Audit, Risk & Assurance Committee

Mon 12 July 2021, 10:30 - 12:30

Teams

Agenda

10:30 - 10:30
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_12July21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 8 June 2021 for approval

ARA_Item_1.3_Minutes_8 June 2021_Unconfirmed.pdf (12 pages)

1.4. Matters arising from previous meeting

1.5. Committee Action Log

ARA_Item_1.5_Action Log_12 July 2021.pdf (2 pages)

10:30 - 10:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waivers

ARA_Item_2.1_Application for Single Tender Waiver July 2021.pdf (3 pages)

10:30 - 10:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Audit Recommendation Tracking

ARA_Item_3.1_Implementation_of_Audit Recommendations.pdf (10 pages)
ARA_Item_3.1a_App C - Outstanding Priority 1 Internal.pdf (1 pages)
ARA_Item_3.1b_App D - Outstanding Priority 2 Internal.pdf (7 pages)
ARA_Item_3.1c_App E - Outstanding Unprioritised Internal.pdf (1 pages)
ARA_Item_3.1d_App F - Outstanding Priority 2 External.pdf (1 pages)
ARA_Item_3.1e_App G - Outstanding Unprioritised External.pdf (1 pages)
ARA_Item_3.1f_App H - Closed LCFS.pdf (1 pages)

3.2. Losses and Special Payments Report

ARA_Item_3.2_Losses and Special Payments Annual Report 2020-21.pdf (6 pages)

3.3. Fire Safety Update

3.4. External Audit Progress Report 2021-22

ARA_Item_3.4a_Audit Wales ARAC Update.pdf (10 pages)
ARA_Item_3.4b_Powys THB Structured Assessment (Phase 1) Report.pdf (12 pages)

3.5. Counter Fraud Update

ARA_Item_3.5_ July 21 Counter Fraud Update Report.pdf (2 pages)
ARA_Item_3.5a_Counter Fraud Update Report.pdf (4 pages)
ARA_Item_3.5b_Appendix 1 - Proactive Exercise - Overpayments.pdf (7 pages)
ARA_Item_3.5c_Appendix 2 - Counter Fraud Investigations Update Report.pdf (2 pages)

3.6. Internal Audit Progress Report 2021-22

ARA_Item_3.6_PTHB AC A&A Progress Report July 21.pdf (9 pages)

3.7. Internal Audit Reviews, 2020-21

3.7.1. Llandrindod Wells Project (Limited Assurance)

ARA_Item_3.7a_PTHB_202021_Llandrindod Wells_Final Report.pdf (51 pages)

3.7.2. Mass Vaccination (Advisory)

ARA_Item_3.7b_PTHB_20-21_Covid-19 Mass Vaccination Programme Advisory.pdf (19 pages)

10:30 - 10:30
0 min

4. ITEMS FOR INFORMATION

4.1. Committee Work Programme

ARA_Item_4.1_Committee Work Programme 2021-22.pdf (4 pages)

4.2. Rollout of the COVID-19 vaccination programme in Wales

ARA_Item_4.2_Vaccination-report-Eng.pdf (30 pages)

10:30 - 10:30
0 min

5. OTHER MATTERS

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

5.2. Any other urgent business

5.3. Date of next meeting: 14 September 2021 at 10:00 am

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
MONDAY 12th JULY 2021
10.30AM – 12.30PM
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 8 June 2021	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 8 June 2021	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 and IT
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Recommendation Tracking	Attached	Board Secretary
3.2	Losses and Special Payments Report	Attached	Director of Finance and IT
3.3	Fire Safety Update	Attached	Director of Workforce & OD and Support Services
3.4	External Audit: a. Progress Report 2021-22 b. Structured Assessment Phase 1: Operational Planning	Attached	External Audit
3.5	Local Counter Fraud Service, Progress Update a. Appendix 1: Proactive Exercise – Overpayments b. Appendix 2: Counter Fraud Investigations	Attached	Head of Local Counter Fraud Services
3.6	Internal Audit Progress Report 2021-22	Attached	Head of Internal Audit
3.7	Internal Audit Reviews, 2020-21 Limited Assurance a. Llandrindod Wells Project		Internal Audit & Director of Planning and Performance

	Advisory b. Mass Vaccination		
4	**ITEMS FOR INFORMATION**		
4.1	Committee Work Programme	Attached	Board Secretary
4.2	Rollout of the COVID-19 vaccination programme in Wales	Attached	External Audit
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: • 14 September 2021 at 10:00 am, Microsoft Teams		

Key:

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

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

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

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Rani Mallison, Board Secretary, rani.mallison2@wales.nhs.uk).

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 8 JUNE 2021 VIA MICROSOFT TEAMS MEETING

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Rani Mallison	Board Secretary
Pete Hopgood	Director of Finance and IT
Alice Rushby	Audit Wales
Amanda Legge	Post Payment Verification
Elaine Matthews	Audit Wales
Osian Lloyd	Internal Audit
Sarah Pritchard	Head of Financial Services
Alison Butler	Audit Wales
Felicity Quance	Internal Audit
Dave Thomas	Audit Wales
Hayley Thomas	Director of Planning and Performance (present for item 2.1.1)
Matthew Evans	Head of Local Counter Fraud Services
Sue Tilman	Post Payment Verification

Observer:

Ronnie Alexander	Independent Member

Committee Support

Caroline Evans	Head of Risk and Assurance

ARA/21/18	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/21/19	**DECLARATIONS OF INTERESTS** The Committee Chair INVITED Members to declare any interests in relation to the items on the Committee agenda. None were declared.
ARA/21/20	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 29 April 2021 were RECEIVED and AGREED as being a true and accurate record, subject to the following amendments: Ronnie Alexander, newly appointment Independent Member, was an observer at the previous meeting, not an attendee. Rhobert Lewis, newly appointment Independent Member, was an observer at the previous meeting, not an attendee.
ARA/21/21	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/21/22	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/20/100: The health board is writing to the two agencies concerned, requesting confirmation that they have the appropriate arrangements in place. Further action will be taken if the agencies fail to respond, and the committee will be updated if there is a further need. ARA/19/115e: This action has been identified as priority level 3 for implementation and will continue to be tracked via the audit recommendations process. ARA/20/64: PPV invited to attend pre-meeting of the Committee on 12th July 2021. ARA/21/8: Appendices will be expanded in the next report presented to the Committee. ARA/21/8: Fire Safety update to be presented to the Committee on 12th July 2021.

	ARA/21/10: Action transferred to the Performance and Resources Action Log.
ARA/21/23	**ANNUAL REPORT 2020-21:** **1. PART 1: PERFORMANCE REPORT** Hayley Thomas presented the previously circulated paper, which provides the Committee with the Final Draft of the Performance Report section of the Annual Report 2020/2021 for consideration prior to being submitted for approval at PTHB Board on 10th June 2021 and submitted to Welsh Government on 11th June 2021. Hayley Thomas advised that the final version incorporates all comments and feedback received from Delivery and Performance Group; Performance and Resources Committee; follow up meetings with Independent Members; Executive Committee collectively and responses from individual Executive Team members on their respective areas of responsibility; recommended amendments received from Audit Wales. The purpose of the Performance section of the Annual Report is set out in the guidance provided in the NHS Wales 2020-21 Manual for Accounts, to provide information on Powys Teaching Health Board, its main objectives and strategies and the principle risks that it faces. Members thanked Hayley and her team for all of their work on this report, which illustrates that whilst it has been a challenging year, there have also been some remarkable achievements. Carol Shillabeer stated that a separate report will be issued in due course, which analyses the work undertaken on the pandemic. **2. PART 2: ANNUAL ACCOUNTABILITY REPORT** Rani Mallison and Carol Shillabeer jointly presented the previously circulated paper, which provides the accountability section of the Annual Report for 2020-21, ahead of its submission to Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410. Rani Mallison advised that Auditors will review the accountability report for consistency with other information in the financial statements and will provide an opinion on the following disclosures which should clearly be identified as audited within the accountability report: • Single total figure of remuneration for each director • CETV disclosures for each director • Payments to past directors, if relevant

- Payments for loss of office, if relevant
- Fair pay disclosures (Included in Annual Accounts)
- Exit packages, (included in Annual Accounts) if relevant and
- Analysis of staff numbers.

3. PART 3: ANNUAL FINANCIAL STATEMENTS, INCLUDING AUDIT OF FINANCIAL STATEMENTS (ISA 260)

Pete Hopgood presented the previously circulated paper, which provides an overview of the Annual Accounts 2020/21.

Pete Hopgood advised that the health board had achieved its statutory duty and key financial performance target to deliver a breakeven position in relation to the revenue and capital resource limits RRL and CRL.

The health board has a statutory duty to ensure that its expenditure does not exceed the funding as allocated (Revenue Resource Limit – RRL) over a 3 year rolling basis. Subject to Audit, the health board has achieved this requirement in 2020/21.

The table below outlines the health board's net expenditure for 2020-21.

Accounts Extract Statement of Comprehensive Net Expenditure (SOCNE) P. 2:

	Note	2020-21 £'000	2019-20 £'000
Expenditure on Primary Healthcare Services	3.1	**72,405**	68,748
Expenditure on healthcare from other providers	3.2	**175,974**	161,711
Expenditure on Hospital and Community Health Services	3.3	**120,723**	109,381
		369,102	339,840
Less: Miscellaneous Income	4	**(12,601)**	(15,328)
LHB net operating costs before interest and other gains and losses		**356,501**	324,512
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**0**	0
Finance costs	7	**(30)**	19
Net operating costs for the financial year		**356,471**	**324,531**

Alison Butler presented the previously circulated Audit of Accounts Report (ISA 260), which summarises the main findings from the audit of the 2020-21 annual report and accounts.

Alison Butler advised that Audit Wales intended to issue an unqualified audit opinion on this year's accounts subject to the satisfactory resolution of the one outstanding matter within the Remuneration and Staff Report. Audit Wales issues a 'qualified' audit opinion where there are material concerns about some aspects of the accounts; otherwise an unqualified opinion is issued.

	Members noted the challenge in completing the audit in a virtual setting and some of the challenges re timing of information and reports being available for review and welcomed the commitment from the Finance and Audit team to complete a lessons learnt review of the process to help improve future years and going forward. Pete Hopgood thanked Alison Butler and the Audit Wales team for their hard work and support in completing the year end audit and noted the good working relationships that had been established between the teams. **Action: Board Secretary** The Committee APPROVED the Annual Report 2020-21 be RECOMMENDED to the Board for final approval, ahead of submission to Welsh Government.
ARA/21/24	**INTERNAL AUDIT REPORTS, 2020-21:** **<u>REASONABLE ASSURANCE</u>** **a) SAFEGUARDING DURING COVID-19** Osian Lloyd presented the previously circulated report, and advised that the purpose of this follow up review was to review health board arrangements for the safeguarding of children and vulnerable adults during the COVID-19 pandemic. Osian Lloyd advised that the review identified one medium and one low priority recommendation. **b) IMPLEMENTATION OF DIGITAL SOLUTIONS** Osian Lloyd presented the previously circulated report, and advised that the overall objective of this review was to assess the adequacy of the arrangements in place for the implementation of digital solutions during the covid-19 pandemic, lessons learned are being implemented and innovative practices are taken forward. Osian Lloyd advised that the review identified three medium priority recommendations. **c) WINTER PRESSURES AND FLOW MANAGEMENT** Osian Lloyd presented the previously circulated report, and advised that the objective of the review was to assess the Powys Teaching Health Board winter 2020/21 planning process regarding patient flow and to provide assurance over the management of patient flow over the 2020/21 winter period. Osian Lloyd advised that the review identified three medium and two low priority recommendations. The Committee Chair noted that it was the last meeting for Helen Higgs and Osian Lloyd with Powys, and thanked them for all of their support. The Committee RECEIVED and NOTED the Internal Audit reports.

ARA/21/25

EXTERNAL AUDIT UPDATE

a) PROGRESS REPORT 2021-22

Elaine Matthews presented the previously circulated report, which provides an update on current and planned Audit Wales work.

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
Quality Governance	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.	Fieldwork underway
Structured Assessment	Chief Executive	This work will continue to reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. The work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.	Phase 1 - Fieldwork completed and feedback provided. Phase 2 due to start in May 2021.
Vaccination rollout		This fact-based review will provide a high-level overview on key aspects relating to the administration, planning and approach for the rollout of vaccinations in Wales. This review will not seek to investigate detailed arrangements within health bodies.	Report due to be published June 2021.

b) TEST, TRACE, PROTECT IN WALES: AN OVERVIEW OF PROGRESS TO DATE

Elaine Matthews presented the previously circulated report, which sets out the main findings from the Auditor General's review of how public services are responding to the challenges of delivering TTP services in Wales. It is a high-level overview of what has been, and continues to be, a rapidly evolving programme. The evidence base for our commentary comes from document reviews, interviews with staff in health boards, local authorities, NHS Wales Informatics Service (NWIS), Public Health Wales (PHW) and the Welsh Government between September and December 2020, and analysis of key metrics that show how well the TTP programme has been performing. As well as commenting on the delivery of TTP up to and

	including December 2020, the report sets out some key challenges and opportunities that will present themselves as part of the ongoing battle to control COVID-19. Elaine Matthews advised that Wales has developed a Test, Trace, Protect service largely from scratch and at unprecedented scale and pace. It has been particularly encouraging to see how well public sector partners have worked together at a national, regional, and local level to combine specialist expertise with local knowledge, and an ability to rapidly learn and adjust the programme as we've gone through the pandemic. It's important that the positive learning is captured and applied more widely. There have been times when the Test, Trace, Protect service has been stretched to the limit, but it has responded well to these challenges. The programme needs to continue to evolve, alongside the rollout of vaccines, to ensure it remains focused on reaching positive cases and their contacts, and supporting people to self-isolate to keep the virus in check. **c) PROCURING AND SUPPLYING PPE FOR THE COVID-19 PANDEMIC** Elaine Matthews presented the previously circulated report, which looks at the procurement and supply of Personal Protective Equipment (PPE) during the COVID-19 pandemic. PPE is essential for protecting those who get close to infected people. It can also prevent people spreading the virus amongst each other and to those they are caring for. The report focuses on the national efforts to supply health and social care in Wales. These efforts have been led by the Welsh Government, working with partners in the NHS Wales Shared Services Partnership (Shared Services) and local government. Shared Services has taken on an expanded role in securing PPE for the whole health and social care sector. Elaine Matthews advised that in collaboration with other public services, Shared Services overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. It is now in a far stronger position, with stockpiles of most PPE equipment and orders in train for those that are below 24 weeks. Some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher level of PPE than required by guidance. The Welsh Government and Shared Services put in place good arrangements overall to procure PPE that helped manage risks and avoid some of the issues reported on in England. However, Shared Services did not publish contract award notices for all its PPE contracts within 30 days of them being let. The Committee Chair and Carol Shillabeer both thanked Elaine Matthews, noting that this is her final meeting. The Committee RECEIVED and NOTED the External Audit Update.
ARA/21/26	**COUNTER FRAUD ANNUAL REPORT 2020-21** Matthew Evans presented the previously circulated paper, which has been written in accordance with the provisions of the Fraud, Bribery and

	Corruption Standards for NHS Wales Bodies (the Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year. Matthew Evans advised that the Counter Fraud Work Plan for 2020/21 was approved by the Audit, Risk and Assurance Committee and identified a total resource of 228 days for the year. This was a reduced allocation from the SLA agreed provision of 245 days. The reduction accounted for a loss of resource with an LCFS absent from role at start of year. This absence impacted the available resource beyond initial anticipation; once recruitment process was completed with a new member of staff joining the team on 01 August 2020 the impact to SLA agreed resource was 84 days. The Counter Fraud Team delivered 184 days of counter fraud work with activity at Powys THB supplemented by unallocated new resource from within the Swansea Bay UHB Counter Fraud Team. The total cost for the provision of local counter fraud services for the year was £42,160. The costs are calculated based on number of staffing days delivered in year and counter fraud activity. The Committee RECEIVED and NOTED the Counter Fraud Annual Report 2020-21.
ARA/21/27	**POST PAYMENT VERIFICATION** **a) ANNUAL REPORT 2020-21** Amanda Legge presented the previous circulated paper, which highlights the narrative on how practices have been performing over the current PPV cycle, and two previous visits. It also demonstrates the overall performance of the health board against the national averages. Post Payment Verification of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP). Amanda Legge advised that in 2020-2021, we have faced major challenges associated with the COVID-19 pandemic. To effectively respond to challenges identified within Primary Care, Welsh Government primary care chief officers, in collaboration with associated clinical directors within the service, agreed that Post Payment Verification (PPV) processes would be stood down. This decision was taken to protect our front-line services, to maintain colleagues' safety and to remove any pressure on primary care contractors and their teams during unprecedented times. A review of opportunities and a recovery plan was considered during this time, to return with an acceptable level of PPV, which would continue to provide Health Boards with reasonable assurance that public monies are being appropriately claimed. PPV reinstatement was 1st October 2020, which was agreed by General Practitioners Committee (GPC) Wales and Welsh Government.

