery plan ended in 2019 and development of the next delivery plan has been delayed due to the impact of Covid-19. We were advised that once this has been finalised the group will reconvene.

We were provided with a selection of papers for meetings held between October 2017 and March 2019 (during the last delivery plan period). Whilst these demonstrated discussion around the *Hearts & Minds: Together for Mental Health* priorities and certain elements of the delivery plan (such as the Talk to Me 2 action plan), the delivery plan has not been reported or discussed at this group and there is no evidence of monitoring progress in implementing the actions within.

Regional Partnership Board

The 2020/21 RPB work plan identifies performance reporting on the Live Well: Mental Health partnership in April 2020, October 2020 and January 2021. We reviewed minutes of RPB meetings held between April 2019 and September 2020 and were unable to identify any evidence of reporting on the Live Well: Mental Health partnership to the RPB. The dementia action plan was reported in April 2019, and there is evidence of meeting minutes from other partnerships being reported to the RPB but not for the MHPDP Board. The agenda for the October 2019 meeting includes a quarterly highlight report for Live Well Mental Health and minutes of the MHPDP Board meeting held in June 2019. Both items are marked as adjourned, although the minutes note that they were shared for information. The quarterly highlight report provided a narrative summary of activity in relation to the Live Well: Mental Health partnership, but no indication of progress in implementing the delivery plan.

See Finding 3 in Appendix A

Reporting to Welsh Government

In accordance with WG requirements, Local Partnership Boards for MH across Wales are required to submit a local delivery plan progress update and an annual statement in November each year.

The deadline for reporting progress in 2018/19 was 15 November 2019. A report to the Strategy & Planning Committee in January 2020 noted that the Powys Live Well Mental Health Planning & Development Partnership met

these requirements and submitted both documents on time subject to final approval from the full Partnership (which took place on 10 December 2019). We were advised that the annual report was prepared using the template required by Welsh Government, providing a narrative update of activity within each delivery plan priority area rather than progress in implementing specific delivery plan actions. Evidence of response/feedback from Welsh Government on the 2018/19 annual report and statement was requested but not provided during the audit.

Reporting for 2019/20 has been postponed until 2021 due to the impact of Covid-19.

Objective 5: the health board is provided with assurance that the partnership is operating effectively to achieve the objectives set out within the framework

There is lack of clarity over the arrangements for reporting assurance on the effectiveness of the Live Well: Mental Health partnership to the Health Board.

A narrative update report on the 2016/19 delivery plan and preparation of the 2018/19 progress report and annual statement for Welsh Government was provided to the Strategy & Planning Committee in October 2019. The final documents submitted to Welsh Government were reported to the committee in January 2020.

We understand that assurance reporting for mental health is to the Experience, Quality & Safety Committee. Minutes and papers were reviewed but there is no evidence of reporting in respect of the Live Well: Mental Health partnership or delivery of the Powys Hearts & Minds: Together for Mental Health delivery plan.

A summary of partnership board activity is reported at each Health Board meeting, however this is very high level referring to the RPB as a whole – mainly confirming the RPB meetings that have taken place – and does not refer to the Live Well: Mental Health partnership.

Performance of the Mental Health service as a whole is reported via the integrated performance report. Reports were suspended during Covid-19, with the latest report going to the January 2020 meeting for Q3 2019/20. The following measures are included for Mental Health services, all of which are RAG rated green:

- 25. Number of Health Board MH delayed transfer of care
- 59. Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult MH
- 61. Percentage of MH assessments undertaken within (up to and including) 28days from the date of receipt and referral

- 63. Percentage of qualifying patients who had their first contact with an independent MH advocacy within 5 working days of their request for an IMHA
- 83. Percentage of HB residents in receipt of secondary MH services who have a valid care and treatment plan
- 84. All HB residents who had been assessed under part 3 of the MH measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place

There is no evidence that the health board is provided with assurance on the effectiveness of the Live Well: Mental Health partnership and it is not clear the extent to which the partnership has contributed to the overall performance of the Mental Health service.

See Finding 5 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	**3**	**1**	**1**	**5**

Action Plan

Finding 1 Partnership Governance Framework (Design)	Risk
There is no partnership governance framework in place within the health board, either as an overarching general guidance document or specifically in relation to the Live Well Mental Health Partnership. Furthermore, a central record of partnerships is not maintained. This would ensure that the health board maintains oversight of all partnerships in which it is engaged, and facilitate monitoring and reporting arrangements in respect of partnership activity. The Board Secretary advised that the Board recognises the need for the development of a partnership governance strategy and central register of partnerships, but the impact of Covid-19 has delayed progress.	Partnerships are inappropriate or unnecessary. Governance arrangements for partnerships are not formally defined.
Recommendation 1	**Priority level**
The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes.	**High**

A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	
Management Response 1	**Responsible Officer/ Deadline**
Accepted. The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Board Secretary September 2021

Finding 2 Roles & Responsibilities (Design)	Risk
The purpose of the *Live Well: Mental Health* partnership is to deliver the Powys *Hearts and Minds: Together for Mental Health* strategy and supporting delivery plan, developed in response to the Welsh Government's *Together for Mental Health* strategy and delivery plan. Responsibilities of the partnership as a whole are set out within the terms of reference for the MHPDP and include to review the progress of specific plans contained within the Together for Mental Health. The most recent delivery plan (dated 2017) covers the period 2016-2019. Publication of the Welsh Government delivery plan for 2020 was delayed from February to October 2020 due to Covid-19 and the next local delivery plan is expected to be in place by March 2021. The 2017 delivery plan follows a standard Welsh Government template and categorises actions according to responsible partners: • Health board and partner actions • Health board specific actions • Local authority specific actions • Local Partnership Board actions • Public Health Wales actions Actions are high level and linked to other projects, plans and schemes. We were advised that further detail is included within the specific projects/plans/schemes that support the delivery plan actions, and relevant individuals would be able to answer queries and provide explanations needed. However, there is no central oversight of these. The delivery plan does	Roles and responsibilities of partner organisations in the delivery of the Hearts & Minds: Together for Mental Health delivery plan are not clearly defined, potentially resulting in poor progress and lack of accountability.