	Pete Hopgood stated that a pre-meeting with the PPV team is being arranged before the next Committee meeting, to provide Members with an overview of the PPV service and a general awareness of escalation points. Matthew Evans stated that the PPV service works closely with Local Counter Fraud Services, and that any claim errors are referred to Counter Fraud. **b) WORKPLAN 2021-22** Amanda Legge presented the previous circulated paper, which provides the visit plan for PPV for 2021-22. The purpose of a PPV visit to contractors is to ensure that claims submitted by contractors in respect of Services provided are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and HBs. Amanda Legge advised that the aim of the PPV process is to ensure propriety of payments of public monies by the HBs. The probity checks conducted during a PPV visit will provide reasonable assurance to HBs that public money has been spent appropriately by contractors making accurate claim submissions, contractors internal protocols are clinically sound, and services are being claimed for in accordance to clinical specifications. The data within the report highlights the history of practices, the percentage of errors they may have incurred during the PPV process and any follow up action taken to negate the risks. The visit plan for the upcoming year will only include General Medical Services (GMS) as we are not able to provide PPV to General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) as yet, due to Covid-19. The Committee RECEIVED and NOTED the Post Payment Verification Annual Report 2020-21 and Workplan 2021-22.
ARA/21/28	**COMMITTEE WORK PROGRAMME 2021/22** Rani Mallison presented the previously circulated report, which provides the Committee with its work programme for 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 2021/22.
ARA/21/29	**AUDIT WALES REPORTS:** **a) AN OVERVIEW OF QUALITY GOVERNANCE ARRANGEMENTS AT CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD: A SUMMARY OF PROGRESS MADE AGAINST RECOMMENDATIONS** Elaine Matthew presented the previously circulated report, which provides a progress update against the original 14 recommendations made in our previous report. We have been mindful of the impact that the COVID-19 pandemic has had on the ability of the Health Board to respond to the

recommendations, however, given the fundamental deficiencies identified in 2019 we felt it was important to establish and assess what progress the Health Board has made. We undertook similar evidence gathering activities as in our previous review.
Elaine Matthews advised that The Health Board is making good progress to address the recommendations that we made in 2019, particularly when taking account of the challenges it has faced in responding to the pandemic. This has impeded progress on improvements in some areas, meaning some actions haven't progressed as quickly as the Health Board originally intended.

b) WELSH HEALTH SPECIALISED SERVICES COMMITTEE GOVERNANCE ARRANGEMENTS

Elaine Matthews presented the previously circulated report, which considers the extent to which there are effective governance arrangements and whether the planning approach effectively supports the commissioning of specialised services for the population of Wales. The Welsh Health Specialised Services Committee (WHSSC) is a joint committee of each local health board in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The remit of the Joint Committee is to enable the seven health boards in Wales to make collective decisions on the review, planning, procurement, and performance monitoring of agreed specialised and tertiary services.
Elaine Matthews advised that since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales.

Dave Thomas suggested that this report should be presented to a future Committee meeting, along with WHSSC's Management Response formulated.

Action: Board Secretary

c) AT YOUR DISCRETION – LOCAL GOVERNMENT DISCRETIONARY SERVICES

Elaine Matthews presented the previously circulated report, which examined how councils have defined their services and sought to protect essential services when dealing with reductions in funding. The review focussed on how councils define services, the systems and processes they have used to review services and how robust and comprehensive these are. Financial pressures led to councils reducing spend and cutting services, but the pandemic has highlighted the importance and relevance of local government in serving and protecting people and communities. Defining whether a service is discretionary or statutory can be complicated and does not reflect the important work of councils. Despite providing

	essential services that people depend on, councils have had to make difficult choices on what to protect in responding to over a decade of austerity. Elaine Matthews advised that overall, councils have sought to protect services that help the most vulnerable when setting budgets. Services that protect and safeguard adults and children and help keep vulnerable people safe. Similarly, activities focussed on the upkeep of the environment, whilst seeing spending falling in the last decade, have not been cut as deeply as others. The Committee RECEIVED and NOTED the Audit Wales Reports.
ARA/21/30	**INTERNAL AUDIT ANNUAL REPORT & OPINION, 2020-21, FINAL VERSION** Osian Lloyd presented the previously circulated report which sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards. As a result of the continued impact of COVID-19 our audit programme has been subject to significant change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion. Osian Lloyd advised that the Board can take Reasonable Assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. The Committee Chair thanked Helen and Osian for all of their hard work, informing the Committee that this is their last meeting as they will be moving to Swansea Bay University Health Board. Helen Higgs thanked health board colleagues for their continued engagement throughout all of the audit work. The Committee RECEIVED and NOTED the Head of Internal Audit Opinion 2020-21.
ARA/21/31	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** • Annual Report and Accounts 2020-21
ARA/21/32	**ANY OTHER URGENT BUSINESS** There was no other urgent business for discussion. The Chair thanked Helen Higgs and Osian Lloyd for all of their hard work and wished them well for the future, and declared the meeting closed at 11.43 am.
ARA/21/33	**DATE OF NEXT MEETING**

	12 July 2021, 10:30 am, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

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

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

Minute	Date	Action	Responsible	Progress	Status
ARA/21/29	8 June 2021	Management Response to be formulated for External Audit review of WHSSC Governance Arrangements	Board Secretary	The Audit Wales report and management response is due to go through the Cwm Taf Morgannwg UHB's (hosting body) Audit Committee in August. Therefore, the report and management response will be presented to the Audit, Risk and Assurance Committee in September 2021.	
ARA/21/23	8 June 2021	Executives to meet with Audit Wales to discuss lessons learned for auditing of Annual Report and Accounts	Director of Finance & IT and Board Secretary	To be arranged.	
ARA/19/115e	9 March 2020	The Machynlleth Hospital Primary & Community Care Project recommendation 6 (lessons learnt) would be shared with	Board Secretary	This action has been identified as priority level 3 for implementation and will continue to be tracked via the audit recommendations process.	

		the Committee, once available.			
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 and IT / Board Secretary	PPV invited to attend pre-meeting of the Committee on 12th July 2021.	Complete
ARA/20/100	26 January 2021	Follow-up on the issue identified in the Counter Fraud Proactive Exercise – Pre-Employment Checks in respect of a lack of engagement by two agencies.	Director of Finance and IT	The health board has written to the two agencies concerned, requesting confirmation that they have the appropriate arrangements in place. Further action will be taken if the agencies fail to respond, and the committee will be updated accordingly.	Complete
ARA/21/8	29 April 2021	Appendices supporting the Audit Recommendations report are expanded to ensure that updates are fully readable	Board Secretary	Appendices have been expanded within the report presented to the Committee today.	Complete
ARA/21/8	29 April 2021	Fire Safety update to be presented to the Committee	Director of Workforce & OD	Update included on agenda, item 3.3	Complete

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 12th July 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's RATIFICATION of Single Tender Waiver requests made between 1 March 2021 and 31 May 2021.
RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 3 items during the period of 1 March 2021 and 31 May 2021 and consider additional information provided regarding the individual single tender documents.

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

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its March 2021 meeting which covered the period from 1 January 2021 to 28 February 2021.

A summary of the use of Single Tender Action from 1 March 2021 and 31 May 2021is 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
POW2122001	QUOTE	Mediaburst	System to enable patients to be increase their involvement in the management of their treatment, condition or lifestyle	Sole - Supplier Extension to Contract	12/05/2021	£14,352	12 months	Prospective	A1
POW2122003	TENDER	British Medical Journal	Subscription for Advertising for Medical Position	Recognised route for advertising Medical Positions	12/05/2021	£33,338	12 Months	Prospective	A2
POW2021022	QUOTE	Inhealth Pain Management Solutions	Daycase and Outpatient Pain Management Services	Continuation of Service - Previous STW POW1920004/ POW2021004 refers	12/05/2021	£23,595	12 Months	Prospective	A3

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

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

NEXT STEPS:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.1

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 12 JULY 2021**
Subject :	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	Executive Committee, 30 June 2021

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee is asked to note the current position of outstanding audit recommendations, following the re-prioritisation of Audit Recommendations for implementation 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	✓

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.

With the support of the Audit, Risk & Assurance Committee, Directorates previously reprioritised their audit recommendations according to 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.

In response to the reprioritised approach to audit recommendations in light of the COVID-19 pandemic, Executives have been asked to provide an update against Priority 1 and 2 recommendations only.

INTERNAL AUDIT

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	0	4	4
Priority 2	5	2	19	2	28
Priority 3	1	0	20	1	22
Not Yet Prioritised	0	0	1	0	1
TOTAL	**6**	**2**	**40**	**7**	**55**

Detail of re-prioritised internal audit recommendations can be found appended to this report as follows: -
Appendix C – Outstanding Priority level 1 Internal Audit Recommendations
Appendix D – Outstanding Priority level 2 Internal Audit Recommendations
Appendix E – Outstanding Un-prioritised Internal Audit Recommendations

EXTERNAL AUDIT

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	0	0	0	0
Not Yet Prioritised	0	0	4	4
TOTAL	**2**	**1**	**8**	**11**

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix F – Outstanding Priority level 2 External Audit Recommendations
Appendix G – Outstanding Un-Prioritised External Audit Recommendations

LOCAL COUNTER FRAUD SERVICES

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

Local Counter Fraud Services Recommendations		
	2020/21	**TOTAL OUTSTANDING**
	Number	**Number**
Not Yet Prioritised	0	0
TOTAL	**0**	**0**

Detail of local counter fraud recommendations can be found appended to this report as follows: -
Appendix H – Recommendations Closed since the last reporting period

NEXT STEPS:

Audit, Risk and Assurance Committee has requested that Executive Directors provide a comprehensive progress update and explanation against outstanding Priority 1 recommendations, which were due for implementation by 31st March 2021. A specific update on delays in implementing Internal Audit recommendations in respect of Fire Safety is included on the agenda at item 3.3
Priority 2 recommendations are now due for implementation during quarters 1 and 2.

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			
			H	M	L	H	M	L	H	M	L	1	2	3	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1							✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	2							✓
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0							✓
171806	Risk Management	Limited	2	1	0	2	1	0							✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0							✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0							✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0							✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1							✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1							✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0							✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1							✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0							✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1							✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3							✓
171817	Policies Management	Reasonable	0	4	2	0	0	1	0	4	1	0	5	0	×
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3							✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1							✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4							✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2							✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3							✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1							✓
171824	General Ledger	Substantial	0	0	1	0	0	1							✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1							✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1							✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	0	0	0	1	0	0	1	×
171828	Personal Appraisal Development Reviews (PADRs)	Reasonable	1	1	0	1	1	0							✓
171829	Records Management Follow-Up	Reasonable	1	4	2	1	4	2							✓
TOTAL			**28**	**81**	**33**	**28**	**77**	**31**	**0**	**4**	**2**	**0**	**5**	**1**	

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				Audit Recs 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	3	0	0	0	5	0	0	2	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3											✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	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	0	1	0	0	1	0	0	4	0	0	1	2	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	3	0	0	0	0	3	0	0	1	2	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	0	3	0	0	0	0	0	1	1	0	1	0	1	×
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	2	1											✓
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	1	1	0	0	1	0	0	1	0				×
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1											✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0											✓
192026	Risk Management and Board Assurance	Limited	2	3	0	0	0	0	2	3	0	0	5	0	0				×
192027	Welsh Language Standards Implementation	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0				×
192028	Section 33 Governance Arrangements Follow Up	Reasonable	0	2	1	0	0	0	0	0	0	0	0	3	0	0	2	1	×
TOTAL			**23**	**63**	**32**	**9**	**43**	**26**	**7**	**12**	**4**	**0**	**19**	**20**	**1**	**6**	**9**	**2**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				Audit Recs Not Yet Due			All Audit Recs Implemented
												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	1	2	0	6	0	0	0	1	2	0	×
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	0	1	0	1	0	0	3	1	0	0	2	1	×
202104	Annual Quality Statement	Not Rated	0	1	0	0	1	0											✓
202105	Advanced Practice Framework	Not Rated																	✓
202106	Capital Systems	Substantial	0	0	4	0	0	3	0	0	0					0	0	1	×
202107	GP Access Standards	Substantial	0	0	1	0	0	1											✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	0	0	0	0	0	0	0	0	0	5	3	1	1	×
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	0	0	0	0					0	0	14	×
202110	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	0	2	0	0	0	0	0	0	0					0	2	0	
202111	Grievance Process	Reasonable	0	1	0	0	0	0	0	0	0					0	1	0	
202112	Safeguarding during COVID-19	Reasonable	0	1	1	0	0	0	0	0	0					0	1	1	
202113	Implementation of digital solutions	Reasonable	0	3	0	0	0	0	0	0	0					0	3	0	
202114	Winter pressures and flow management	Reasonable	0	3	1	0	0	0	0	0	0					0	3	1	
TOTAL			**5**	**21**	**24**	**0**	**3**	**5**	**1**	**3**	**0**	**6**	**3**	**1**	**5**	**4**	**15**	**19**	

2018/19 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			Audit Recs Not Yet Due	All Audit Recs implemented
					Priority				
					1	2	3		
181951	Structured Assessment 2018	12	9	3	0	2	1	0	×
181952	Clinical coding follow-up review	4	4						✓
181953	Audit of Financial Statements Report	4	4						✓
TOTAL		**20**	**17**	**3**	**0**	**2**	**1**	**0**	

2019/20 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			Audit Recs Not Yet Due	All Audit Recs implemented
					Priority				
					1	2	3		
192051	Structured Assessment 2019	3	1	2	0	1	1	0	×
TOTAL		**3**	**1**	**2**	**0**	**1**	**1**	**0**	

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs implemented
					Priority			Not Yet Prioritised		
					1	2	3			
202151	Effectiveness of Counter-Fraud Arrangements	3	1	1	0	0	0	2	1	×
202152	Structured Assessment 2020	11	3	6	0	4	2	2	2	×
202153	Audit of Accounts	6	4	2	0	0	0	2	0	×
TOTAL		**20**	**8**	**9**	**0**	**4**	**2**	**6**	**3**	

Local Counter Fraud Services									
Ref	**Audit Title**	**Audit Recs Made**	**Audit Recs Implemented**	**Audit Recs Overdue (agreed timescale)**	**Audit Recs Revised Re-prioritised**			**Audit Recs Not Yet Due**	**All Audit Recs implemented**
					Priority				
					1	**2**	**3**		
202181	Pre-Employment Checks	3	3						✓
TOTAL		**3**	**3**	**0**	**0**	**2**	**1**	**0**	

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	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	No. of months past agreed deadline
													Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
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 policy or rather an update to the operational procedures. For the changes in WHTM 05-01 (2019) the latter applied. Noting the impact of recommendation 2, the Fire Safety Policy will be updated.	Jan-21	Overdue	1	Partially complete		The Fire Safety Policy has been reviewed against, and is consistent with WHTM 05-01; the fire safety management structure, in particular site management arrangements is on-going.	The fire safety policy is due for review in August and first draft has already been updated in line with current WHTM's. The document cannot be completed until the Fire Safety Management Structure has been agreed.	Fire Infrastructure risks including planned maintenance and reactive jobs, continue to be managed. Fire Evacuations were brought up to date.	Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021		4
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 Executive Director of Primary Care, Community & Mental Health Services to identify the appropriate operational site structures for fire safety.	Jan-21	Overdue	1	Partially complete		Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021	Agreement of details of the Fire Safety Management Structure and identification and agreement of key roles	Fire Infrastructure risks including planned maintenance and reactive jobs, continue to be managed. Fire Evacuations were brought up to date.	Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021		4
202102	Estates Assurance – Fire Safety	Limited	Chief Executive	Executive Director of Primary Care, Community & Mental Health Services Fire Safety Advisers	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	Overdue	1	No progress							4
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health (in consultation with the Senior Operational Managers – once defined)	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	Overdue	1	Partially complete		Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021	Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021	Fire Infrastructure risks including planned maintenance and reactive jobs, continue to be managed. Fire Evacuations were brought up to date.	Senior Executive direction given in June in respect of Fire Safety Management Structure and this will need to be implemented in time for the policy renewal in August 2021		1

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	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
															Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and how feedback received has been incorporated into the policy. The recommended consultation period of a minimum of 14 days should be applied to ensure that consultation with relevant stakeholder groups has been conducted thoroughly and that comments have been incorporated into the policy.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Dec-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	Dec-20		36	5	May-21	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content checks have been carried out.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. As set out in recommendation 4 below, the ability to upload polices onto the intranet will be restricted to members of the Corporate Governance Department.	May-18	Dec-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	Dec-20		36	5	May-21	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. Going forward policies submitted to the Corporate Governance Department without the submission and approval form will be returned to the relevant Executive Director.	May-18	Dec-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	Dec-20		36	5	May-21	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate Governance Department. The Policy and Procedures Index should be published on the intranet at regular intervals and consideration given to widening the scope of this document to include polices which are due for review.	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed and will be updated by the end of April 2018.	Apr-18	Dec-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-Dec-20		37	5	May-21	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	May-18	Dec-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	Dec-20		36	5	May-21	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 should be adopted in Occupational Therapy.	The policies and procedures will be updated to ensure compliance with GDPR. Occupational Therapy Teams will be reminded of the standards for records management to promote a consistent approach.	Apr-19	Dec-20	Nov-19	Overdue	2	Partially complete		A revised Records Management Framework is being developed.	Impact of COVID-19 on the IG team	IG advice and support is provided to the organisation when requested.	31-Dec-20		25	5	May-21	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 Development Group, bringing together the Cluster Team Leads and senior health board executives, as outlined in the Cluster Development Framework proposed in August 2018. 2. Furthermore, within this implementation, the health board should consider: - • regular Executive attendance at cluster meetings; • supporting localities to enable them to deliver consistent support across all three clusters; • making health board guidance and expertise available to support clusters (e.g. Workforce and OD, and Capital and Estates); and • the health board needs to consider how Executive Directors' governance role can extend into Primary 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. This Framework is based on the all Wales guidance for Cluster Governance.	Jul-19	Sep-21	Jul-20	Deadline Revised	2	Partially complete		Due to covid implications and deployment of former cluster manager to the mass vaccination programme the finalisation of this document has been again delayed. Cluster leads continue to meet fortnightly with Exec DPCCMH and other service leads. A recent meeting with representatives of the national Strategic Programme for Primary Care discussed the national survey of clusters and stakeholders. It is expected that a new governance framework will be developed nationally as a consequence of this work and thus PTHB will implement that new document in 2021/22.			Sep-20		22		May-21	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 responsibility document.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: Review and update the Health Boards Record Management Policy and supporting Procedures to ensure clarity on roles, responsibility and the framework for operation in the organisation.	Feb-20	Dec-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. A Records Management Framework is in draft awaiting wider consultation and approval.	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 extant.	31-Dec-20		15	5	May-21	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 procedures should be communicated to staff. The health board should consider rolling out training / workshops to remind staff of the agreed procedures and practices to ensure consistent application.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation. Publish the updated Policy and Procedures, raising awareness across the organisation. Introduce a programme of records management training for clinicians and staff, including management of identified risks.	Feb-20	Dec-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. A list of supporting procedures has been identified. A Covid-19 Health Records Management procedure has been developed and implemented in May 2020 - to be reviewed in June 2020. Key ICT procedures to support ICT Security and the use of Email have been developed and published to the intranet. The Health Records Management Advisory Group (HRMAG) has established a T+F Group to review, develop and implement Records	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 extant.	31-Dec-20		15	5	May-21	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 should be developed, but aligned to the policies regarding records management and tracking. Practices should be consistent from one site to another. The health board should strengthen the current processes for the transport of health records through the introduction of standard packaging and labelling requirements along with a standard signatory system for collection and delivery. The health board should investigate the access issues to Wye Valley NHS Trust's digital records, including the extent this applies to other NHS organisations, and revisit the information sharing protocol to ensure a better flow of patient information. The health board should ensure robust business continuity arrangements are in place to minimise the impact of system outages, WCCIS in particular, and work with the local authority to ensure the effective implementation of the integrated system, including the merging of multiple records and removal of duplicate records to create one single record.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Review and update procedures and guidance to support effective tracking of records. • Ensure adequate Business Continuity Planning arrangements are in place relating to records management. • Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation. • Develop a business case for the digitisation of active records. • Review Information Sharing Protocols in place for commissioned services.	Mar-20	Dec-20		Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. The Information Services Department lead on the rollout of Intelligence Tracking. Intelligence Tracking guidance exists, is updated in accordance with system changes and is regularly communicated to all users of WPAS. Training is provided to all new users and refresher training is undertaken. Drop-in sessions are also available to users on an ongoing basis. KPI and DQ reports are sent routinely to service leads. Future reporting requirements to be confirmed.	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed.	31-Dec-20		14	5	May-21	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 and that the points raised in this report are addressed, where weaknesses are identified.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-20	Apr-22		Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the RM Improvement Plan. Detailed actions and lead officers have been identified. Options for on and off-site storage continue to be explored.	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		13	#NUM!	May-21	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 implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-20	Apr-22		Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified.	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		13	#NUM!	May-21	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 a targeted approach focussing on directorates, departments or staff groups with higher levels of stress related absenteeism in the first instance. The health board should try to identify whether there is a correlation or inverse correlation between staff accessing the various stress management initiatives it has in place and the impact on stress related absenteeism on the various staff groups / departments / directorates with a targeted approach where stress related absenteeism is higher. Managers should be encouraged to complete the 'Manager's Stress Management Toolkit User Guide' or alternative to help identify whether management style is negatively impacting their team. Additionally, the health board should capture the number of managers completing any stress management self-assessment toolkit which could be used to identify whether completion of the toolkit positively impacts stress related absenteeism within their team.	HR Business Partners 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 where there are high levels of stress. We will track how quickly Staff return to work after counselling sessions and provide updates at Stress Steering Group. The stress management toolkit will be added to the Managing attendance at work toolkit that is available to all managers and discussed within the training. We will track the number of managers that have completed the Management user guide self assessment toolkit as part of the Management Development programme. As part of chat 2 change work programme we will seek to design and implement an in house 'PULSE' survey on the topic of stress and wellbeing.	May-20	Dec-21		Deadline Revised	2	Partially complete		Over the past 12 months, a range of wellbeing initiatives have been implemented to support the workforce's ability to respond to the Covid-19 situation. This includes: - A new wellbeing website portal including pages on the stress risk assessment tool kit - Wellbeing hubs providing refreshments and information across all sites - Increased access to counselling services, including a 24/7 support line - Wellbeing Workshops on personal stress management, stress management for managers and healthy eating (Stress Workshops attendance: 42 staff and 48 managers) - An Agile working policy to enable staff to work from home where possible - A staff recognition		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.		12	#NUM!	May-21	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 Risk – transfer of inaccurate data from Adastra between Shropdoc and 111 Constraints – stakeholder engagement (Advance & Shropdoc) Methodology – data accuracy and consistency being checked by PTHB Information Team" Amber Rated Actions: The Executive Director of Primary Care, Community and Mental Health (DPCCMH) will formally escalate the performance variation on the specific 111 measures which are not complying with the National Director for 111 at the same time as sharing this full audit report for comment and confirmation of improvement plan.	Feb-20	Sep-21		Deadline Revised	2	Partially complete		End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept 30th, Data will be available since go live with 111 in Oct 18 – PTHB information will analyse this. Service specification agreed and purchase order raised. Advanced committed to undertake data extract in June/July 2021 and following this the PTHB Information team will analyse the data and provide the relevant reports in line with the All Wales OOH standards.	Reliant on input and agreement from 3rd parties: Advanced, Shropdoc &	Monthly data continued to be received from Shropdoc which provides assurance on the 2nd line triage and face to face contact. This includes breach reasons and patient outcomes.	Sep-21		15	#NUM!	May-21	
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-21		Deadline Revised	2	Partially complete		End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept 30th, Data will be available since go live with 111 in Oct 18 – PTHB information will analyse this. Reporting on OOH metrics will then be achieved against the all wales OOH standards.	reliant on WAST		Sep-21		14	#NUM!	May-21	
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 teaching Health Board.	Jan-20	Sep-21		Deadline Revised	2	Partially complete		111 attendance at OOH Performance Mgt meeting. Patient complaints / concerns and compliments reviewed as part of the meeting.		Powys representation into national 111 Ops group. Expectation that 111 will provide local data at future Powys quarterly OOH performance Management Group meetings.	Sep-20		16	#NUM!	May-21	

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-21		Deadline Revised	2	Partially complete		111 attending OOH Performance Mgt Group meeting. Performance reviewed and exceptions documented. Risks captured on risk register. End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept 30th, Data will be available since go live with 111 in Oct 18 – PTHB information will analyse this. Powys representation into national 111 Ops group where risks are reviewed			Sep-21		15	#NUM!	May-21	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance and IT & Director of Primary, Community and Mental Health Services Director of Nursing	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC. 2.3 The CHC Standard Operating Procedures should be aligned with the Scheme of Delegation (Section 12) and practices in Adult and MH&LD CHC should be aligned. The CHC SOP should also be updated to clarify when contract renewals valued over £50,000 p.a. should go through a High Cost Resource Panel. 2.4 The health board should ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for CHC packages across Adult and Mental Health Nursing.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned to be 3-6 months long and commenced in early November 2019. Once the recommendations and/or revised Scheme of Delegation is issued the health board will undertake a review focusing on the recommendations of this report 2.3 CHC Standard Operating Procedure to be updated to ensure the all cases over £50,000 are referred to High Cost Panel 2.4 Formal communication to be issued from the Director of Finance to services leads for CHC (Adult and Mental Health) on the need to ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for all CHC packages. Additionally, to offer support if clarity is required on the Scheme of Delegation or SOP.	Dec-20	Sep-21		Deadline Revised	2	Partially complete		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 forward through the Section 33 Group by the end of September.	Not completed, but due to the WG's approach to the financial system and ability of care homes during C-19, this action has not been a priority, and the current white paper out for consultation, this action is of less priority but will be considered in S33 Group meetings when they are reinstated within the wider picture.		Sep-21		5	#NUM!	May-21	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent inspectorate visits and feedback from the relevant local authority. 3.2 This process should be documented in the CHC SOP (see finding 4 also). In-county care homes monitoring 3.3 The health board should clarify how it receives assurance that the LA has escalated issues identified through the joint monitoring process to the JQAP as appropriate, for example through its representation at the JIMP and JQAP meetings and through feedback to the CCSG. 3.4 The health board's CHC SOP should be updated to make reference to the joint monitoring process under the S33 agreement, including the assurance it receives as per 3.3 (see finding 4 also). 3.5 The above recommendations on in- and out-of-county care homes monitoring should take into consideration the NHS Wales National Collaborative Commissioning Unit project on provider care map dashboards. 3.6 The assurance mechanisms over CHC and FNC packages, including for monitoring both in- and out-of-county care homes, should be incorporated into the Board Assurance Framework. Funded Nursing Care	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	Apr-20	Jul-21		Deadline Revised	2	Partially complete		Out of county reviews are up to date. 3.1 remains in draft format and we are working to try and make it a Powys wide document but to also make it electronic 3.2 & 3.4 The HB has completed the SOP but there is some further work to do to ensure LA /PCC are content with it's content. There is also an out of county SOP completed please see attached. 3.3 The Quality Safety Experience FNC/CHC has now superseded the CHCSG and governance is discussed here. It is also discussed within our weekly QA panel as a way of an update I have added both documents 3.3. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart for ensuring payment is made.	Covid has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	Jul-21		13	#NUM!	May-21	

192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit. 4.2 The health board should undertake a demand and capacity review in light of the updated processes, in order to ensure compliance with legislation and maintain patient safety.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	Mar-20	Apr-21		Overdue	2	Partially complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date.	LA have requested to review the SOP and have contested some areas of the SOP 4.2 Covid has impacted on the way in which reviews are undertaken. Care home too busy to support completion, reviews completed virtually	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21		14	1	May-21	
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-21		Deadline Revised	2	Partially complete		Due to covid implications and deployment of former cluster manager to the mass vaccination programme the finalisation of this document has been again delayed. Cluster leads continue to meet fortnightly with Exec DPCCMH and other service leads. A recent meeting with representatives of the national Strategic Programme for Primary Care discussed the national survey of clusters and stakeholders. It is expected that a new governance framework will be developed nationally as a consequence of this work and thus PTHB will implement that new document in 2021/22 (once nationally developed). Recruitment of a new Cluster Development Manager is currently in			Sep-21		13	#NUM!	May-21	
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 the training programme timetable proposed in the RMF. Ensure training materials are available on the intranet.	Agreed.	Sep-20			Overdue	2	Partially complete		c. A T&F Group has been established with other RM colleagues through the Wales Deputy Board Secretaries Network, to develop a training plan needs assessment.					8	1456	May-21	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ 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 Risk Registers so that they incorporate directorate level risks, where applicable, in due course.	Agreed.	Dec-20			Overdue	2	No progress							5	1456	May-21	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.	Dec-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 risks and any new risks to prevent harm, minimise loss and reduce damage.					5	1456	May-21	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ 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 Register. b. Ensure that summary papers presented by RAG to the Executive Committee accurately reflect discussions and decisions made and documented.	Agreed	Dec-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 risks and any new risks to prevent harm, minimise loss and reduce damage.					5	1456	May-21	26/09/2020

192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and, • the relevant committees have regular oversight of the strategic objectives and risks assigned. b. Consider enhancement of the Board Assurance Framework review process by implementing and presenting a detailed BAF report at Board meetings. c. Establish the concept of Local assurance frameworks into the risk management hierarchy and then introduce them as a process documentation and discussion at directorate level.	Agreed	Mar-21			Overdue	2	No progress							2	1456	May-21	26/09/2020
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development & Assistant Director of Facilities and Support Services	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 guidance documents should be communicated to relevant staff, particularly those with management	• 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 managers and upload to intranet. • Undertake benchmarking against other health boards and carry out gap analysis of current policies that should be managed by Health & Safety. • Drafting and consultation of new policies following gap analysis. • Signing off of new policies following gap analysis. • Communicate reviewed policies to managers and upload to intranet.	Mar-21	Jun-21		Deadline Revised	2	Partially complete	Risk Mgt Framework template returned to date – 19 V&A incidents report paper to H&S group 9/2/21 H&S – HSE paper on HAVS improvement notices to Board March 2021 All H&S policies apart from corporate H&S policy reviewed and published	All policies outstanding have been reviewed and approved, these are now live on the intranet. Awaiting sign off of the Corporate Health & Safety overarching policy.	1 outstanding policy	Policies were extant whilst being reviewed.	Anticipate sign off of the Corporate Health & Safety Group in June 2021.	Health & Safet	2	#NUM!	May-21	
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 schedule of health and safety audits / inspections on a risk based approach. For example, sites with high risk characteristics, a higher number of health and safety incidents or sites identified as having lower compliance to health and safety legislation should be prioritised. • The implementation of the schedule of health and safety audits / inspections should be embedded, coordinated between the health board's Health and Safety Team and external parties as appropriate based on the required skills and expertise. • The health board should put in place a formal mechanism to capture, manage and monitor findings and actions raised through to closure. Risk assessments are an agenda item on site/service management meetings. Health & Safety will continually review service risk assessments through attendance at management meetings.	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 random sample of 1:20 returns will be undertaken by the Senior Health & Safety officer to check that they are suitable and sufficient. The schedule of Health & Safety audits / inspections will be informed through sampling along with any trends / data from Datix accidents and incidents. Through the Health & Safety Group all audits will be monitored including actions through to closure.	May-21	Aug-21		Deadline Revised	2	Partially complete		An exercise has taken place with service leads indicating domains of risk where assurance has been sought that risk assessments are in place. Returns have been received from 41 service managers confirming whether risk assessments are in place (or not applicable). The responses indicate: • a high degree of assurance that risk assessments are in place in relation to COSHH, DSE, lone working, staff pregnancy and manual handling risk assessments • a medium level of assurance that assessments are in place in relation to fire safety, health & safety, security, sharps, violence & aggression and workplace stress. • there may be gaps in departmental risk assessments with regard to driving for work, staff evacuation, legionella,	None	The risk has been mitigated via the training that has taken place to date; and the partial assurance from the initial tranche of information provided by service managers.	The remaining work will be completed by 31/08/21.		0	#NUM!	May-21	

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?					
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and IT		R2	The health board should investigate options for the implementation of an electronic referral management system as a replacement for the manual activities that currently cover the processes from initial patient referral up to booking of a patient's outpatient appointment into WPAS. This could be considered in alignment with the work being undertaken by the health board's newly created Health Records Management Group.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. Booking systems are automated and PTHB uses WPAS for booking. This action refers to some of the supporting systems, and recommends a move to electronic patient records, increasing the development of WCP and digital health solutions. This would require alignment with the Health Records Management Group and further investment prioritised in Digital Health at a local and NWIS level.	Mar-21			Overdue		No progress								2	1456	May-21	26/09/2020