not clearly or consistently identify the lead officer(s) responsible for delivery, the arrangements for monitoring implementation or reporting assurance on progress. An example to illustrate this point is section 1.2 of the delivery plan (*"to prevent and reduce suicide and self harm in Wales"*) which has the following health board and partner action: *"working with PHW, local authorities and third sector, implement the Talk to Me 2 action plan by March 2019"*. It is not clear from the delivery plan which departments/officers within each partner organisation are responsible for implementation of the *Talk to Me 2* action plan or how and where progress will be monitored and reported. The Head of Mental Health Operations assured that relevant individuals involved in the partnership and supporting projects/plans/schemes are aware of these arrangements, but acknowledged that there is lack of central oversight.	
Recommendation 2	**Priority level**
Responsibilities for delivery and arrangements for monitoring and reporting on implementation of specific actions within the Together for Mental Health delivery plan should be formally documented and mapped to the delivery plan. This will enable the Mental Health Planning & Delivery Partnership Board to maintain oversight of and gain assurance in respect of the delivery of the plan as a whole.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Accepted. The (reviewed) National Together for Mental Health Delivery Plan (2019-2022) released in October 2020 is undergoing significant focus and preparation to reflect a Powys regional perspective. This re-vision needs to also align with related new regional plans, such as	Mental Health Partnership Manager

Housing. Welsh Government have not clarified monitoring and reporting for priorities within the T4MH Delivery Plan, as yet. We are progressing on drafting a detailed iteration of the Powys plan, clearly identifying priorities/milestones, responsible partner, strategic/responsible leads (by name) for the March 2021 Partnership Board meeting. Governance, monitoring and reporting arrangements will be communicated/aligned as soon as information is released from Welsh Government.	First Draft – March 2021 Final Draft – By June 2021

Finding 3 Performance Reporting – Monitoring Implementation of the Delivery Plan (Design)	Risk
The Live Well: Mental Health partnership is responsible for supporting and reviewing progress in implementing the local delivery plan for the *Powys Hearts & Minds: Together for Mental Health* strategy. Minutes and papers of the MHPDP were reviewed, but there is no evidence of monitoring and reporting in respect of the delivery plan. The MHPDP is supported by a Performance Subgroup. The Head of Mental Health Operations advised that the subgroup was amalgamated with the Mental Health Officers Group and was responsible for monitoring performance against the 2016-19 delivery plan. This is not reflected in the terms of reference, which are yet to be updated to reflect the revised structure and responsibility arrangements. The subgroup has not met within the last 12 months as the previous delivery plan ended in 2019 and development of the next delivery plan has been delayed due to the impact of Covid-19. We were advised that once this has been finalised the group will reconvene. We were provided with a selection of papers for meetings held between October 2017 and March 2019 (during the last delivery plan period). Whilst these demonstrated discussion around the Hearts & Minds: Together for Mental Health priorities and certain elements of the delivery plan (such as the Talk to Me 2 action plan), the delivery plan has not been reported or discussed at this group and there is no evidence of monitoring progress in implementing the actions within. The MHPDP reports directly to the RPB. The 2020/21 RPB work plan identifies performance reporting on the Live Well: Mental Health partnership in April 2020, October 2020 and January 2021. We reviewed minutes of RPB meetings held between April 2019 and	Progress in implementing the Hearts & Minds: Together for Mental Health delivery plan is not monitored.

September 2020 and were unable to identify any evidence of reporting on the Live Well: Mental Health partnership to the RPB. The dementia action plan was reported in April 2019, and there is evidence of meeting minutes from other partnerships being reported to the RPB but not for the MHPDP. The agenda for the October 2019 meeting includes a quarterly highlight report for Live Well Mental Health and minutes of the MHPDP meeting held in June 2019. Both items are marked as adjourned, although the minutes note that they were shared for information. The quarterly highlight report provided a narrative summary of activity in relation to the Live Well: Mental Health partnership, but no indication of progress in implementing the delivery plan.	
Recommendation 3	**Priority level**
Terms of reference for the amalgamated MH Officers Group / Performance Subgroup should be documented and reflect the groups responsibility for monitoring performance against the Together for Mental Health delivery plans. The Hearts & Minds: Together for Mental Health delivery plan should be monitored by the MH Officers Group / Performance Subgroup, with clear status updates on the implementation of actions within. Assurance on delivery of the plan should be reported via the MHPDP to the RPB in line with the RPB work plan.	**High**
Management Response 3	**Responsible Officer/ Deadline**
Accepted. The Mental Health Officers Group (MHOG)/Performance Subgroup is being re-engaged and the best, most efficient way of monitoring performance, as a multi-agency operational group,	Mental Health Partnership Manager

is being discussed with partner agencies along with timescales. The landscape has significantly changed due to Covid-19 and new multi-agency Delivery Plan(s). We are looking at possibilities of utilising technology to reduce the need for so many (monitoring/performance) meetings so as to "automate" reporting and monitor progress of linked priority areas. Our aim is to holistically satisfy a number of different inter-related Delivery Plans and oversight groups, including the Strategic Leads (Partnerships) joined up reporting within the RPB governance structure.	June 2021

Finding 4 MHPDP Membership & Attendance (Design)	Risk
Minutes of the MHPDP were reviewed to establish whether there is good representation and attendance by the key partner organisations – health board, Powys County Council, Powys Association of Voluntary Organisations and Dyfed Powys Police. Meetings are jointly chaired by the Director of Primary, Community & Mental Health Services (PtHB) and Director of Social Services (PCC). We noted that: • the PCC Chair has not attended any of the three meetings held between December 2019 and September 2020. We were advised that the Head of Adult Services (PCC) has deputised at each meeting. • 10 of the 17 members identified in the terms of reference have not attended any of the three meetings. Other representatives from the key partners have been present at the meetings, but it is not clear in what capacity they were attending – whether they were attending as a deputy and if so, who they were deputising for. • 17 individuals were identified as having attended at least one of the three meetings despite not being on the members of 'in attendance' list per the terms of reference. • Apologies are recorded from individuals not on the members or in attendance list per the terms of reference. However, the Director of Primary, Community & Mental Health Services is confident that the right representatives are attending and attendance is good, which suggests that the terms of reference for the partnership board require updating.	The health board does not receive assurance that the Live Well: Mental Health partnership is operating effectively to implement the Heart & Minds: Together for Mental Health delivery plan.
Recommendation 4	**Priority level**