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?				
181951	Structured Assessment 2018	Board Secretary	R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Overdue	2	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	19	2	May-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.	Oct-19	Mar-21	Overdue	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	19	2	May-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	Overdue	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 effectiveness.	Mar-21	13	2	May-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	To be considered in-line with the roll out of live streaming of board and committee meetings.			Overdue	2	No progress								May-21	
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.			Overdue	2	No progress								May-21	
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	• 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)			Overdue	2	No progress								May-21	
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	• Linked to 2019 Structured Assessment Actions and Update. Business Cycle to be reviewed, recognising the impact of COVID-19 during 2020.			Overdue	2	No progress								May-21	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	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?					
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I1	Implement mandatory counter-fraud training for some or all staff groups.	Implementation of mandatory counter fraud training would be seen as gold standard in terms of assisting to develop a counter fraud culture within the Health Board. There are a range of options from face to face delivery of training to mandatory counter fraud e-learning. Mandatory learning could apply for all or sections of staff at higher risk of fraud that can be explored to supplement the established programme of awareness work undertaken by the Health Board's Counter Fraud Team.	Mar-21	Mar-22	Deadline Revised		Partially complete		12/4/21 The Counter Fraud Team now have a presence as part of the Health Board's Mandatory Induction Programme to deliver counter fraud awareness sessions. Delivery of training to groups of staff at higher risk of exposure to fraud has been delivered or in the process of being arranged. Formalisation of future mandatory training for these key staff groups will be explored.	Congested mandatory and statutory learning schedule for staff may be barrier to full implementation for all staff.	Training has been or will be delivered to staff at higher irks of exposure to fraud.	Formalisation of Mandatory training for staff at higher risk of exposure to fraud will be explored in 2021/22.				May-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 outcomes, particularly with Health Board's bordering one another. The impact of embedded LCFS' within Health Boards should not be forgotten in considering this approach but there is certainly scope to achieve the desired effects of proactive and investigative outcomes, staff training, and increased resilience across Wales with a more joined up approach.	Apr-21		Overdue		Partially complete		Proposal received to be approved and implemented from April 2021.			Apr-21				May-21	
202153	Audit of Accounts	Director of Finance, Information and IT	3	We recommend that management review and implement consistency in creation of purchase order conventions and to remind all staff with receipting responsibility of the necessity to ensure receipts are entered in the same convention as the purchase order. This will negate examples of the significant accounting entries highlighted during the audit taking place.	This will require a joint approach with the procurement team in Shared Services and receipting staff within the Health Board to ensure that the required process is followed correctly. This will include general communication to all users of the system to mitigate errors by providing some further training on the process and offering further support to any user who has further issues with the process.	Dec-20	Oct-21	Deadline Revised		Partially complete		12/04/21 This work has been delayed due to covid - however part of oracle upgrade due in July 2021 a training programme will be developed for users which will should help to mitigate some of these errors.			Linked to Oracle Upgrade and the training programme due to be launched along side this.	Yes			May-21	
202153	Audit of Accounts	Director of Finance, Information and IT	4	We recommend that management ensure that contracts are signed.	The Health Board will work to ensure all contracts are signed within the financial year. Should this not be possible due to the any issues with the contractual documentation then the Board/Audit Committee will be advised of the breach in the SFI's by the end of the Financial Year in which the contract relates.	Mar-21		Overdue		Partially complete		Due to Covid there will be contracts that will not be signed in 2020/21 e.g. LTA contracts with England, which have been reported WG/Board monthly. As pandemic continues into 2021/22 unclear on national required for contracts linked LTAs. On specific BPSA contract a STW was actioned for 2020/21 contract.				Yes			May-21	

PTHB Ref. No.	Report Title	Director	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	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?					
202181	Pre-Employment Checks	Director of Workforce & OD and Support Services	R1	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.					Closed		Closed	The All Wales Agency Nursing contract is managed nationally and includes an audit activity which is managed via the All Wales Temporary Staffing Group. Changes to the contract are subject to the procurement process, therefore, we are unable to directly enforce these recommendations. However, the recommendations have been shared with the NWSSP procurement lead.			All Wales National Contract	National Risk - raised via the NWSSP procurement lead. This will also be shared with the National Temporary Staffing Group.		0	0		
202181	Pre-Employment Checks	Director of Workforce & OD and Support Services	R2	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.					Closed		Closed	The All Wales Agency Nursing contract is managed nationally and includes an audit activity which is managed via the All Wales Temporary Staffing Group. Changes to the contract are subject to the procurement process, therefore, we are unable to directly enforce these recommendations. However, the recommendations have been shared with the NWSSP procurement lead.			All Wales National Contract	National Risk - raised via the NWSSP procurement lead. This will also be shared with the National Temporary Staffing Group.		0	0		
202181	Pre-Employment Checks	Director of Workforce & OD and Support Services	R3	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.					Closed		Closed	The All Wales Agency Nursing contract is managed nationally and includes ad audit activity which is managed via the All Wales Temporary Staffing Group. Changes to the contract are subject to the procurement process, therefore, we are unable to directly enforce these recommendations. However, the recommendations have been shared with the NWSSP procurement lead.			All Wales National Contract	National Risk - raised via the NWSSP procurement lead. This will also be shared with the National Temporary Staffing Group.		0	0		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

Audit, Risk and Assurance Committee	**Date of Meeting: 8th June 2021**
Subject :	**Annual Report for Losses and Special Payments for the period 1st April 2020 to 31st March 2021**
Approved and Presented by:	Director of Finance & ICT
Prepared by:	Head of Financial Services and Assistant Director, Quality and Safety
Other Committees and meetings considered at:	None

PURPOSE:
To NOTE the Annual Report of Losses and Special Payments for the period 1st April 2020 to 31st March 2021.
RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to: It is recommended that the Audit, Risk and Assurance Committee NOTE this Annual Report on Losses and Special payments covering the period 1st April 2020 to 31st March 2021.

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

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

EXECUTIVE SUMMARY:

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

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

DETAILED BACKGROUND AND ASSESSMENT:

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

The Audit, Risk and Assurance Committee received an Interim report at its January 2021 meeting documenting Losses and Special payments made between the period 1st April 2020 to 31st October 2020.

This paper provides an annual report for the period 1st April 2020 to 31st March 2021.

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. The next paper is scheduled for the Executive Committee 14 July 2021.
- 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 March 2021, the THB made payments in respect of 7 cases totalling £191,773.20 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)	13	7	£191,773.20
Total	**13**	**7**	**£191,773.20**

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 March 2021.

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 14 open which are inclusive of clinical negligence (9) and personal injury (5) claims, with NWSSP Legal and Risk Services instructed to act on behalf of the health board.

Redress (Putting Things Right)

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

Details of the payments made during 1st April 2020 to 31st March 2021 are included in **Appendix Aii.**

	No. of payments/receipts	No. of cases	£
Redress Payments	9	5	£6,570.00
Total	**9**	**5**	**£6,570.00**
Redress Receipts	1	1	800.00
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 16 open redress cases at variable stages, plus 4 recently closed:

- 3 cases awaiting expert reports
- 13 cases at various stages of review/ progression
- Of 4 closed – (1) ex-gratia payment £1,000.00 (2) financial redress £1500.00, (3) apology extended, breach of duty but no harm, (4) no breach of duty.

There has been one reimbursement during 2020/21.

Other Special Payments

Details of the payments are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
Other Special Payments	2	2	£535.69
Total	**2**	**2**	**£535.69**

Conclusion

The Audit, Risk and Assurance Committee is asked to note the above annual 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

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 1st April 2020 to 31st March 2021			Appendix Ai			
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		Payment on account of costs
Clinical Negligence	Claimant Costs	176C4MN0001	Jan-21	£30,000.00		Payment on account of costs
Clinical Negligence	Defence Costs	176C4MN0001	Mar-21	£2,070.00	£169,547.00	Defence Costs - Damages Paid Negotiating Costs
Clinical Negligence	Defence Costs	176C4MN0002	May-20	£255.00	£255.00	Case ongoing
Clinical Negligence	CRU	206C4MN0003	Jul-20	£4,998.00		
Clinical Negligence	Claimant Costs	206C4MN0003	Jul-20	£5,425.00	£10,423.00	Damages and costs paid case Closed
Clinical Negligence	CRU	206C4MN0005	Sep-20	£4,165.00		
Clinical Negligence	Claimant Costs	206C4MN0005	Jul-20	£2,500.00		
Clinical Negligence	Damages	206C4MN0005	Jul-20	£750.00	£7,415.00	Case Withdrawn and Closed
Personal Injury	Defence Costs	206C4PI0002	Feb-21	£720.00	£720.00	Case ongoing
Clinical Negligence	Defence Costs	216C4MN0010	Mar-21	£37.30	£37.30	Case ongoing
Personal Injury	Defence Costs	206C4PI0001	Mar-21	£3,375.90	£3,375.90	Case Withdrawn and Closed
		TOTAL		£191,773.20	£191,773.20	

Appendix Aii

Redress Losses And Special Payments for 2020-21 Financial Year

1st April 2020 to 31st March 2021 — **Appendix Aii**

Payment Date	Redress Reference	Laspar Reference	Nature of Payment	Amount
Aug-20	3940	216C4MN0002	Defence Costs	£300.00
	3940	216C4MN0002	Defence Costs	£500.00
Jul-20	3925	206C4MN0007	Defence Costs	£1,050.00
Oct-20	3925	206C4MN0007	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
			Total	**£6,570.00**

Reimbursements from Welsh Risk Pool

Receipt Date		Laspar Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
		216C4MN0002	Reimburse Defence Costs in full	-£800.00
			Total	**-£800.00**

Appendix Aiii

Other Losses And Special Payments for 2020-21 Financial Year

1st April 2020 to 31st March 2021 — **Appendix Aiii**

Payment Date	Laspar Reference	Nature of Reimbursement	Amount
Sep-20	216C4EG0001	Payment to Staff Member in respect of costs incurred	£477.92
Feb-21	216C4EG0002	Excessive Call Costs when calling THB Transport booking line	£57.77
		Total	**£535.69**

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

Date issued: July 2021

Document reference: 2001A2020-21

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

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Contents

Audit, Risk & Assurance Committee Update

About this document

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Accountability Report and Financial Statements	The Audit Committee and Board considered our audit report on 8 and 10 June respectively. The accounts were submitted to Welsh Government in line with the submission deadline of 11 June. The Auditor General for Wales placed an unqualified audit opinion on the accounts on 15 June and laid them before the Senedd on the 16 June. The Auditor General also issued a substantive report on the impact of a Ministerial Direction issued in December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund certain clinicians' pension tax liabilities. All NHS bodies will be 'held harmless' for the impact of the Ministerial Direction, however, in the opinion of the Auditor General any transactions included in the health board's financial statements to recognise this liability would be irregular.
Audit of the 2020-21 Charitable Funds Account	Planned for late 2021

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment (Phase 1) Report – Operational Planning Arrangements	July 2021
Rollout of the COVID-19 vaccination programme in Wales	July 2021
Welsh Health Specialised Services Committee Governance Arrangements	June 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service	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.	
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.	Report due to go out for clearance September 2021
Structured Assessment Executive Lead – Chief Executive	This work will continue to reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. The work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.	Phase 1 – Completed and report presented to ARAC in July Phase 2 - Fieldwork underway September 2021

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.	Whole system commentary and data analysis currently being completed Further work not yet started
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 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. This includes the material from our COVID-19 Learning Week held in March 2021.

6 Details of future events are available on the GPX website.

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 5** 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 5 – NHS-related or relevant national studies reports

Title	Publication Date
Rollout of the COVID-19 vaccination programme in Wales	June 2021
NHS Wales Finances Data Tool – up to March 2021	June 2021

9 The Auditor General has also published his Annual Report and Accounts for 2020-21.

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Structured Assessment 2021 (Phase One) – Operational Planning Arrangements: **Powys Teaching Health Board**

Audit year: 2021

Date issued: June 2021

Document reference: 2450A2021-22

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

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

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

Contents

Summary report

About this report

1 This report sets out the findings from phase one of the Auditor General's 2021 Structured Assessment on the operational planning arrangements at Powys Teaching Health Board (the Health Board). Our Structured Assessment is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2014.

2 Health bodies are required to submit a three-year Integrated Medium-Term Plan (IMTP) to the Welsh Government on an annual basis. In January 2020, health bodies submitted IMTPs, covering the period 2020-2023, for approval. However, the Welsh Government suspended the process for approving IMTPs to allow health bodies to focus on responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic.

3 The Minister for Health and Social Services set out shorter planning cycles for health bodies covering 2020-21. Guidance set out key considerations for planning, with the requirement for health bodies to produce a quarter one plan by 18 May 2020, a quarter two plan by 3 July 2020, and a combined plan covering quarters three and four by 19 October 2020.

4 The planning framework for quarters three and four 2020-21 covers the maintenance of effective and efficient operational planning arrangements in health bodies to guide their continuing response to the pandemic as well as responding to winter pressures and the implications of EU transition. Health bodies also need to continue to lay the foundations for effective recovery beyond 2020-21.

5 In our 2020 Structured Assessment report we considered the Health Board's planning arrangements for developing the quarters one and two plans. This report considers the planning arrangements which underpinned the development of the operational plan for quarters three and four of 2020-21.

Key messages

6 Overall, we found **the Health Board has effective operational planning arrangements, underpinned with good arrangements to engage with staff members and the public, and to monitor delivery of operational plans.**

7 The Health Board's Quarters 3-4 Plan was submitted to the Welsh Government within the required timeframe, covers the necessary areas within the planning framework guidance and received independent member scrutiny.

8 The Health Board's operational planning arrangements are robust, and plans were developed through extensive engagement with staff and the public.

9 The Health Board had good arrangements for monitoring and reporting on the delivery of the operational plans to the Board, albeit that the use of delivery

milestones was temporarily stood down which made assessment against delivery difficult.

10 We have not made any recommendations based on our 2021 Structured Assessment phase one work.

Detailed report

Scope and coverage of the 2020-21 Quarters Three-Four Plan

11 Our work considered the scope and coverage of the Health Board's Winter Protection Plan 2020-21 which sets out the arrangements for 2020-21 Quarters Three-Four (the Quarters 3-4 Plan) in line with Welsh Government planning guidance.

12 We found **the Health Board's Quarters 3-4 Plan was submitted to the Welsh Government within the required timeframe, covers the necessary areas within the planning framework guidance and received independent member scrutiny.**

13 The Quarters 3-4 Plan and supporting minimum dataset were produced in partnership with colleagues from Powys County Council, the Joint Partnership Board, and the Regional Partnership Board. The Strategy and Planning Committee held a private in-committee session to discuss the Quarters 3-4 Plan on 6 October 2020. The Committee received a presentation which was followed by a wide-ranging discussion of the detail and independent members had the option to return additional comments offline.

14 The Quarters 3-4 Plan was submitted to the Welsh Government on the 19 October 2020, as a draft pending approval by the Board. The Board approved the Quarters 3-4 Plan on 22 October which was the first opportunity to discuss the plan in public due to the compressed timetable. However, regular Board briefings took place to update members on the development of Quarters 3-4 Plan.

15 The Quarters 3-4 Plan covers the requirements established by the Welsh Government in the NHS Wales Operating Framework for Quarters 3 and 4 (2020-21). Each of the four harms is covered and underpinning plans have been completed including the updated Clinical Response Model, the Support Services Model and the Prevention and Response Plan. The Health Board fully populated all relevant areas of the minimum data set.

16 The Health Board adapted the planning guidance to ensure that they were able to distinguish between their role as a provider and a commissioner of services to meet the needs of the people of Powys. The Health Board worked closely with organisations providing commissioned services to ensure that the needs of the Powys population were included in their respective plans.

17 Alongside the Quarters 3-4 Plan, the Board approved the Powys Regional Partnership Board Winter Unscheduled Care Plan in November 2020 setting out arrangements to meet the demand for health and social care services.

18 Following the formal Winter Planning & Delivery Assurance Meeting in December 2020, the Welsh Government wrote to the Chief Executive expressing confidence that the Board has a good approach to responding to workforce challenges, and the delivery of primary and community services, safeguarding arrangements, and Test, Trace, Protect, and mass vaccination programmes. The Welsh Government

also expressed satisfaction that the Health Board is projecting a financial breakeven position, has good engagement and support for workforce and the third sector, and is delivering new models of care in North and South Powys.

Arrangements for developing operational plans

19 Our work considered the Health Board's arrangements for developing the Quarters 3-4 Plan to support its ongoing response to COVID-19, maintain essential services and resume more routine services.

20 We found **the Health Board's operational planning arrangements are robust and plans were developed through extensive engagement with staff and the public.**

21 The Quarters 3-4 Plan was developed by the COVID-19 Strategic Gold Group (referred to as the Gold Group in this report) that was initiated at the start of the COVID-19 pandemic in March 2020. All Executive Directors were members of the Gold Group along with a military liaison officer and the Director of Adult and Children's Services at Powys County Council.

22 The Quarters 3-4 Plan built on the comprehensive Quarter Two plan which was submitted as required in July 2020. The Quarters 3-4 Plan sets out achievements delivering the actions from the Quarter Two plan for each of the four harms. At the end of each section is a summary of remaining actions from quarter two although this does not set out the time frame or milestones for delivery.

23 The Health Board undertook extensive engagement with staff during the summer 2020 to gather their experiences of new ways of working during the pandemic. Staff provided over 300 pages of narrative which was drawn together into themes in a report 'Sharing insights and learning about our response to the COVID-19 pandemic to date'. The Health Board is keen to take forward innovations and increased agility in decision making. At the time of writing this report, the capture of lessons learned was ongoing, with work underway to identify learning on specific workstreams, including how learning might change focus and shape longer-term ambitions. Engagement with the local partnership forum has continued on a weekly/fortnightly basis since the start of the pandemic with strong engagement with Trade Union representatives.

24 The Health Board has various mechanisms for engaging with communities when service changes are planned. Prior to the pandemic, the Health Board used locality-based focus groups to engage with communities, but these were stood down due to COVID-19. The Health Board is finding new ways of working with the public and representatives from the third sector. Social media is being used extensively and the Health Board's website was refreshed last year with links to the Health Board's strategies and plans. The Chief Executive attended Town and Community Council events and has undertaken regular online public question and answer sessions. The Health Board also engages with local politicians who share

concerns raised by constituents about health and social care services and any proposed service changes.

25 The Health Board has worked very closely with the Community Health Council (CHC) throughout the pandemic. The Health Board met with representatives from the CHC at least once a week throughout the pandemic to make sure the public voice was heard. In August 2020, the Health Board held an online workshop for all CHC members which was an opportunity to share the framework for the Quarters 3-4 Plan and for CHC members to input into development of the plan.

26 The Health Board is keen to strengthen its engagement with patients and carers. The Health Board recognises that the patient experience framework has needed a refresh for some time, and this is set out in the clinical quality framework. Understandably, revising the approach to capturing and learning from patient experiences was delayed due to the pandemic, and now needs to be progressed at pace. Our review of quality governance will provide more detail on these arrangements.

27 Planning arrangements have strengthened in recent years. The Health Board has a small team dedicated to planning who have worked hard to succeed in developing timely plans which comply with Welsh Government requirements. During the pandemic, the planning team was strengthened with a temporary Assistant Director of Support Services to support the testing and mass vaccination programmes. Staff were also redeployed from the North Powys Programme team to provide additional central capacity, with the Assistant Programme Director playing a key role in the Quarter Two plan.

28 As set out in our structured assessment report 2020, input by clinicians into the planning process was strengthened at the start of the pandemic with the establishment of a clinical leadership group. A new Medical Director is now in post who is providing leadership for the clinical response model.

29 Alongside delivering the 2020-21 quarterly plans, the Health Board has maintained focus on delivering the Powys ten-year health and care strategy, and the three-year IMTP 2020-23. In addition to the quarterly plans, the Health Board has continued to progress its twelve strategic priorities agreed in July 2020 and revised in November 2020. These 12 key areas included bringing forward the opening of the Grange Hospital as part of the South Powys Plan, the North Powys Programme, the health and care academy, the Machynlleth full business case and Llandrindod Wells Programme business case. The physical environment has needed to fundamentally change due to the increased need for space due to social distancing, improvements to ventilation and increased oxygen supply.

30 The Health Board has undertaken significant activity to develop the required Annual Plan 2021-22. A Board development session in December 2020, set out learning from the pandemic work that the Health Board had undertaken with staff and a detailed look at the performance of provider and commissioned services. The Board were informed that the Annual Plan 2021-22 would focus on developing a programme of work underpinned with whole system approaches, such as

prevention and alternative solutions, extending capacity, ensuring quality and safety of services, and making use of digital solutions and informatics.

31 The planning approach was discussed at a Board meeting in January 2021 and assurance provided as to how the Health Board would address Welsh Government planning requirements.

Arrangements for monitoring delivery of operational plans

32 Our work considered the Health Board's arrangements for monitoring and reporting on the delivery of the Quarters 3-4 Plan.

33 We found **the Health Board had good arrangements for monitoring and reporting on the delivery of the operational plans to the Board, albeit that the use of delivery milestones was temporarily stood down which made assessment against delivery difficult**.

34 The Health Board updated its COVID-19 Pandemic Governance Framework 2020-21 in October 2020 and shared it with the Board in November 2020. This framework set out the arrangements for monitoring the implementation of the Quarters 3-4 Plan through the Delivery Coordination Group (the DCG). The DCG is chaired by the Director of Planning & Performance and reports to the Gold Group. The DCG may make operational decisions, in line with the Health Board's Scheme of Reservation and Delegation of Powers to Executive Directors. All strategic decisions are reserved for the Gold Group.

35 The DCG's role is to oversee delivery of the plan and coordinate actions taken by the Health Board to limit the impact of any business continuity disruption. The DCG coordinates performance monitoring and reporting, communications and engagement, tracking service changes, liaison with the CHC, liaison with commissioned services and the Welsh Ambulance NHS Trust.

36 The delivery of the Prevention and Response Plan is overseen by the Prevention and Response Strategic Oversight Group (SOG). Specifically, the SOG receives reports to support oversight of the Test, Trace, Protect and mass vaccination programmes, the performance dashboards situation reports (SITREP), incident management and prevention related activities. The Executive Committee's Delivery and Performance Group is responsible for development and review of performance for provided and commissioned services. High level feedback is provided to the Board as part of the Executive Committee report.

37 The Board was updated in January 2021 on progress against delivering Quarters 3-4 Plan. A detailed performance update was also provided. The documents set out the key achievements against each of the actions within the Quarters 3-4 Plan. However, the previous use of delivery milestones was stood down temporarily to enable a more agile monitoring approach to be taken by the Gold Group. The absence of delivery milestones meant it was not clear whether actions were on

track to be delivered on time or not. Milestones have been reinstated for the Annual Plan 2021-22, but it was also not clear whether actions were complete or more work was needed. Going forward, the progress report would also benefit from providing a summary of mitigating actions where delivery is off track.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Audit Risk and Assurance Committee	**Date of Meeting: 12th July 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 2021/22.
RECOMMENDATION(S):
It is recommended that the Audit, Risk & Assurance Committee receive the report for discussion and information the content of this update report.

Ratification	**Discussion**	**Information**
	X	

Evans,Caroline
07/07/2021 17:46:47

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	✓

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Item 3.5

Counter Fraud Update Report

12 July 2021

Fraud Update Report

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 30 June 2021.

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	**35**	**14**
Inform and Involve	**83**	**7**
Prevent and Deter	**90**	**23**
Hold to Account	**100**	**26**
TOTAL	**308**	**69**

4. STRATEGIC GOVERNANCE

4.1 NHS Counter Fraud Authority have commenced a two-part national fraud exercise around post event assurance in relation to Covid spend. Part 1 will require the submission of PO vs Non PO spend data relating to 2019/20 and 2020/21. The information will be analysed to identify potential outliers in spend.

A meeting is to be held between CFS Wales and other Heads of Counter Fraud within NHS Wales to standardise approach for response to ensure a consistent submission.

4.2 The Health Board's Director of Corporate Governance has agreed to be nominated as the Fraud Champion for the Organisation. The role will allow joint working to be carried out on areas of cross-over such as risk management relation to fraud and Bribery Act compliance around declaration of interests

and gifts and hospitality. The separation of this role from the Director of Finance also gives the Health Board further opportunity to scrutinise counter fraud work within the Organisation and is welcomed by the Counter Fraud Team and Director of Finance.

5. INFORM AND INVOLVE

5.1 As detailed within the agreed Counter Fraud Work Plan, an on-going programme of work has been put in place to raise awareness of fraud, bribery and corruption amongst all staff and practitioners across all sites. Since the start of the financial year the Counter Fraud Team have delivered 12 sessions of fraud learning including attendance at 2 corporate inductions.

6 PREVENT AND DETER

6.1 The Counter Fraud Team have undertaken proactive work around overpayments of salary following previously issued advice from Counter Fraud Service Wales. An outcome paper is at Appendix 1 of this report for information of findings of this work.

The Counter Fraud Team have since liaised with Finance and Payroll colleagues around a referral route to the Counter Fraud Team of instances of overpayments of salary to review for potential Theft or Fraud Act offences. The agreement has been reached to refer to the Counter Fraud Team any instances of overpayment of salary were the staff member or ex-staff member has been in receipt of payments for over 3 months or a value of £5000 without contact to the individual. This will ensure that the integrity of potential investigations is protected at an early stage.

The Policy around overpayments is to be reviewed in this financial year and will be fraud proofed as part of that process to formally include this referral route to counter fraud and consider recommendations made as part of the proactive exercise report.

6.2 Utilising the Health Board's National Fraud Initiative datasets around Payroll to Companies House and Payroll to Creditors matches the Counter Fraud Team have liaised with the Corporate Governance Team around Declaration of Interests compliance within the Health Board. Those matched datasets essentially highlight instances where staff members have conducted business with the Health Board directly, are linked to a limited company who has conducted business with the Health Board or staff members that have a close link to a third party who has conducted business with the Health Board or has links to a limited company that has done so.

7 HOLD TO ACCOUNT

7.1 The status of the LCFS investigative caseload at the time of reporting is summarised within Appendix 2 to this report for information.

8. RECOMMENDATION

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

COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise

Overpayments

May 2021

Executive Summary

In response to an identified risk the Local Counter Fraud Specialist (LCFS) has undertaken an exercise to explore the current procedure around the identifying and rectification of overpayments within Powys Teaching Health Board (PTHB).

This report has been written with the 'FCP 009 Debtors procedure' policy in mind, which covers the system for reporting, recording and investigating on all debts within PTHB.

In order to establish the Health board's compliance with this policy, research was conducted on the figures provided by the Finance department and the control team department.

At the conclusion of the exercise the LCFS found that there was a need for the policy to be updated, and improvements in manager training to be provided, as well as how the different departments involved in the overpayments process store the facts and figures. The LCFS has made some recommendations to mitigate the elements of risk identified.

Introduction and Background

The Local Counter Fraud Specialist (LCFS) for PTHB identified a risk relating to overpayments made by PTHB, and the means for discovering those overpayments. There was often a substantial delay between the overpayment being made, and its discovery, or process for recovery. The LCFS therefore proposed to undertake a proactive exercise to identify the most common cause for overpayments taking place, the existing process for rectifying them, and how changes could be made to improve the process and lessen the occurrences.

Scope of Exercise

The exercise looked at the ways in which overpayments were uncovered within PTHB by a number of different departments.

The Finance department provided the LCFS with a debtor's spreadsheet covering the period 2019-2021. Finance are notified of overpayments by the control team, who send them the gross and Net amount of debt owed, as well as a memo, with an instruction to invoice the subject. During the time 2019-21, PTHB was carrying a total of 138 overpayments, which amounted to £161,484.33. Of those 138 debts, many had made instalments via a payment plan or through payroll, while 66 had been paid back in full, reducing the overall amount outstanding to £74,778.11.

Internal Audit was consulted to ascertain whether they had conducted any work on the matter of overpayments. It was established that they had conducted a dip

sample exercise for the year as part of the Annual Payroll Audit, to establish if any overpayments had been identified by using the normal system checks that take place. They tested ten starter forms, ten leaver forms and ten changers forms, and from that pool of data, they identified seven overpayments. At this stage, the NWSSP recorded the overpayments and sent a letter to the Finance department for follow up.

The payroll department are responsible for discovering the overpayments and raising them to the control team. The Control team then process the information and input relevant dates, in order to work out the net amount owed, raise a memo and forward all the information to the finance department. It is the finance department who then raise an invoice, and liaise directly with the subject in order to recoup the money.

Method

The LCFS requested data from the Finance department, which detailed all of the Debtors for 2019/20 and 2020/21. This spreadsheet provided information on who owed money to PTHB, why the overpayment had been made, (all of which were an overpayment of salary) how much they owed, and whether they had made any payments to reduce the outstanding balance. It was found that there were 138 debtors who owed money to PTHB at the point the data was provided, with the highest total being owed by any one person, amounting to £9637.13.

The Debtors procedure policy sets out a timescale for which overpayments should be paid back to the health board. It's broken down as follows:

- After one month 1st Reminder;
- After two months 2nd Reminder;
- After three months inform financial accountant and seek confirmation from originating department to send to Debt Collection Agency.

At all times any correspondence/communication received regarding a debt should be maintained to keep track of letters and telephone calls made in chasing up of all debts.

Payments by instalment should be avoided if possible and should only be allowed in cases of genuine hardship, or if the debt was incurred as a result of an error by the tHB e.g. overpayment of salaries. All attempts should be made to minimise the recovery period and recovery should be completed within the financial year in which the problem occurred.

Instalments payable by staff still in tHB employment should be recovered by deduction from salary. All other instalments should be recovered via standing order.

Despite this timeline being in place, there were 24 debtors on the 2019/20 list that still owed a balance to PTHB, and 36 debtors that owed money for the financial year

2020/21. The remaining 12 were all reported within April 2021 and therefore form part of the 2021/22 data.

Internal audit within shared services were consulted and explained how they capture overpayments via a number of processes.

- On a daily basis, entries made onto ESR are independently checked. Any errors observed at this stage should be explored and rectified.
- Secondly, a monthly report is run, called a "checking report". This report looks at all starters, leavers and changers forms in comparison to ESR entries. So for example, if there are 100 leavers recorded on ESR, are there 100 corresponding leavers forms.
- Finally, the "exception report" extracts data within set parameters, ie, if there is a £500 difference in an individual's pay from one month to another, it's included in the report; or if there is a 35% difference in pay on a previous months pay it too is included in the report as a trigger. These triggers and amounts are different for medical and dental Doctors, but there are still parameters set to identify if there are any errors for these staff members alike.
- As a final "safety net" the NWSSP do expect that the budget holder for any department should also be conducting checks, and any anomalies in the budget should be discovered.

The control team were consulted and explained their process for discovering and recording overpayments. A few times a month a "retro" report is run by payroll which will identify any staff members who have had their information amended on ESR, but the date of the changes form does not match the date of the change. This information is added to a debt notification and forwarded to the control team. The control team use the gross figure from the Retro report to work out what the Net figure owed is, after all relevant deductions. This, along with a memo, is sent to the finance team to create an invoice for the Net amount and send it, with the memo, to the person that owes the money.

During the period of the Covid-19 pandemic, there were some resourcing issues within the control team, and that, coupled with a lot of debts, has meant there was a backlog in dealing with the retro reports and its information. All such backlog information has now been processed and the finance team have been updated.

WOD were spoken with about any input they have regarding overpayments, as they work closely with the NWSSP, including payroll, to address any issues with the process around ESR. On a quarterly basis a Customer Liaison Group meeting his held between NWSSP and WOD. During this meeting the topic of overpayments is discussed and payroll provide the information, as above, regarding what overpayments have been made and the reason or cause. If the reason relates to a human action/inaction, ie a manager submits a form late etc, then WOD progress the issue by advising the line manager and asking them to address the matter with the relevant members of staff. The advice given by WOD is that all terminations and changes must be processed in line with the payroll timetable, a copy of which is available on the intranet.

During the initial response to the Covid 19 pandemic, these customer liaison group meetings were postponed, however they have now started back up.

Findings

Finance Department figures

The spreadsheet of debtors that was provided to the LCFS by the finance department was reviewed and showed there to be 138 debtors in total for the relevant time period. There were 66 people that had received a salary overpayment, but had made good on that payment, in full, and therefore no longer owed PTHB any monies.

Of the 72 remaining people that owed PTHB monies, one had been sent a repayment letter and not made any payments, one person had made a payment but was also querying the balance, nine had made arrangements to pay via payroll or standing order, there were two without a repayment plan in place, and 57 who had an "outstanding" balance but no other details recorded with regards to payment plans etc. These 72 debts amounted to £74,778.11 owed to PTHB. In accordance with the policy timeline, these debtors should have been sent reminder letters and potentially sent to the debt collector for furtherance, however this is not the case within PTHB.

PTHB do still send the reminder letters to the debtors, however they recognise that sending a matter to a debt collection agency, when the fault is often with PTHB anyway, is very debilitating and life impacting to the debtor. The policy is under review at present, with a view to changing the procedure around referral to debt collectors. The suggestion is that reminders will still be sent, but a regular review on a case by case basis will take place to help with debt recovery without the need for a debt collection agency; or for cases where debt collection is required, a referral to an executive team for a decision to be made on the matter prior to instruction of the debt collection agency.

Since the invoicing for April 2021 had been shut down by the finance department, they had received a further 32 notifications of debt from the payroll department, which still required processing and an invoice to be raised. This is due to the backlog that had been sitting with payroll (as mentioned above). These will be included in the 2021/22 figures and do not form part of this report.

NWSSP Control Team figures

The control team were asked to provide their debtors spreadsheet so an overall picture of the outstanding debt, and its causes, could be identified. A spreadsheet covering April 2020 to April 2021 was provided for review, and was not an identical match to that provided by the finance department. This was confusing, as it meant that there was no method of knowing at any one time, how many debtors owed money, and what the overall deficit totalled, because no one spreadsheet contained all of the information. Further exploration has determined that the difference in the spreadsheets comes down to dates/timing. Where the control team record a debt on their spreadsheet at the point of discovery, it then forwarded to finance, often days later, and finance then record it on their spreadsheet at the point they raise an invoice.

A review of the reasons for the overpayments took place and it was discovered that the most popular cause for overpayments being made was due to a late submission of a leavers form by the responsible manager. There were 32 instances of leavers forms being submitted late (where an employee worked their notice period) and the delay in submission ranged from being made 2 weeks in advance of the employee leaving, to 9 weeks after the employee had terminated.

The next most common cause of overpayments being made was due to a late submission of a changes form; be that a reduction in hours, an increase in hours or a change in pay band. There were 19 occurrences where a late submission of a change form had resulted in an overpayment being made.

Other reasons for overpayments included 11 errors on sickness forms, both normal sickness and maternity sickness, as well as errors contained on, or duplicate timesheets, overpayments of unpaid leave, enhancements or annual leave and incorrect start dates.