Membership of the MH Planning & Development Partnership Board should be reviewed to ensure appropriate representation from each partner organisation and the terms of reference updated accordingly.	**Low**
Management Response 4	**Responsible Officer/ Deadline**
Accepted. It has always been the intention, upon receipt of the reviewed T4MH Delivery Plan, to adjust membership if this was needed to align with new priority areas and gaps. The majority of partner agencies and members remain unchanged. New areas may warrant further discussion/agreement, such as Education, Housing and Employment. The intention is to agree any final adjustments to the TOR's and Membership once the draft Delivery Plan is presented to the MH Partnership Board in March 2021.	Mental Health Partnership Manager June 2021

Finding 5 Assurance Reporting Arrangements (Design)	Risk
There is lack of clarity over the arrangements for reporting assurance on the effectiveness of the Live Well: Mental Health partnership to the Health Board. A narrative update report on the 2016/19 delivery plan and preparation of the 2018/19 progress report and annual statement for Welsh Government was provided to the Strategy & Planning Committee in October 2019. The final documents submitted to Welsh Government were reported to the committee in January 2020. We understand that assurance reporting for mental health is to the Experience, Quality & Safety Committee. Minutes and papers were reviewed but there is no evidence of reporting in respect of the Live Well: Mental Health partnership or delivery of the Powys Hearts & Minds: Together for Mental Health delivery plan. A summary of partnership board activity is reported at each Health Board meeting however this is very high level referring to the RPB as a whole – mainly confirming the RPB meetings that have taken place – and does not refer to the Live Well: Mental Health partnership. Performance of the Mental Health service as a whole is reported via the integrated performance report. Reports were suspended during Covid-19, with the latest report going to the January 2020 meeting for Q3 2019/20. The performance measures for Mental Health services are RAG rated green. There is no evidence that the Health Board is provided with assurance on the effectiveness of the Live Well: Mental Health partnership and it is not clear the extent to which the partnership has contributed to the overall performance of the Mental Health service.	The health board does not receive assurance that the Live Well: Mental Health partnership is operating effectively to implement the Heart & Minds: Together for Mental Health delivery plan.

Action Plan

Recommendation 5	Priority level
Arrangements for reporting assurance to the Health Board on the effectiveness of the Live Well: Mental Health partnership need to be determined.	High
Management Response 5	**Responsible Officer/ Deadline**
Accepted. Reporting arrangements will be reviewed and clarified through the Partnership Governance Framework development and ongoing implementation. This reporting mechanism will also need to reflect existing reporting arrangements to Welsh Government and the RPB in order to reduce duplication.	Board Secretary September 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

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.*

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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.

Office details:

POWYS Office
Audit and Assurance
Hafren Ward
Bronllys Hospital
Powys
LD3 0LS

MAMHILAD Office
Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS

Contact details

Helen Higgs (Head of Internal Audit) – Helen.Higgs@Wales.nhs.uk
Osian Lloyd (Deputy Head of Internal Audit) – Osian.Lloyd@Wales.nhs.uk
Sophie Corbett (Audit Manager) – Sophie.Corbett@Wales.nhs.uk

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Audit Risk and Assurance Committee	**Date of Meeting: 26 January 2021**
Subject:	**Counter Fraud Update Report**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this report is to update the Audit, Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2020/21.
RECOMMENDATION(S):
It is recommended that the Audit, Risk & Assurance Committee receive the report for discussion and information the content of this update report.

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

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

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Powys Teaching Health Board

Item 3.5

Counter Fraud Update Report

26 January 2021

1. INTRODUCTION

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

2. BACKGROUND

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

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

3. RESOURCE UTILISATION

3.1 Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below. Figures are correct as of 31st December 2020.

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	**25**	**24**
Inform and Involve	**40**	**22**
Prevent and Deter	**57**	**37**
Hold to Account	**106**	**31**
TOTAL	**228**	**114**

4. STRATEGIC GOVERNANCE

4.1 The Head of Local Counter Fraud Services (HoLCFS) attended a Counter Fraud Steering Group meeting in early November. An agenda item included the potential for NHS Wales to introduce Government Functional Standards on Counter Fraud to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'.
NHS England plan to replace current standards with the Government Functional Standards in 2021/22; additionally, NHS CFA will not be maintaining their Standards going forward following the replacement.
The replacement in NHS Wales requires Welsh Government authorisation who await the finalised version of Government Functional Standards from NHS CFA to consider; it is anticipated that the new standards will be adopted.
The HoLCFS maintains a good working relationship with NHS CFA Quality Assurance Inspectors leading work on the replacement standards for the organisation and has had detailed meetings directly with those officers. The

new standards broadly align to the existing standards but with additional emphasis on fraud risk management and particularly the recording of this work. These practices are already underway within the Health Board, being reinforced throughout this year. It is expected that impact of replacement standards, if adopted, will be minimal with only slight changes in strategy required. The Health Board's Counter Fraud Work Plan 2021/22 will be appropriately devised to meet the standards in place at that time

5. INFORM AND INVOLVE

5.1 As detailed within the 2020/21 Counter Fraud Work Plan, an on-going programme of work has been put in place to raise awareness of fraud, bribery and corruption amongst all staff and practitioners across all sites. Virtual delivery of awareness sessions via Microsoft Teams is now in place within the Health Board for general awareness purposes. The Counter Fraud Team are also focusing on fraud risk specific training for key partners within the Health Board.

5.2 The Counter Fraud Team took part in International Fraud Awareness Week 15-20 November alongside NHS and public sector partners. During this event the Team produced refreshed literature based around available resources issued from Counter Fraud Service Wales and NHS Counter Fraud Authority. The Team also created content such as 'Ethical Dilemmas' which posed fraud risk based situations asking staff what they would do in those circumstances, a special edition Newsletter and a counter fraud leaflet. The event was run virtually with resources disseminated to staff on multi-platform basis throughout the week.
The HoLCFS is concerned however around the reach that this event has had at a time when the communication landscape and people's minds are focussed on Covid. It is planned that this event will run again within the Health Board in late Q4 utilising the resources already collated with greater cut through and impact anticipated once winter pressures are declining.

5.3 The Counter Fraud Team has commenced delivery of an input into the Health Board's induction programme to provide a level of general awareness to new starters within the Health Board.

6 PREVENT AND DETER

6.1 A proactive fraud detection exercise has been undertaken around compliance with pre-employment checks in relation to recruitment of substantive and bank staff to the Health Board as well as examination of pre-employment checks undertaken by supplier agencies for workers supplied to the Health Board. A separate report has been provided to the Committee covering outcomes of this exercise.

6.2 The Counter Fraud Team are undertaking a series of fraud risk assessments in relation to strategic risk areas outlined in previous fraud alerts, NHS CFA Fraud Prevention Notices and national guidance. The risk assessments will be undertaken on a formal basis in line with Risk Management Policy and Procedure within the Health Board. The LCFS has received training input on approach form the Health Board's Risk Manager to enable this. Once complete the individual risk assessments will form part of the Health Board's fraud risk profile to be used to inform future Counter Fraud Work Plans.

7 HOLD TO ACCOUNT

7.1 The status of the LCFS investigative caseload at the time of reporting is summarised within appendix to this report for information.

8. RECOMMENDATION

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

Open Cases					
WARO Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
WARO/18/00070	11/05/2018	Abuse of Position	Staff	Unaccounted for controlled drugs – suspected fraud/theft by member of staff.	Counter fraud actions completed resulted in no further action. Information provided for consideration of disciplinary action. Suspect resigned position. Awaiting outcome of disciplinary action.
WARO/18/00143	18/10/2018	Timesheet	Staff	Unauthorised extended breaks resulting in non-completion of contracted hours.	Allegation was not corroborated following investigation. Case closure to be sought.
WARO/18/00159	09/11/2018	Abuse of Position	Staff	Inappropriate disposal of assets potentially resulting in a personal gain or undue loss to Health Board.	Enquiries concluded. Case assessed as not having realistic prospect of conviction due to evidential conflict. Case closure being sought.
WARO/19/00099	27/08/2019	Abuse of Position	Staff	Non-completion of contracted sessions alongside claiming of expenses for journeys relating to those sessions.	Disciplinary investigation underway. Subject has variously been absent due to sick leave, annual leave and career break. Internal investigation awaiting return.
WARO/19/00119	14/10/2019	Timesheet	Staff	Additional unworked hours added to timesheet.	Disciplinary investigation underway.
WARO/20/00105	11/11/2020	Forgery	Patient	Subject alleged to have amended prescription in relation to dispensing date for post-dated scripts.	Matter was referred to Police for investigation. A community resolution has been reached by way of out of court disposal and subject has sought assistance from rehabilitation as part of this.

Closed Cases					
WARO Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
WARO/19/00100	28/08/2019	False Prescription	Staff	Theft of patient prescription which was alleged to be cashed by staff member presenting at pharmacy as patient.	Conviction at Merthyr Tydfil Magistrates on fraud offences and was sentenced to 60 hours of unpaid work and a Community Punishment Rehabilitation Order for 12 months, the subject resigned prior to the internal disciplinary hearing but the panel confirmed that subject would have been dismissed for gross misconduct.
WARO/19/00073	12/07/2019	Working elsewhere whilst on sick leave	Staff	Subject alleged to have been working elsewhere whilst in receipt of occupational sick pay.	Subject found to have been completing unpaid activities whilst on sick leave. Subject resigned from Health Board and no further action taken in relation to disciplinary proceedings. No realistic prospect of conviction in this case.
WARO/18/00153	02/11/2018	Theft	Staff	Theft of money at Health Board site.	Subject dismissed from Health Board employment. Matter not pursued further by Police due to evidential issues. Counter Fraud advice provided for increased balance checks to reduce risk.
WARO/18/00091	29/06/2018	False expenses	Staff	Staff member found by Police to have been driving whilst otherwise in accordance with licence and therefore invalidated insurance.	Counter Fraud actions resulted in application of simple caution and recovery of £1786.74.

Closed Cases					
WARO Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
				Expense claims made during this time were therefore made fraudulently.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Audit, Risk and Assurance Committee	**Date of Meeting: 26 January 2021**
Subject:	**Counter Fraud - Proactive Exercise - Pre Employment Checks**
Approved and Presented by:	Director of Finance and IT / Head of Local Counter Fraud
Prepared by:	Local Counter Fraud Officer
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

This paper is for information to update the Committee in relation to an exercise completed by Counter Fraud to review pre Employment Check arrangements.

The full report is as attached and includes action taken and recommendations to improve.

The recommendations and agreed actions will be included in the Health Board Audit Tracker going forward.

RECOMMENDATION(S):

The Committee is asked to:-

- Note the Pro Active work as completed.
- Note the recommendations and method of tracking action and implementation going forward.

Ratification	Discussion	Information
x	✓	x

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

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Powys Teaching Health Board

COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise

Pre-Employment Checks

October 2020

Executive Summary

In response to an identified risk the Local Counter Fraud Specialist (LCFS) has undertaken an exercise to seek assurance that agency staff supplied to Powys Teaching Health Board (PTHB) have had the relevant pre-employment checks (PECs) completed and recorded in line with the "Contract specification for the supply of Registered Agency Nurses, Midwives and Health Visitors, Healthcare Assistants and Operating Department Practitioners to Health Boards and Trusts in Wales. From here on, within this report, this will be referred to as the Agreement.

The LCFS established that there is overall good compliance with Agreement requirements. However, some issues were identified including 2 supplier agencies who did not reply to requests for information – an Agreement requirement. Further information around identified issues is outlined below.