Recommendations

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

1. The most common reason for overpayments was down to when a manager or supervisor submits a form when a change or termination takes place. There was a very vast time difference across the cases, ranging from a couple of weeks in advance, to 9 weeks after termination. When an online ESR form is completed it is tasked to an “approver” in the chain of command. If that approver doesn’t action it within one week, it automatically escalates to the next in the chain of command and so on. This takes place all the way up to the Chief executive and the chair. While there is guidance on the intranet around the payroll timetable, the initial action of completing the information on ESR is down to the manager.

   Training should be provided to all managers on how to deal with a leaver/changes form, and when they should be submitted ie. When a colleague gives their notice/requests a change of hours/commences or resumes from sick leave, the paperwork should be completed and submitted there and then, and before the next payroll cut-off date in all cases.

2. The debtors procedure policy states that after 3 months the matter should be referred to a debt collection agency to assist with recovery, however in a number of the cases reviewed, it took longer than 3 months for action to be instigated when the debtor had notified PTHB of an error. For existing employees consideration should be given to revision of the policy to recover overpaid amounts automatically over the same time frame as overpayment

initially occurred this is in line with the approach taken in other NHS Wales Health Boards and ensures the swift recovery of overpaid amounts.

3. The Counter Fraud Team should be referred cases where there is potential for fraud or theft to have occurred. Previously issued guidance by the CFS Wales Team outlines that case of overpayment of salary where that overpayment has occurred for 3 months or more should be referred to their financial investigators for consideration without contact to the individual. This should be used a referral point to the Counter Fraud Team to allow that onward referral and protect the integrity of potential cases.

Conclusion

The processes around overpayments of salary were found to be relatively robust and functioning. There is opportunity however to strengthen policy in particular the referral route to the Counter Fraud Team and recovery of funds. Common errors that result in overpayments should be considered going forward with a view to minimising the instances of overpayment of salary within the Health Board.

Key Contacts

Name	Job Title	Contact
Kirsty James	Local Counter Fraud Specialist	Kirsty.James5@wales.nhs.uk 01874 712419
Sarah Pritchard	Head of Financial Services	Sarah.Pritchard@wales.nhs.uk
Ceri Thomas	Deputy Payroll Team leader	Ceri.Thomas16@wales.nhs.uk

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.
INV/21/00103	21/06/2021	Working Whilst Sick	Staff	Working for own private business whilst in receipt of occupational sick pay.	Subject has been interviewed and gave admission of offence confirming that work had been undertaken whilst on sick leave. Subject has agreed to repay salary earned whilst on sick leave and a calculation has been made which totals around £400 to reclaim. It is not assessed as proportionate to pursue criminal charges in this case in line with CPS guidance. This information has been shared with internal investigators.
INV/21/00078	04/06/2021	Overpayment of Salary	Ex-Staff	Subject received additional pay after leaving employment of the Health Board totalling £11,164.75.	Financial investigators were engaged and undertook basic checks which showed available funds to repay amounts. This suggested that a Theft Act offence had not been committed as property was available for recovery and not transferred or spent. The Counter Fraud Team

Open Cases					
WARO Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					contacted subject who agreed repayment in full.

Closed Cases					
WARO Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
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.
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.	Evidential quality assessed as not being able to give a realistic prospect of conviction.
WARO/19/00119	14/10/2019	Timesheet	Staff	Additional unworked hours added to timesheet. Forgery of authorising signature.	No viable sanctions available in this case due to lack of supporting evidence. Risks around the storage of access to timesheets was raised locally and recommendations to address have been adopted.
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.

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee July 2021

NWSSP Audit and Assurance Services

Contents

1. Introduction

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

The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

The plan for 2021/22 was agreed by the Audit Risk & Assurance Committee in April 2021 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Outcomes from Completed Audit Reviews

Two audits from the 2020/21 plan were not finalised in time for submission to the Audit Committee in June, although the draft outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2020/21.

The audits have now been finalised, as detailed in the table below along with the allocated assurance ratings. The full versions of these reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS (2020/21 Opinion)	ASSURANCE RATING	
Covid-19 Mass Vaccination Programme (Advisory Review Report)	N/A	
Llandrindod Wells Hospital Reconfiguration Project	Limited	

3. Delivery of the 2021/22 Internal Audit Plan

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

During the first quarter of 21/22, initial work has commenced on delivery of the following audits from the plan:

Audit Review	Objective overview / Outline Scope	Current Position
Access to Systems	To provide assurance to the Audit Committee that a process is in place for ensuring access is managed in an efficient and secure manner and that reflect the needs of the organisation	In Progress
Safeguarding – Midwifery Supervision	A review of the midwifery supervision process following the introduction of a new system. We will consider quality metrics in place and the implementation of learning.	Planning
Post Covid-19 Syndrome	To assess the establishment of the service.	Planning
Estates Assurance – Control of Contractors	To assess the adequacy of management arrangements to ensure compliance with the requirements of Health & Safety Executive guidance.	Planning
Medical Equipment & Devices	To provide assurance on the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems. We will include an assessment of the Welsh Point of Care Test (POCT) system.	Planning
Theatres Utilisation	To provide an opinion on theatre efficiency. We will include a review of financial performance; use of staff resource; patient experience and clinical outcomes.	Planning
Dementia Service	We will consider the effectiveness of the arrangements in place to deliver Dementia Services. To include a focus on the Dementia Home Treatment Service	Planning

4. Proposed Changes to the 2021/22 Plan

- Delays in commencing delivery of the current plan, due to the overrun of the 20/21 plan and the transfer of service provision to the new Audit & Assurance team, have resulted in the following audits being postponed from Q1 to Q2:
  - Safeguarding – Midwifery Supervision
  - Medical Equipment & Devices
  - Post Covid-19 Syndrome
  - Estates Assurance – Control of Contractors

- **Site Management**

  The Board Secretary has requested that this advisory audit review be postponed from Q1 to Q4 due to the on-going review of Executive and Management responsibilities.

5. Engagement

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

Board / Sub Committees

- Board - 26 May
- Board – 29 June

Health Board Meetings

- Carol Shillabeer, CEO – 10 May
- Rani Mallison, Board Secretary – 28 May / 28 June

Introductory meetings with Executives

- Pete Hopgood, Director of Finance, Information IT – 26 May
- Julie Rowles, Director of Workforce & OD - 27 May
- Claire Madsen, Director of Therapies & Health Science – 4 June
- Alison Davies, Director of Nursing – 4 June
- Jamie Marchant, Director Primary, Community & Mental Health – 7 June
- Hayley Thomas, Director Planning & Performance – 14 June
- Kate Wright, Medical Director – 14 June

Audit Wales Meeting

- Sarah Utley – 10 May

6. Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Note the outcomes from the finalised 20/21 audits;
- Note the progress with delivery of the 21/22 plan; and
- Agree the proposed changes to the 21/22 plan.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Recevied	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Access to Systems	Q1	24/05						September	In Progress
Safeguarding – Midwifery Supervision	Q2								Planning
Medical Equipment & Devices	Q2								Planning
Post Covid-19 Syndrome	Q2								Planning
Estates Assurance – Control of Contractors	Q2								Planning
Theatres Utilisation	Q2								Planning
Dementia Service	Q2								Planning
Mortality Reviews	Q2								
Machynlleth (Bro Ddyfi Hospital)	Q2								
North Powys Well-being Programme	Q3								
Breath Well Programme	Q3								
Looked after children with mental ill health	Q3								
Job Matching & Evaluation Process	Q3								
Financial Savings & Budgetary Control	Q3/4								
Performance Management & Reporting	Q3/4								

Planned output.	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Recevied	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Network and Information Systems (NIS) Directive	Q3/4								
Site Management (Advisory)	Q4								
Risk Management & Assurance	Q4								
Concerns Tracking/Monitoring Assurance	Q4								
Cancer Services	Q4								
Estates Assurance - Decarbonisation	Q4								
Workforce Futures Framework	TBC								
Annual Governance Statement	Q4								Year-end
Follow-up Action Tracker	Q4								

Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

Assurance not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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Llandrindod Wells Hospital Reconfiguration Project

Final Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Limited Assurance

Previous rating: Reasonable

CONTENTS Page

Review reference:	SSU_PTHB_2021_05
Report status:	Final
Fieldwork commencement:	11 January 2021
Fieldwork completion:	18 March 2021
Draft report issued:	23 March 2021
Draft report meeting:	20 April 2021
Management response received:	17 June 2021
Final report issued:	21 June 2021
Auditor/s:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign off	Hayley Thomas, Director of Planning & Performance
Distribution	Wayne Tannahill, Assistant Director of Estates & Property Louise Morris, Head of Capital Rani Mallison, Board Secretary
Committee	Audit, Risk & Assurance Committee

Evans Caroline 07/07/2021 17:46:47

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

The review was undertaken to assess Powys Teaching Health Board's (the THB) processes, procedures, and operational management of the current stage of the Llandrindod Wells County War Memorial Hospital reconfiguration project (the project).

The Full Business Case (FBC) for Phase 1 was approved in October 2017 in the sum of £3.407m. Additional Welsh Government funding was subsequently allocated for X-ray (£225k), lightning protection (£75k) and calorifier replacement (£60k) increasing the overall budget to £3.767m.

Completion of Phase 1 of the project was originally scheduled for May 2019. However, a review of the plans and construction programme, undertaken by the main contractor, revised the planned completion; which was further amended due to other issues impacting the project. All works were complete and handed over in February 2020 (nine months later than the original contract completion date of May 2019) with the exception of the endoscopy suite, for which a key element (air handling unit) was identified as being non-compliant with required standards.

The replacement ventilation [air handling unit (AHU)] works were progressing on site at the time of the audit fieldwork, funded from the discretionary capital programme and with a budget of £404k. Available options for the recovery of the THB Costs incurred as a result of the AHU compliance issues were being explored at the time of the audit.

The THB has reported a total overspend on Phase 1 of £654k to date and an overspend of £32k associated with the AHU (all funded from the THB's discretionary capital programme).

Noting the impact of Covid-19, the delivery of this assignment has involved an increased element of remote working. Any limitations to the audit fieldwork as a consequence of the Covid-19 restrictions are clearly outlined at the report.

2. Scope and Objectives

The overall objective of this audit was to evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support its successful delivery. The review seeks to provide assurance to the Audit Committee that risks material to the system's objectives were managed appropriately.

The previous audit was undertaken during 2017/18 (*final report issued April 2018, Reasonable Assurance*) and was undertaken shortly after FBC approval with the main works having recently commenced on site.

The current review is the only audit undertaken on the project which assesses the progression and delivery of the works.

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

- **Follow up –** review of the status of previously agreed management actions (see **Appendix C**).
- **Governance –** the adequacy of project governance arrangements including the linkage with the THB Board / Committees, structures, accountability, roles and responsibilities etc.
- **Design / Change Control –** a review of the adequacy and application of the change management processes applied at the project
- **Monitoring & Reporting –** sufficient information on project performance was monitored and reported to an appropriate forum to ensure the project was delivered within control parameters.
- **Risk Management –** arrangements were in place to identify, assess and mitigate/manage key project risks; assurance that the risk profile was monitored against available contingencies.
- **Cost Management –** an assessment of the adequacy of the data collated, evaluated and reported representing the cost position of the project.

3. Associated Risks

The potential risks considered at the review were as follows:

- The THB failed to address known risk issues identified at prior audits.
- The project progressed outside of control parameters due to inadequate governance arrangements.
- Time, cost and/or quality were adversely affected by key decisions that were not subject to appropriate approvals.
- The design process was not progressed in a controlled manner impacting the critical path and project costs.
- Costs agreed with the contractor did not demonstrate value for money.
- Project costs escalated uncontrollably through an absence of adequate cost monitoring and reporting.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

This audit is the first undertaken on the project, following FBC approval, which assesses the progression and delivery of the works.

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the THB and the performance of the project against its key delivery objectives i.e. time, cost and quality.

Whilst recommendations have been made to improve existing systems of control and / or compliance, generally these areas were positively assessed (see **Section 5: Assurance Summary**).

However, there were significant time, cost and quality issues (fully attributed by the THB to its external agents) impacting the delivery of the Llandrindod Wells Reconfiguration Project. Accordingly, **Limited assurance** has therefore been determined.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that the project achieved its key delivery objectives and 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 an audit is dependent on the severity of the findings as applied against the specific audit objectives and should therefore be considered in that context.

4.1 Systems of Control

We evidenced reasonable control arrangements to have operated in a number of key areas, including:

- A well-defined governance structure operating as intended;
- Appropriate assignment and operation of key project roles; and
- Appropriate routine performance monitoring processes in place, with escalation of contractor performance issues to the Board.

The THB also took steps to manage the situation faced at the project ensuring all key parties / stakeholders [including Executive level at the main contractor] were suitably informed.

While a range of compliance and control issues have been identified for the THB to address, these were not significant factors in the overall assurance assessment (see **Section 5**). The key recommendations (see **Appendix B**) relate to:

- The agreement of compensation events outside contractual timeframes, and an insufficient audit trail of THB change approvals (also identified at prior audits – see **Appendix C**);
- The exclusion of delay damages from the main works contract, removing the THB's ability to obtain financial redress for the delays caused by the contractor at this project; and
- Improvements needed in the content of cost reporting.

The planned post project evaluation exercise had not been undertaken a year after completion of the project. Whilst management advise this is still proposed, the unprecedented issues encountered during 2020/21 (e.g. the Covid pandemic and the associated remediation works; and pressures on staff during this period) has delayed its progression.

Noting that this was the first major capital development progressed by the THB in circa 20 years and the delivery issues experienced, the early completion of the planned post project evaluation is therefore considered a priority, ensuring lessons are learnt and applied at future projects and further enhance internal control mechanisms (particularly recognising the anticipated approval and progression of the Machynlleth Hospital Reconfiguration Project).

Management have indicated that certain practices have already been improved following conclusion of this project. Therefore, some issues have been reported as observations, rather than recommendations (see **Appendix A** for detail).

4.2 Project Objectives

The audit also sought to assess project performance against the key parameters of time, cost & quality.

Time:

The appointed main contractor underwent internal reorganisation, driven by their corporate financial position, and the project was assigned a new contractor team. The nature and scope of the project was reviewed by the new contractor's team which identified changes to programme sequencing and phasing. These changes resulted in a change to the construction programme with completion delayed from May 2019 to February 2020 (a nine-month programme extension).

It is recognised that the above prolongation of the programme was outside of the direct control of the THB, nevertheless this has had an adverse impact on the project delivery objectives.

Further delays were also incurred as a result of the discovery of issues such as asbestos and low water pressure as works progressed on site.

Cost:

The project was significantly overspent on completion, with a reported £654k (17%) variance to the approved budget of £3.767m. The additional costs were funded from the THB's discretionary capital programme.

Quality:

The project achieved its primary aim i.e. the range and scale of services available at the hospital have been expanded and services integrated to a single location with added clinical space, albeit nine months later than anticipated. Improvements have been made to the patient experience and the hospital now has modern settings allowing for greater compliance across infection prevention, HTM/HBN guidance and safer working environments.

However, during commissioning, NWSSP-SES identified that the endoscopy air handling plant had not been designed in line with HTM compliance requirements. As a consequence, the air handling plant had to be redesigned, tendered and reinstalled after the main works had concluded, at an additional cost of £436k, funded from the THB's discretionary capital programme.

Available options for the recovery of the additional THB costs incurred as a result of this issue were being explored at the time of the audit.

5. Assurance Summary

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

Assurance Summary					
1	Follow Up	*Not applicable*			
2	Governance				✓
3	Change Control			✓	
4	Monitoring & Reporting			✓	
5	Risk Management			✓	
6	Cost Management		✓		

** 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 **two** issues that are classified as weaknesses in the system control/design in the management of the Llandrindod Wells Reconfiguration Project.

Operation of System/Controls

The findings from the audit have highlighted **four** issues that are classified as weaknesses in the operation of the designed system/control in the management of the Llandrindod Wells Reconfiguration Project.

6. Summary of Audit Findings

Follow Up

That previously agreed management actions had been implemented.

The status of the outstanding action as at the last Capital Follow Up report (issued May 2020) was as follows:

Closed	Outstanding	Partially Implemented	Superseded	Total
-	-	-	1	**1**

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

Noting there was no improvement in the documentation of compensation event approvals during the period of review, a new recommendation has been raised at this report**.** The assurance rating will therefore be assessed within the ***Change Management*** section.

Governance

That adequate governance arrangements were operating, including linkage with the THB Board / Committees, structures, accountability and roles and responsibilities.

The project operated within a well-defined governance structure; with regular Project Board and sub-group meetings held during the period under review (April 2019 to December 2020 - acknowledging a short recess during the initial stages of the Covid pandemic).

Appropriate sub-groups also operated during the period, with a construction delivery team and operational group, ensuring effective liaison between the capital team and operational colleagues (noting a decision was taken not to operate a central project team).

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

Appropriate reporting channels were also observed i.e. to Project Board and the Innovative Environment Group. Matters had been escalated to Board / Committee level where required, for example, to update on the contractor performance issues experienced; the progression of the design liability issues (see ***Monitoring & Reporting****)*; and the project overspend position (see ***Cost Management***).