The LCFS also reviewed recruitment of staff during the Covid-19 pandemic between April-May 2020. It was established that Internal Audit colleagues had conducted a similar review and no further counter fraud input was required as a result of their findings.

At the conclusion of the exercise the LCFS found that there was a need for some improvements and has made recommendations to mitigate the elements of risk identified.

Introduction and Background

The NHS Counter Fraud Authority identified a risk relating to the pre-employment checks for new employees and agency staff not being conducted satisfactorily and prior to the commencement of work. The Local Counter Fraud Specialist (LCFS) therefore proposed to undertake a proactive exercise to identify any instances of pre-employment checks not being conducted to the relevant standard according to the agreement.

Scope of Exercise

The exercise was twofold and looked at the utilisation of agency staff to cover bank shifts for the financial year 2019/20 within Powys Teaching Health Board. In total 5683 duties were fulfilled by 227 agency workers. Those 227 workers were sifted down to a pool of 41 staff. Those 41, which were selected randomly from 8 agencies, were included within the exercise specification. Each of their pre-employment checks, conducted by their respective agency, was checked and verified by the LCFS to ensure that the checks had been completed and retained in accordance with the agreement.

A sample review of newly recruited PTHB employees during Covid-19 intake was also considered. The LCFS established that a review had been conducted by the

Internal Audit Department. In order to avoid duplication of work, the LCFS liaised with Internal Audit to review audit work undertaken in this area. It was found that the audit covered the same risks being considered and that this had resulted in key priorities being set that did not include recruitment or PEC recommendations. The LCFS did not therefore review substantive and bank staff pre-employment checks and no further Counter Fraud input was required in relation to Internal Audit findings.

Method

The LCFS requested data from the Temporary Staffing Unit (TSU) of all the agencies that had provided workers to cover PTHB shifts throughout the financial year 2019/20. The list contained a total of 52 different agencies, all providing a different percentage of cover. This list was re-ordered to show who the top 20 providers were. From the reduced list of 20 agencies, 8 were randomly selected.

The LCFS liaised with TSU to obtain a report showing the names of the employees that were supplied from each selected agency. The LCFS contacted the 8 selected agencies and asked them to provide a list of names of the employees they had allocated to cover bank shifts within PTHB for 2019/20. Once in possession of the names, the LCFS dip sampled a small number of employees and requested that the agency provide the pre-employment checks for those staff members.

The pre-employment checks that were requested were as follows:
Identity, Right to Work, DBS, References, Occupational health clearance, Professional qualifications and Professional registrations. These were requested as they are contained within the Agreement as the checks that the agency will obtain and verify for its employees.

The information provided by Agencies was then assessed for compliance against Agreement requirements.

Findings

The LCFS sought points of contact from each of the 8 selected agencies and requested their assistance with the provision of information in accordance with the Agreement.

<u>Direct Nursing Services (DNS)</u>
DNS were asked to provide the PEC information for six of their agency staff that had completed PTHB bank shifts within 2019/20. DNS were able to provide the information and within the Agreement timescales. Of the PEC documents required, all were present and correct, with the exception of evidence of Qualifications. Within agencies it would appear that it is common practice for professional registration checks to be completed, but not actual qualifications or certificates. Furthermore, Healthcare Assistants (HCAs) are not professionally registered, so their evidence of qualifications

comes from their references and previous experience alone. There were two HCA's within the sample of six agency staff for DNS.

Thornbury Nursing Services

Thornbury Nursing Services were asked to provide a sample of ten agency staff that had completed PTHB bank shifts within 2019/20. The PECs were provided within the required timeframe. There were four HCA's whom did not require to have professional registrations present. One DBS check was located within an incorrect staff file, however this was rectified. Of the DBS checks conducted by Thornbury, all of them were found to be over a year old, some having not been updated since 2015. This was discussed with the agency who confirmed that the evidence of DBS checks provided were those that took place at the pre-employment stage. Subsequently Thornbury offered to provide up to date DBS checks for all the sampled candidates that had already been undertaken but had not provided the information at the time of the report writing. With regards to the professional qualifications evidence (as per the common practice mentioned above), there were no certificates to show, however those positions that held professional registration had confirmation from the NMC that a qualification was present.

MPS Healthcare

MPS were asked to provide a sample of fifteen agency staff. All of the PECs reviewed were provided within the Agreement time frame and in full. All checks were present, correct and within a satisfactory date range. There was one HCA within the sample of staff and there professional registration and qualifications was not necessary.

Biggs Agency

Biggs was asked to provide the details for five agency staff. They were able to provide the PECs for each employee within agreed timescales. One DBS check was completed in 2016, and therefore poses a risk around the length of time elapsed since the last check, however all other documentation was included and correct. Those staff that were HCAs did not have professional registration however their qualifications were present. An observation that was made by the LCFS was that the occupational health check forms were all dated on the date of submission to the LCFS, as if they were completed for the purpose of this exercise.

Concept Care

Concept Care only allocated one staff member to cover shifts for PTHB within the 2019/20 period, and were able to provide the PECs for that member of staff. The information was provided to the LCFS outside of the Agreement time frame. Review of provided information presented no issues however.

Jane Lewis

Jane Lewis only provided four agency employees to cover PTHB shifts within 2019/20. The PECs for these four staff members were not provided within the Agreement timescales. One worker's PECs were not provided at all as they were in an archived file due to individual no longer working for the agency.

MBNS
This agency failed to respond with the details of a point of contact despite repeated email requests as well as telephone calls. They also failed to provide any information regarding how many of their staff had covered PTHB shifts, nor their basic information in order to allow the exercise to progress.

Coyles Agency
Coyles also failed to respond to the LCFS with either a point of contact, or details of the staff that had worked agency shifts. Again, numerous emails were sent and a number of phone calls made, all of which went unanswered. The agency did not provide any information that allowed the exercise to progress and were informed that it was a compliance issue by failing to do so.

Recommendations

The LCFS recommends some amendments and updates being made to the existing Agreement:

1. DBS checks are a mandatory requirement of the pre-employment process, under Annex 1, point A1.8p, however the requirements for ongoing DBS updates is not mentioned. The criteria asks for a photocopy of the top section of the enhanced DBS check to be retained, but no further DBS checks are required. The only annual check that is required is against the Protection of Vulnerable Adults (POVA) list on an annual basis; this being the list of persons barred from working with vulnerable adults. It is therefore recommended that a clause is added to the Agreement making it mandatory for agencies to conduct and retain annual DBS checks for all of their staff.

2. The 'Service Specification' of the Agreement states that agencies/suppliers will supply Health Boards with any information requested within 5 working days from receipt of request. Pre-employment checks are included within the list of records that the agencies are obliged to retain and maintain, and subsequently make available, as per any requests for such information. During this exercise there were a number of agencies that failed to abide by this condition within the Agreement, and therefore it is recommended that a clause be added to advise of the possible sanctions for lack of co-operation with the Agreement terms and conditions. This could include suspension of business with the agency for repeated breaches of contract.

3. The Recruitment Criteria (Annex 1) within the contract states that an agency worker that claims to have additional certificates or qualifications (other than NMC) should provide copies of the certificates to the agency. The agency is required to view the original document and retain a copy on the employees file. It was described as "common practice" within some agencies that registration with the NMC or other professional body was sufficient evidence and they did not therefore conduct checks of the additional qualifications. This is not what is stated in the contract, therefore it is recommended that suppliers be reminded of this clause and sanctions considered for repeat breaches.

Conclusion

Overall the process of conducting and retaining pre-employment checks is complied with by agencies, as well as the Health Board itself in relation to substantive staff. However, there are concerns around potential bad practice with regards to verification of qualifications/certificates and regular DBS checks.

The LCFS also had difficulty with some agencies supplying information when requested to do so. There is risk to the Health Board in instances of issues arising in relation to supplied staff and subsequent verification by the Health Board of that workers relevant documentation. It is imperative that the health board is given access to the PECs when requested in line with Agreement.

There is also risk to the Health Board when agencies do not conduct regular DBS checks on agency staff. Regular checks should be undertaken in order to ensure the safety of all patients and staff. Responsibility for notification of incidents that affect DBS checks should be shifted to agencies, ensuring that they are actively verifying staff remain safe to work with patients

Key Contacts

Name	Job Title	Contact
Kirsty James	Local Counter Fraud Specialist	Kirsty.James5@wales.nhs.uk 01874 712419
Leanne Winston	Temporary Staffing Unit Manager	Leanne.Winston@wales.nhs.uk
Emma Rees	Principal Auditor	Emma.Rees13@wales.nhs.uk

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

Date issued: January 2021

Document reference: 2001A2020-21

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Contents

Audit Committee Update

About this document

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

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Accountability Report and Financial Statements	Completed. Certified by the Auditor General and laid by the Senedd in early July 2020.
Audit of the 2019-20 Funds Held on Trust	Completed. Certified by the Auditor General on 15 December 2020, ahead of the Charity Commission's deadline of 31 January 2021.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning began in December.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment 2020	November 2020
Effectiveness of Counter-Fraud Arrangements	September 2020
Structured Assessment 2019	January 2020
Implementing the Wellbeing of Future Generations Act	January 2020

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service	Report being drafted TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	looks to tackle the significant elective backlog challenges.	
Review of the Welsh Health Specialised Services Committee (WHSSC) Executive Lead – Chief Executive Officer	WHSSC is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales. This work will use aspects of our structured assessment methodology to examine the governance arrangements of WHSSC. Our findings will be summarised into a single national report.	Report drafting TBC
Test, Track and Protect Executive Lead – Director of Public Health	In response to the COVID-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local COVID-19 Prevention and Response Plans for each part of Wales.	Clearance process; publication expected February 2021 TBC
Quality Governance Executive Lead – Director of Nursing	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Set-up meeting held. TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed Further work postponed to 2021 and replaced with work on Test, Track and Protect TBC
Local work 2020 (TBC)	The precise focus of this work is yet to be determined.	TBC

Good Practice events and products

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

5 **Exhibit 5** outlines the Good Practice Exchange (GPX) events which have been held since the Committee last met. Materials are available via the links below. Details of future events are available on the GPX website.

Exhibit 5 – Good practice events and products

Event	Details
Mental Health and Wellbeing During COVID-19	At this webinar, public services shared how they adapted services during the pandemic, as well as successes and challenges.

6 In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

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

8 **Exhibit 6** provides information on the NHS-related or relevant national studies published since the Committee last met, including all-Wales summaries of work undertaken locally in the NHS.

Exhibit 6 – NHS-related or relevant national studies reports

Title	Publication Date
Doing it differently; doing it right? Governance in the NHS During the COVID-19 Crisis – Key Themes, Lessons, and Opportunities	January 2021
Procurement and supply of PPE during the COVID-19 pandemic	December 2020

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Annual Audit Report 2020 – Powys Teaching Health Board

Audit year: 2019-20

Date issued: January 2021

Document reference: 2161A2020-21

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

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

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2020 audit work at Powys Teaching Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3 This year's audit work took place at a time when public bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Given its impact, I re-shaped my planned work programmes by considering how to best assure the people of Wales that public funds are well managed. I considered the impact of the current crisis on both resilience and the future shape of public services and aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. All on-site audit work was suspended whilst we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on the delivery of some of my planned audit work but has also driven positive changes in our ways of working.

4 The delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account of new considerations for financial statements arising directly from the pandemic. The success in delivering to the amended timetable reflects a great collective effort by both my staff and the Health Board's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 At the onset of the pandemic I suspended the publication of some performance audit reports nearing completion, reflecting the capacity of audited bodies to support remaining fieldwork and contribute to the clearance of draft audit outputs. I have also adjusted the focus and approach of some other planned reviews to ensure their relevance in the context of the crisis. New streams of work have been introduced, such as my review of the Test, Trace and Protect programme, and my local audit teams have contributed to my wider COVID-19 learning work.

6 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of planned work currently being re-scoped.

7 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2020 Audit Plan.