Whilst recognising the governance arrangements in place, the following issues have been noted:

- The Project Board terms of reference had not been updated to reflect the management of the AHU scheme and some attendance issues were noted during the period (**recommendation 1**); and
- The Project Execution Plan required enhancement to reflect THB internal governance arrangements (**observation 1**).

Noting the above areas for enhancement, recognition has been given to the wider Board assurance i.e. reporting of both adverse time and cost issues to the THB Board and Welsh Government. In this context, **substantial assurance** has been determined.

Change Control

That adequate change control procedures were in place and had been appropriately applied at the project.

Appropriate change control procedures were documented within the Project Execution Plan. However, it was noted the THB's delegated authority arrangements were not captured within this key control document (**observation 1**).

We reviewed a sample of 11 changes actioned and areas of good practice were evidenced i.e.:

- scrutiny of contractor quotations by the External Cost Adviser, achieving cost savings for the THB; and
- regular review of the financial position between the External Cost Adviser and the Internal Project Manager.

However, we were not able to identify a clear audit trail demonstrating compliance with the defined contract control mechanisms / timetables (**recommendation 2**) i.e.:

- seven of the 11 compensation events had been agreed post-completion of works: and
- there was only evidence of appropriate approval in place for three of the changes. It was noted that this issue has been raised at prior audits (see **Appendix C**).

For full details of audit testing, refer to **Appendix D.**

Further, it was noted that the change management information presented within the External Cost Adviser's monthly cost reports was limited, therefore reducing the THB's ability for scrutiny / performance management (see **recommendation 6**, ***Cost Management***).

At the completion of the works (March 2020), the External Cost Adviser reported that a number of compensation events remained unresolved (£200k total with net additional cost to the project of £30k). Whilst acknowledging that 'not-to-exceed' figures (to cap unconfirmed costs) had been agreed with the main contractor when instructing additional works, the significant proportion of unconfirmed costs after completion reduced the certainty of cost reporting and budget management (**recommendation 2**).

Whilst there was an absence of a detailed audit trail to support the application of change management controls, we recognise, from review of the change register linked to the final account (as at August 2020), that all outstanding costs had been confirmed. Therefore, **reasonable assurance** has been determined whilst highlighting areas for improvement at future projects.

Monitoring & Reporting

That sufficient information on project performance was monitored and reported.

Significant performance issues have been experienced at this project i.e.:

- The main contractor's internal governance changes. A change in the contractor's team working on this project resulted in significant changes in the contractor's construction programme and an overall delay in completion from May 2019 to February 2020. Whilst the costs attributable to the extended programme were borne by the contractor, additional adviser fees (reported to be in the region of £120k), were incurred by the THB associated with the same; and
- External design team issues. A non-compliant air-handling unit was installed as part of the main works. A new installation was required to be designed and installed by a different contractor (post completion of the main works), at an additional cost of circa £436k. Management has indicated that they are currently seeking the recovery of the additional costs incurred.

The performance issues with the main contractor had been appropriately escalated - within the THB, to the Directors at the main contractor; and to the SCAPE framework.

Routine performance management processes additionally operated throughout the project. Key Performance Indicators were prepared and appropriate progress reporting to the Project Board was received from the external advisers.

A post-project evaluation exercise was planned at the time of reporting but had not yet taken place (recognising the unprecedented pressures faced by the THB during the last year). A recommendation has been made to ensure this incorporates a detailed review of the issues adversely impacting on the successful delivery of this project, including time, cost and quality issues (**recommendation 3**).

It is, however, recognised that an initial, high-level, consideration of the key issues impacting the delivery of the project was undertaken in August 2020. Identified issues included:

- Phasing difficulties.
- Fabric of the existing building providing unforeseen issues;
- Contractor issues (including programme issues); and
- Design team issues.

Whilst recognising that management consider that the delay issues to be outside of the direct control of the THB, and recognising the high-level issues identified as impacting delivery, the completion of a robust and detailed post-

project evaluation exercise for this scheme is still seen as a priority noting the imminent approval of further high value projects within the THB. Therefore, **reasonable assurance** has been determined in this area.

Risk Management

That arrangements were in place to identify, assess, mitigate / manage key project risks; and that the risk profile was monitored against available contingencies.

Both Phase 1 of the project and the AHU scheme were supported by detailed and costed project risk registers, prepared by the External Project Manager.

However, the risk registers were construction focused and did not incorporate an assessment of THB risks (e.g. service delivery) (**observation 2**).

It was further noted that, whilst the value of costed risks at the AHU scheme exceeded available project contingency, this had not been referenced within the cost reports presented to the THB (**recommendation 4**).

Accordingly, **reasonable assurance** has been determined in this area.

Cost Management

That adequate cost data collation, evaluation and reporting mechanisms were in place.

The cost position on completion of the main works was reported as follows (*taken from the March 2020 cost report*):

Original project budget	£3,407m
Additional WG funding for X-ray	£225k
Additional WG funding for Lightning protection	£75k
Additional WG Funding for Calorifier replacement	£60k
Total project budget	**£3,767m**
Final project cost	**£4,421m**
Variance from budget	**£654k**

The reported overspend has been funded from the THB's discretionary capital programme.

Management advised that an overspend had been anticipated from the outset of the project, attributed in part to the capped level of contingency (approved by Welsh Government) being insufficient for the level of unforeseen issues arising when working in an ageing building of this nature. The position has been exacerbated by issues stated in ***Monitoring & Reporting***.

Good practice was evidenced in that the insufficient approved budget, and associated financial risk to the THB's discretionary capital programme, had been reported to Board and Committee level on a number of occasions during the works programme.

In considering the financial performance of this project, it was noted that the main works contract excluded delay damages. Therefore, the THB would have no financial redress for the significant impact of such programme delay – including any associated revenue implications (**recommendation 5**).

The reasons for the significant overspend had not yet been formally analysed and reported. This should form a part of the lessons learnt exercise (see **recommendation 3**).

It was noted that an overspend has also occurred at the AHU scheme - budget of £404k and a reported overspend of £32k upon completion. The overspend primarily resulted from additional Mechanical & Electrical design requirements and an associated four-week extension of time. These additional costs have been included in the previously mentioned legal claim (noting the same design team was responsible)

Whilst monthly cost reports had been submitted by the External Cost Adviser, these could be improved to aid the THB's scrutiny and performance monitoring. At this project, reporting ceased in March 2020 on completion of the works (**recommendation 6**). Cost reporting should continue until the final account has been agreed and retentions have been released.

Noting the significant overspends incurred at both the main project and the AHU scheme, and the associated impact on the THB's discretionary capital programme, **limited assurance** has been determined in respect of cost management. The THB should undertake a post project evaluation exercise to affirm the basis of this cost position.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Audit observations ***(not for inclusion in THB audit tracker)*** ***See Appendix A***	-	1	1	**2**
Audit recommendations raised ***See Appendix B***		5	1	**6**

Appendix A

Audit Observations

Finding 1: Project Execution Plan	Risk
A Project Execution Plan (PEP) had been prepared for the project by the external Project Manager, which focused on construction management arrangements. It included little in the way of internal THB governance requirements (including structure / delegated authority limits etc.), and as such would not be a complete central reference point for key project stakeholders.	Insufficient clarity of project control arrangements.
Observation 1	**Priority level**
Project Execution Plans should be prepared with input from the THB, to ensure they capture relevant internal project governance / control arrangements	**Low**
Management Response	
This issue has already been identified and addressed at the Machynlleth Hospital Reconfiguration Project, with the PEP for that project prepared by the THB themselves to ensure adequacy of content.	

Finding 2: Project Risk Register	Risk
The main project risk register had been prepared by the External Project Manager. Whilst detailed and costed, it did not incorporate THB operational risks: focusing primarily on construction matters. It is acknowledged that this issue had already been noted at Project Board at the end of Phase 1, with an instruction given that the template risk register be improved for future projects.	Project objectives may be at risk if appropriate risks have not been adequately considered and reported.
Observation 2	**Priority level**
Project risk registers should consider THB / operational risks, in addition to construction risks.	**Medium**
Management Response	
A template risk register has been prepared to incorporate both operational and construction risks. This register will be used on all future projects.	

Appendix B

Management Action Plan

Finding 3: Governance – Project Board	Risk
The Llandrindod Wells Reconfiguration Project Board operated consistently throughout the period under review (spanning delivery of both Phase 1 and the Air Handling Unit (AHU) scheme: April 2019 to December 2020), with only a short recess during the initial stages of the Covid pandemic. The Project Board was supported by a clearly defined governance structure (including a construction delivery team and operational sub-groups), with reporting and accountability arrangements documented at the terms of reference (ToR). Whilst recognising the generally robust arrangements operating, the following issues were noted: - The ToR was last updated in January 2020, and accordingly did not reflect any additional responsibilities for the AHU scheme; - Membership and sub-group requirements would benefit from a review and refresh, to ensure focus and responsibilities remain appropriate as the project moves into Phase 2; - Whilst membership attendance was generally good (particularly recognising the other pressures impacting during the period, i.e. Covid), poor attendance was noted from the Community Services Project Board member during the period of main works reviewed (April 2019 to February 2020). Representation and commitment should be confirmed for Phase 2; and - Four meetings (October 2019, March 2020, October 2020 and December 2020) did not achieve quorum. This was only documented in the minutes	Defined governance arrangements lack clarity. The Project Board cannot function as intended if key members are absent.

for one of the meetings. It is, however, recognised that Covid priorities impacted during this period and that no decisions were taken at these meetings.	
Recommendation 1	**Priority level**
Project Board activities should be reviewed to consider the following: • The Terms of reference should be updated at key junctures, to ensure arrangements remain appropriate for the current stage (including membership, responsibilities, reporting lines, sub-group arrangements); and • Project Board minutes should clearly record where a meeting is not quorate (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
The terms of reference will be updated at key junctures and meetings will consistently record when the meeting is not quorate for future projects.	Assistant Director of Estates & Property Phase 2 / future projects

Finding 4: Change Management	Risk
The PEP sets out the project's change control procedure, including a flow chart demonstrating the review and approval route to be applied by the External Project Manager (EPM) and the THB. However, as per **finding 1**, it did not include reference to internal delegated authority limits. The aim of the compensation event process determined at the NEC form of contract is for compensation events to be assessed as early as possible at the time they incur and not at the end of the project. For this reason, the NEC3 form imposes strict notification provisions and timetables for resolution. Failing to adhere to these timetables risks contractor quotations being accepted by default. At the time of completion of the main works, a number of compensation events remained unresolved (£200k total with net additional cost of £30k). Management advised that 'Not-to-Exceed' figures were agreed between the EPM and main contractor, to enable works to progress in a timely manner. Whilst recognising it is not always feasible to have agreed compensation events in place prior to works being undertaken, a high value of unagreed changes post-completion of works does not represent good practice. The delay in agreeing compensation events reduces the time and cost certainty afforded to the employer/client, increases the difficulty in managing cash flow and risks breaching the strict NEC contract and the defined resolution timescales. It is noted the External Cost Adviser presented a 'worst case scenario' position to the THB via the monthly cost reports.	Project time and cost is not appropriately controlled. Reduced ability to maintain an accurate project budget. Increased pressure on the THB's discretionary funds, if projects go over budget. Compensation Events may be charged at contractor assessed values by default.

A sample of 11 compensation events (eight from Phase 1, three from the AHU scheme) were reviewed (see **Appendix C** for test findings). The following good practice was noted: • Compensation events had been assessed for value for money by the External Cost Adviser, in a number of cases achieving cost reductions from the contractor's quotation; and • A good working relationship was evidenced between the External Cost Adviser and Internal Project Manager, reviewing and agreeing the financial position of the project (including changes) on a regular basis. However, whilst recognising the above, the following issues were also identified: • Seven of the 11 compensation events were agreed post-completion of the works noting (based on the information provided by the THB and the ECA) the period of approval ranging from one-month post initiation to six months post initiation; and • Appropriate approval, in line with the THB's delegated authority limits, was only evidenced for three of the 11 compensation events. It was noted, however, that in a few of the cases (3 out of 11), prior verbal agreements between the ECA and Internal Project Manager were referenced in the communication evidenced. Further, two of the most significant changes had been reported to Project Board. Whilst formal sign off in line with delegated limits has not been confirmed in all cases, it was clear that relevant parties were aware of the changes and associated costs. Management should ensure that all approvals are based on formal, written authorisation in line with delegated limits.	

The approval of compensation events was previously raised in the 2017/18 audit report, and re-visited in the 2019/20 Capital follow up, on both occasions concluding that compensation events had not been appropriately approved (see **Appendix B**).	
Recommendation 2	**Priority level**
a) Compensation Events should be assessed and discharged within the stated contractual requirements. b) Compensation events should be approved in accordance with the THB's scheme of delegation (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
a) Assessment and discharge of compensation events will be undertaken within the contractual requirements. b) Compensation events will be approved within the scheme of delegation limits.	Assistant Director of Estates & Property During Phase 2 / at future projects

Finding 5: Post Project Evaluation	Risk
Noting this was the first major project delivered by the THB's current capital team, management clearly recognised the importance of a lessons learnt exercise and the benefits it would bring to future major projects (particularly noting the Machynlleth Hospital Reconfiguration Project currently awaiting Welsh Government approval). Section 6.2 of the Welsh Infrastructure Investment Guidance (2018) states: *"All appropriate programmes and project will be subject to Design and Construction Post Project Evaluation in accordance with recognised best practice. A Design & Construction Post-Project Evaluation should be carried out within three months of completion and handover of the project. This will be facilitated by NWSSP: SES in order to record lessons learnt from the procurement and commissioning of a project."* Formal plans had been made for the progression of a lessons learnt exercise at the project, with the Full Business Case (at section 6.7.3) documenting the proposed arrangements for post-project evaluation. The exercise was initially scheduled for May 2020, however, management have advised that a delay in completion of the exercise has been attributed to the unprecedented impact of Covid and the associated remedial works required, in addition to the management of Welsh Government slippage monies allocated during Quarter 4 of 2020/21. A presentation was made to the Project Board in August 2020, setting out the proposed approach. Whilst this included a proposal for consideration of primarily	Lessons are not learnt from this project. Improvements are not achieved at future projects. Advisers and contractor are not available to provide input to the exercise if it is not undertaken in a timely manner.

client-side matters (phasing difficulties, fabric of the existing building, contractor issues and design team issues), it did not include consideration of e.g.: • Input from the current Project Manager / Cost Adviser (including a review of change control arrangements, cost reporting etc.); • Detailed assessment of time / cost / quality issues (including a full analysis of the reasons for the project overspend, assessment of revenue implications arising from the programme delays, and impact on the THB's discretionary capital programme noting the significant contribution to the project); or • Matters such as business case development / project scoping, contract strategy and contract documentation (see **finding 7**), benefits or otherwise of the procurement approach. Further examples of areas of consideration of a Post Project Evaluation are included in **Appendix E**. Whilst noting the FBC arrangements also set out a requirement for contractor involvement, it is recognised that management do not consider it appropriate at this stage for them to be consulted further, noting the performance issues experienced and addressed during the project. It is acknowledged that management have not been in a position to progress this exercise during the last year; however, it is considered essential by Audit & Assurance that the THB completes a formal Post Project Evaluation soon, to inform internal governance and project management arrangements, and the delivery of future schemes (also noting the specified deadlines for a number of review areas has elapsed). It is also acknowledged that the timeframe for the	

review of all project benefits has yet to be fully achieved (as per FBC Appendix J: Benefits Realisation Plan).	
Recommendation 3	**Priority level**
Whilst recognising the impact of the Covid pandemic, a formal Post Project Evaluation should be undertaken as soon as possible including the areas identified at this audit. The completed evaluation should be reported to the Innovative Environments Group and the subsequent action plan applied to forthcoming projects and applicable internal control mechanisms (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
A 'lessons learnt' culture is an integral part of the PTHB approach to delivering major capital projects and, as the project at Llandrindod hospital has been the first significant project undertaken by the Health Board for a number of years, it is absolutely recognised that there are areas for improvement, and that this learning needs to be documented and transferable. The main project completion was February 2020 and the significant constraints imposed by COVID-19, in addition to the particular challenges involving the Principal Contractor and issues with the Design Team and associated legal process has meant that a full post project evaluation has not been possible with all stakeholders. Significant work has, however, been undertaken and documented in relation to improvements to the Handover process, for example, and Project Execution Plan and other documents have been made available to the audit team from subsequent projects (Machynlleth) to evidence that learning has been put into practice.	Assistant Director of Estates & Property July 2021

A lessons learnt report/presentation will be discussed at the Innovative Environments Group in August 2021 to identify what further work could beneficially be undertaken.	