8 **Appendix 3** sets out the financial audit risks set out in my 2020 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit, Risk and Assurance Committee on 26 January 2021. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

11 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit). However, I placed two Emphasis of Matter paragraphs in my report to draw attention to disclosures in the accounts relating to Clinicians' pension tax contingent liabilities and the effects of COVID-19 on the estimation of valuations of land and buildings. I brought several additional issues to the attention of officers and the Audit, Risk and Assurance Committee which are set out in my detailed report below.

12 The Health Board achieved financial balance for the three year period ending 31 March 2020, and had no other material financial transactions that were not in accordance with authorities nor used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Health Board's 2019-20 accounts.

13 As the Health Board achieved financial balance and had an approved three-year plan in place and there were no other issues which warranted highlighting, no substantive report was placed on the Health Board's accounts.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

14 My programme of Performance Audit work has led me to draw the following conclusions:

- The Health Board maintained overall good governance during the COVID-19 pandemic
- The Health Board adapted its financial control procedures to manage during COVID-19 but there is an increasing risk to financial balance at the end of 2020-21
- Operational plans are informed by data modelling and demonstrate a clear commitment to staff wellbeing and, although progress and performance is monitored and reported, information on commissioned services is currently limited
- The Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs

15 These findings are considered further in the following sections.

Detailed report

Audit of accounts

16 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2019-20. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

17 My 2020 Audit Plan set out the financial audit risks for the audit of the Health Board's 2019-20 financial statements. **Exhibit 5** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

18 My responsibilities in auditing the Health Board's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2019-20 financial statements

19 **I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit), however, I placed two Emphasis of Matter paragraphs in my report to draw attention to disclosures in the accounts relating to Clinicians' pension tax liabilities and the effects of Covid-19 on the estimation of valuations of land and buildings.**

20 We received the draft financial statements for the year ended 31 March 2020 on 21 May 2020, in line with the agreed timetable. The working papers were prepared to a high standard.

21 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit, Risk and Assurance Committee on 25 June 2020. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	We identified that the prescribing accrual for 2019/20 had been under accrued by £322k when compared to the actual amounts for March 2020. We do not consider that this represents a weakness in the Health Board's estimation methodology as this was consistent with previous years. An additional allocation for the value of £270k has been received against this amount and has therefore been corrected in the financial statements leaving an uncorrected amount of £52k. If the £52k were to be adjusted, this would reduce the underspend against allocation from £55k to £3k. We identified that an error had been made when entering a value for the impairment of assets. This error amounted to £314k. If this error were to be adjusted, this would have a nil effect on the year end position as this would result in an allocation adjustment to match this value.
Corrected misstatements	• Additional narrative note to describe the potential impact of a decision to fund NHS Clinicians' pension tax liabilities • Additional narrative note to describe the material uncertainty included in the valuer's report • A small number of presentational and typographical errors were identified within the draft financial statements
Other significant issues	None

22 In addition, we identified some areas for improvement around journal procedures, classification of expenditure and year-end cut off procedures to ensure expenditure and income are included in the correct year.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2020 and the return was prepared in accordance with the Treasury's instructions.

24 My separate independent examination of the charitable funds financial statements is substantially complete.

Regularity of financial transactions

25 **The Health Board achieved financial balance for the three-year period ending 31 March 2020 and had no other material financial transactions that were not in accordance with authorities nor used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Health Board's 2019-20 accounts.**

26 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

27 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. The Health Board achieved financial balance in 2017-18, 2018-19 and 2019-20 as shown in **Exhibit 2**. The Health Board therefore met its statutory duty to break even over the three years.

Exhibit 2: financial position at year end

Financial year	Financial position at year end (£000)
2017-18	96
2018-19	65
2019-20	55

28 As the Health Board met both of its financial duties: to achieve financial balance (as set out above) and to have an approved three-year plan in place; and there were no other issues warranting report, I did not issue a substantive report on the accounts.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

29 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively and economically;
- reviewing the effectiveness of the Health Board's counter-fraud arrangements.

30 My conclusions based on this work are set out below.

Structured assessment

31 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they responded to the next phase of the COVID-19 pandemic. The key focus of the work was on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations where these related to important aspects of organisational governance and financial management especially in the current circumstances.

32 The structured assessment grouped our findings under three themes:

- governance arrangements;
- managing financial resources; and
- operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.

Governance arrangements

33 My work considered the Health Board's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic. My work found that **the Health Board maintained overall good governance during the COVID-19 pandemic**.

34 The Board adapted its governance arrangements to maintain openness and transparency, support agile decision-making and ensure effective scrutiny and leadership during the pandemic. The Board is committed to using learning to help

shape future arrangements. A strong and resilient Executive Team supported by the Board led the organisation during the COVID-19 response.

35 Essential systems of assurance were maintained during the COVID-19 response. The Health Board's risk management system ensured it was well placed to respond to COVID-19-related risks. The Health Board is strengthening quality assurance arrangements, including updating key policies and its commissioning assurance arrangements.

Managing financial resources

36 I considered the Health Board's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance. I found that **the Health Board adapted its financial control procedures to manage during COVID-19 but there is an increasing risk to financial balance at the end of 2020-21**.

37 The Health Board continued to meet its financial duties in 2019-20. It also delivered £3.7 million of savings in 2020-21 but COVID-19 is affecting its ability to achieve the £5.6 million savings target it set for 2020-21. It continues to forecast breakeven for 2020-21 on the assumption that additional COVID-19 expenditure is funded in full. The Health Board's assessment of the net financial impact of COVID-19 for the year is estimated at £20.1 million. Financial control procedures were adapted to manage during COVID-19 in line with Welsh Government guidance.

Operational Planning

38 My work considered the Health Board's progress in developing and delivering quarterly operational plans to support the ongoing response to COVID-19 and to provide other essential services and functions in line with Welsh Government planning guidance. At the time of our work, the focus was on essential services with the aim of restoring normal and routine activities when it is safe and practicable to do so. My work found that **operational plans are informed by data modelling and demonstrate a clear commitment to staff wellbeing. Although progress and performance is monitored and reported, information on commissioned services is currently limited**.

39 Quarterly plans reflected the requirements set out in the Welsh Government's Operating Framework. The Health Board revised its strategic priorities as part of its response to COVID-19, which included the identification of additional surge capacity as both a provider and commissioner of services.

40 Staff wellbeing is a high priority for the Health Board with focussed attention on protecting staff safety and in ensuring their wellbeing during the pandemic. Some workforce challenges were experienced as the pandemic progressed, but these were less severe than the original modelling has predicted.

41 There is good oversight and scrutiny of overall performance and operational plan delivery but the lack of performance information for commissioned services is

particularly challenging with providers largely focused on responding to the pandemic. The pandemic provides challenges to the existing arrangements, although the relationships developed with providers have helped to maintain communication and provide assurance.

Effectiveness of counter-fraud arrangements

42 In June 2019, I published an overview for the Public Accounts Committee describing counter-fraud arrangements in the Welsh public sector. My team then undertook a more detailed examination across a range of Welsh public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement. In July 2020 I published Raising Our Game – Tackling Fraud in Wales setting out a summary of my findings and seven 'key themes' that all public bodies need to focus on in raising their game to tackle fraud more effectively.

43 Whilst this work was not included in the Health Board's audit plan, I also published an additional report setting out the Health Board's specific arrangements for preventing and detecting fraud. I found that **the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs**.

Appendix 1

Reports issued since my last annual audit report

Exhibit 3: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2020.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	2 July 2020
Opinion on the Financial Statements	2 July 2020
Performance audit reports	
Structured Assessment 2020	October 2020
Effectiveness of counter-fraud arrangements	August 2020
Other	
2020 Audit Plan	March 2020

Exhibit 4: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work. These dates are subject to change as we adjust our work in response to the COVID pandemic.

Report	Estimated completion date
Orthopaedics	February 2021
Review of Welsh Health Specialised Services Committee	March 2021
Test, Trace and Protect	February 2021
Unscheduled care	Phase 1 – March 2021 Further work to be included as part of 2021 plan
Quality Governance arrangements	June 2021

Appendix 2

Audit fee

The 2020 Audit Plan set out the proposed audit fee of £262,655 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Financial audit risks

Exhibit 5: financial audit risks

My 2020 Audit Plan set out the financial audit risks for the audit of the Health Board's 2019-20 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
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.	We completed the following audit work in relation to this risk: • tested the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewed accounting estimates for biases; • evaluated the rationale for any significant transactions outside the normal course of business. We have raised a recommendation in relation to the journals. Our testing has not identified any other issues to bring to your attention.
Healthcare commissioning contracts are a high value expenditure stream which could potentially be incorrectly stated resulting in a material misstatement with the	My audit team will: • walkthrough the controls; • substantively test contract expenditure; • agree NHS creditors, debtors, income and	We completed the following audit work in relation to this risk; • undertaken a walkthrough of the controls; • substantively tested contract expenditure;

greatest risk arising from variations that have not yet been settled in Q4.	expenditure to balance agreements; • test around the year-end transactions to ensure that accruals are complete; and • substantively test accruals.	• agreed NHS creditors, debtors, income and expenditure to balance agreements; • tested the year-end transactions to ensure that accruals are complete; and • substantively tested accruals. During our testing we noted one contract that was unsigned. Our testing has not identified any other issues to bring to your attention.
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.	We received the majority of audit evidence in electronic format via the use of the Inflo portal. We have used various techniques to ensure its validity, such as the use of screen sharing via Microsoft Teams software to observe reports being run and observed these being uploaded directly in Inflo or attached to secure Mimecast emails.

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2020-21

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

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

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

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-2021						
		18 May	25 June	20 July	08 Sept	03 Nov	26 Jan	09 March
Governance & Assurance:								
Annual Accountability Report 2019-20	BS	✓	✓					
Annual Accounts 2019-20, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS						✓	
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit Recommendation Tracking	BS	✓	✓		✓	✓	✓	✓
Charitable Funds Annual Report and Accounts 2019-20	DF&IT				~~✓~~	✓		
Losses and Special Payments Annual Report 2019-20	DF&IT				✓			
Losses and Special Payments Update report	DF&IT						✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS				✓			
Review of Standing Orders	BS					✓		
Internal & Capital Audit:								
Head of Internal Audit Opinion 2019-20	HoIA	✓						
Internal Audit Progress Report 2020-21	HoIA		✓	✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2020-21**						
Internal Audit Plan 2020-21	HoIA		✓					
External Audit:								
External Audit Annual Report	EAO						✓	
External Audit of Financial Statements 2019-20	EAO		✓					
External Audit Plan 2021	EAO							✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-2021						
		18 May	25 June	20 July	08 Sept	03 Nov	26 Jan	09 March
External Audit Progress Report 2020-21	EAO	✓	✓	✓	✓	✓	✓	✓
External Audit Review Reports	EAO	**In line with External Audit Plan 2019/20**						
External Audit Structured Assessment	EAO					✓	✓	
Anti-Fraud Culture:								
Bribery Policy	HoLCF		✓					
Counter Fraud Annual Report 2019-20	HoLCF			✓				
Counter Fraud Update	HoLCF			✓	✓		✓	
Counter Fraud Workplan 2020-21	HoLCF							✓
Post Payment Verification Annual Report 2019-20	PPVO				✓			
Post Payment Verification Workplan 2020-21	PPVO				✓			
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2019-20	BS				✓			
Development of Committee Annual Programme of Business	BS			✓				
Review of Committee Programme of Business	BS				✓	✓	✓	✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓
Local Counter Fraud Team				✓			✓	

KEY:

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

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales & HEIW

Our Ref: SE&IG/

Date: 30 November, 2020

Dear All

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

LHBs and HEIW
Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

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Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 03000 253245
Steve.elliot@wales.gov
Gwefan • website:
www.wales.gov.uk

NHS Trusts
Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;
- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

Steve Elliot & Ian Gunney
Diprwy Cyfarwyddwr Cyllid - Deputy Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group