Finding 6: Risk Management	Risk
A costed risk register was in place for the Air Handling Unit (AHU) scheme. However, it was noted that the value of costed risks on the risk register was significantly higher than total project contingency available. This presented a risk that the project would be unaffordable, if assessed risks materialised. Whilst the decreasing contingency balance was reported each month to the Project Board, reference was not made to the variance between contingency and risk value.	Project objectives may be at risk if appropriate risks have not been adequately considered and reported.
Recommendation 4	**Priority level**
Cost reports should reference any discrepancies between costed risk values and available contingency funds (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Cost consultancy reports will reference any discrepancies between risk value and contingency.	Assistant Director of Estates & Property At future projects

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Finding 7: Delay damages	Risk
Delay damages are paid by a contractor if they fail to complete the works by the specified completion date. They may also be applied to sectional completion if key dates are specified. The SCAPE NEC Option A Delivery Agreement as completed at this project specifically excluded delay damage clauses X5 and X7. Significant programme delays, arising from the contractor's change in approach to the project, saw the completion date move from May 2019 to February 2020. Whilst the contractor has borne the additional site costs themselves, the THB was liable for increased adviser fees (reported to be in the region of £120k), with revenue implications also reported. Absence of delay damages within the contract may also have reduced the THB's ability to influence the contractor's performance in this area and prevents recovery of THB costs incurred as a result of the significant delays. The THB has subsequently obtained professional advice in respect of the SCAPE Framework which stated that delay damages are generally not contained nor utilised within SCAPE contracts with a preference to collaborative working. However, the option to apply, or not apply, delay damages rests with the THB. While noting the above, NWSSP:SES are currently developing guidance in respect of the NHS Building for Wales Framework / NEC contracts. In the interim, they advise that NHS England guidance should be applied i.e. the inclusion of delay damages within all contracts. Both NHS England (P22) and NHS Wales (Building for Wales) Frameworks are based on NEC / collaborative working arrangements	The THB is not compensated appropriately for contractor failure to meet contractual obligations.

similar to the SCAPE framework applied at this project. See **Appendix F** for information.	
Recommendation 5	**Priority level**
a) Noting that no action can be taken at this project, management should ensure that the THB is adequately protected and that commercially assessed delay damages (reflective of any potential losses to the organisation) are provided at all future contracts. b) In the event the THB decides not to include delay damages at future individual contracts, there should be evidence of the associated risk assessment and appropriate senior approvals of the decision at an appropriate stage of contract negotiations (in accordance with THB delegated limits). (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
a) Professional advice is sought from the client appointed external Project Manager and Cost Advisor to inform the Health Board decision in respect of which contractual option to apply. The application, or not, of delay damages has benefits and disbenefits, for example, applying the damages clause can give rise to increased tender costs and engender an adversarial approach. b) This above advice has been sought, considered, documented and approved at Project Board for the subsequent project at Machynlleth.	Assistant Director of Estates & Property At future projects

Finding 8: Cost Management - Reporting	Risk

Cost reports had been presented to the THB by the External Cost Adviser on a monthly basis throughout the works. However, reporting ceased on completion of the works in March 2020.
 	
Noting costs continued to be revised after this point, and with final retentions not due until the end of defects period, cost reporting should continue until the final account has been agreed and all monies released.
 	
Whilst also noting the cost reports presented a range of cost information, the content of reports could be improved, in line with best practice, to provide the following additional information to further aid THB scrutiny:
• Cash flow reporting: whilst recognising previous audits have determined this was managed separately, it would be expected that this information be presented within the cost reports themselves, for completeness; and
• Improved information regarding contract changes, including:
  • classification of compensation events such as client, contractor and legislative change [noting this would also aid the lessons learnt review as discussed at **finding 7**]; and
  • a full register of contractual information such as details of Early Warning Notices, timelines of submission of information and instruction, information regarding formal approval.
	The THB does not receive sufficient information with which to facilitate its cost management, or to monitor the performance of the cost adviser.

Recommendation 6	Priority level
Future projects Cost reports should include sufficient information to facilitate THB scrutiny and cost management (**D**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
A professional external cost advisor was appointed by the Health Board for the Llandrindod project, with detailed fortnightly meetings held to review and agree the cost status, and a robust approach to deliver value for money was engendered. Future schemes will reflect a suitable degree of detail in the Cost Advisor reports to Project Board.	Assistant Director of Estates & Property At future projects

Appendix C

Follow up of previously agreed recommendations

Prior Ref	Recommendation	Status reported May 2020	Priority Rating	Current status as at March 2021	Revised responsibility & timescale
3	Compensation events should be approved in accordance with the THB's scheme of delegation.	**Partially implemented** A sample of eight compensation events were reviewed to confirm approval in accordance with the THB's scheme of delegation: • Evidence of appropriate approval was noted for one change; • Evidence of communication regarding the need for the change, but no evidence of appropriate approval of the value of the change was noted for two changes; and • No evidence of appropriate THB approval for five changes, for which management advised the Project Manager used their ability under the contract to instruct. Review of the Project Manager Contract [Appendix A: Schedule of Services to be performed by the Project Manager: Section 1.9] states "The Project Manager will require written authority from the Project Director in relation to any instruction to Designers / Contractors involving a commitment to additional cost.	**Medium**	**Superseded** See **Finding 5** for detail of the change management findings resulting from this year's review, with a new recommendation raised.	See finding 5

Prior Ref	Recommendation	Status reported May 2020	Priority Rating	Current status as at March 2021	Revised responsibility & timescale
		Review of the Project Initiation Document further states that the Project Manager provides all information and the Employer takes a decision on how to proceed with the change. The above guidance was not consistently evidenced. For future changes / projects, it is recommended that a schedule is maintained by the Capital team of the changes received from the Project Manager. This can be used as a reconciliation tool when receiving the change control tracker; with references to date of agreement / officer authorising and link to the email communication [retained on the shared drive].			

Appendix D

Change Management Test

Scheme	Works area	Detail recorded on the Change Control Tracker						Date of receipt of quotation	Test 1	Test 2
		EWN	PMI	CE	Detail	Date of issue[1]	Value			
Phase 1	Endoscopy	Not recorded	202	59	Insulation & platform access	Not recorded	£7,479.00	Not evidenced	Yes	15/03/2019
	Outpatients	Not recorded	193	175	Additional void protection	Not recorded	£4,162.00	Not evidenced	Yes	No[2]
	Dental	Not recorded	176	176	Fire alarm and electrical investigations	14/10/2019	£4,759.00	17/01/2020	Yes	No[2]
	Birthing	Not recorded	195	218	Comfort cooling to scanning room	Not recorded	£20,297.00	6/02/2020 for work done Jan 20	Yes	No[2]
	Waiting area	Not recorded	181	80	Asbestos removal	14/10/2019	£10,042.00	09/09/2019	Yes	03/03/2020
	Waiting area	Not recorded	203	245	Works to existing wiring to maintain sitting and dining room	Not recorded	£5,152.00	11/02/2020	Yes	No[2]
	Miscellaneous	Not recorded	186	207/208/ 209	Roof works	11/11/2019	£14,951.00	Not evidenced	Yes	11/02/2020

Scheme	Works area	Detail recorded on the Change Control Tracker						Date of receipt of quotation	Test 1	Test 2
		EWN	PMI	CE	Detail	Date of issue[1]	Value			
	Miscellaneous	Not recorded	204	58a	M&E changes for Waterloo Road corridor, OPD, Reception and waiting DWG update	Not recorded	£18,649.00	04/02/2020	Yes	No
AHU	-	Not recorded	5	3	Complete works in Xray store	28/08/2020	£4,602.00	18/08/2020	Yes	25/08/2020
	-	Not recorded	12	14	Additional mechanical requirements inc. 4-week extension of time	16/10/2020	£16,990.00	19/10/2020	Yes	No
	-	Not recorded	17	18	Stair fabrication + other costs	21/01/2021	£43,313.00	20/01/2021	Yes	No

Detail of tests

Test 1*: Was there evidence of scrutiny / value for money assessment by the cost adviser?*

Test 2*: Was there evidence of formal approval in line with the THB's delegated authority limits?*

Notes

[1] Formal date of issue of the compensation events could not be confirmed, no compensation events themselves were provided in the evidence pack. Where dates have been recorded, these were as per the Change Control Tracker (however, did not always tie in with the dates of communication subsequently evidenced).

[2] Whilst reference was seen in email communication to a meeting with the THB on 5/3/20, no evidence of formal agreement was provided.

Noting the incomplete detail seen at the change control register and as incorporated into the cost reports presented to the THB, **recommendation 2** has been raised regarding completeness of information presented

Appendix E

Example Post Project Evaluation Questions

	Topic	Key considerations of a PPE
1	**Summary evaluation**	• Brief description of project – covering service objectives, expected benefits, start date, completion date, original capital costs at time of approval, final outturn capital costs, and reasons for any variances between approved and final costs. • Was the project completed on time, within budget and in accordance with the approved business case? • Were there any significant barriers to completion of the project? • Were there any unexpected problems experienced during the preparation and implementation of the project? • What lessons were learned?
2	**Revisiting the strategic context**	• Was the investment needed? • Did anything change in the project environment that rendered the original project objectives unsound? • Have commissioners continued to support the project? • Were the assumptions made at the appraisal stage borne out by actual experience? • Was the organisation ready (i.e. cultural readiness) for the investment? • What lessons were learned?
3	**The investment decision**	• Was the decision-making process robust, sound and consultative? • Were any important stakeholders overlooked or insufficiently involved during the consultative process? • Were the right options identified and assessed? • Was the right option chosen? • Was the risk analysis valid? • Was the costed risk register appropriate and robust in practice? • Was the affordability analysis robust? • Could the decision-making process have been improved? • What lessons were learned?

4	**The procurement**	• Was the procurement based on a framework? • Was the framework appropriate for the project in question? • Did the framework provide value for money? • Did the use of the framework reduce conflict between supplier and client (the THB)? • Did the framework enable and encourage co-operative working across all stakeholders? • Was the procurement conducted robustly and in accordance with all relevant procurement guidelines? • Was the bidding process competitive? • Was the contract negotiated and managed robustly and properly? • Could any steps have been taken to improve the procurement process? • What lessons were learned?
5	**Project management and implementation**	• Was the project and implementation conducted and managed effectively and properly (including communication and consultation with staff and other stakeholders, management of suppliers, contract, benefit realisation, evaluation)? • Was the project brief adequate and appropriately signed off before issue? • Was change management well managed and documented in terms of design and design creep? • Was the board kept appraised of progress and any pressures developing during the project in a timely manner? • Was the project team appropriate for the project and adequately resourced? • Has the expertise and experience gained from the execution of the project been retained within the THB for the benefit of future projects? • What lessons were learned?
6	**Benefits management**	• Was the need for benefit management recognised? • Were benefits identified properly? • Were suitable plans made to effect their realisation? • Were benefits monitored and assigned to appropriate managers or business units? • Was timing for their delivery correctly assessed? • Were appropriate targets sets for benefits? • Were the cash and non-cash-releasing benefits delivered in line with the approved business case? • Were the risks to benefit delivery identified and properly assessed? • What lessons were learned?

7	**Organisational impact and change management**	• What support was provided by senior management in preparing for implementation of the project? • Was change managed properly? • Was design sign-off in relation to construction schemes robust and well informed? • Was appropriate support and training provided? • Was change communicated effectively? • Was the consultation process effective and sufficiently comprehensive? • What lessons were learned?
8	**Outcome and impact**	• What were the direct and indirect outcomes from the project? • Were there any undesirable outcomes? • What impact did the project have on the organisation sponsoring the project? • What impact did it have on staff? • What impact did it have on commissioners? • What impact did it have on patients/service users? • What impact did it have on other stakeholders (including non-NHS organisations) in the local health economy? • How did the actual outcomes compare with what was envisaged in the original business case? • How do outturn costs, benefits and risks compare with what was assumed and estimated in the original business case? • How does the timing of the various outcomes compare with what was assumed in the business case? • What was the process by which outcomes were achieved? • What lessons were learned?
9	**Lessons for future projects**	• With the benefit of hindsight, would other options have met the project objectives? • Would you have chosen the same preferred service solution? • Would you have managed the procurement process in the same way? • Would you have used the same framework for the project? • Would you have implemented the project in the same way? • Is there anything that you would have done differently?

		• Were specialists engaged at an early enough stage in the project and were business cases robust from the outset? • Were the approving bodies – WG etc. – involved at an early enough stage in the process to avoid abortive work or the need to resubmit the various business cases due to the approvers' needs and requirements not being met?
	Post-occupancy evaluation	• Has a post-occupancy evaluation (POE) been carried out? • Has the POE been shared with the project team to assist with future schemes? • Have the records relating to the project been collated and securely filed for future reference when preparing new schemes or projects? • Has relevant information been provided by the design and construction team to the THB to help future schemes and the day-to-day management of the facility? • Are stakeholders satisfied their comments on design have been correctly interpreted? • Does the new facility function as it was envisaged? • Are there any fundamental design issues that need to be resolved? • Where shortcomings have been identified, has the cause been evaluated to avoid problems in future projects? • What lessons were learned?
10	**Approvers' input**	• Was the input and engagement from/with the various approvers timely, clear and supportive? • Did the approvers clearly explain their expectations and required deliverables? • What lessons were learned?
11	**External support**	• Was external support adequate? • Was the brief to the external support appropriate to ensure the THB's needs were met? • What lessons were learned?

Appendix F

Guidance on application of Delay Damages

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Delays to completion of Capital Investment Projects in the NHS: Liquidated & Ascertained Damages/Delay Damages

1.0 Introduction

Most standard forms of contract contain provisions that enable an NHS organisation acting as the Employer in a construction contract (below referred to as NHS Client) to recover what are referred to as Liquidated & Ascertained damages (JCT Contracts) or delay damages (NEC Contracts) in the event that the Contractor does not complete the Project by the Completion Date or by any Revised Completion Date agreed between the parties under the provisions of the contract.

Liquidated & Ascertained /Delay Damages can be simply described as being a pre-estimate of the anticipated direct costs that the Employer will incur as a result of any delay that a Contractor is responsible for.

When considering engaging a Contractor to deliver a Capital Investment Project, it is recommended that NHS Clients include contractual provisions for Liquidated & Ascertained/Delay Damages. An example being that the P22 Framework NEC3 Option C Contract Template identifies that he provisions in respect of Secondary Option X7 – Delay Damages are included.

In determining whether a project is commercially attractive a Contractor will consider both the level of delay damages inserted and the sufficiency of the Completion Dates/Sectional Completion dates.

2.0 Liquidated & Ascertained Damages/Delay Damages vs Consequential Losses

The difference between Liquidated & Ascertained Damages/Delay Damages and Consequential Losses needs to be understood:

a. Liquidated & Ascertained Damages are pre-determined and contractually enforceable estimates of costs/losses that the parties agree should result from breach of a secondary obligation in the contract, such as due to a delay with a contractual deliverable. In construction contracts these are typically expressed as Delay Damages and provide that, if completion is delayed by reason of the Contractor's breach, the Contractor will be liable to pay the Employer a specified sum for each day, week or month during which the delay continues. Such sum must represent an agreed and genuine pre-estimate of actual losses that the Employer

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would suffer as a result of the breach, which can include Direct Damages/Losses (being those which flow naturally and necessarily from the breach e.g. costs incurred by an Employer to repair or complete the work of the Contractor and reduced project value due to nonconforming work) and Consequential Costs/Losses (see below). However, as stated above, they must reflect a reasonable measure of anticipated damages and not amount to penalties, for otherwise they will not be enforceable.

b. Consequential Damages/Losses are Indirect costs/losses that an NHS Client may incur as a result of a Contractor's breach in the special circumstance of the particular contract, and not in the usual course of things. So, although these could not be predictable (unlike Direct Damages/Losses), they must still be directly traceable to the breach of contract and result from it. Common examples are lost profits, financing costs, reduced value or lost sales of real estate and extended general conditions/overhead costs. These are recoverable if the Contractor's liability for them has not been excluded from the contract and the Contractor is therefore liable for them. The Contractor will be liable if they knew or ought to have known of that circumstance when it made the contract. There are two ways in which an NHS Client may recover consequential damages: by proving actual consequential damages, or through a pre-agreed liquidated damages clause in the contract.

3.0 Estimating the Value of Liquidated and Ascertained Damages/Delay Damages

The following identify the key issues/activities required when ascertaining the value of Liquidated and Ascertained Damages/Delay Damages:

a. The timing of the calculation of the value of Liquidated and Ascertained Damages/Delay Damages: they must be calculated during the development of and prior to the issue of tender documents/agreement of costs for the works dependant on the procurement process being utilised. They must not be identified after the contract has been signed/executed.

b. It is likely that the rate of Liquidated & Ascertained Damages/Delay Damages will include all or some of the following:

   i. Additional costs arising from additional time spent by administrative, professional, supervisory or other staff (including the NHS Client's own officers) managing the contract.

   ii. Direct losses and expenses arising from the necessity to rent or use alternative accommodation until the contract is completed and the new facilities being available for use.

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iii. Loss of revenue associated with the delivery of service from the new facilities.

iv. Loss of amenities for providing healthcare services (that is, since construction projects in the NHS mostly provide additional facilities designed to provide healthcare services, there may be a loss of expected amenities when a project's completion is delayed).

c. Additional staff costs and direct losses and expenses can be more easily estimated by way of interest on the contract sum; however, loss of amenities cannot normally be assessed by any generally acceptable calculation other than by expressing the cost as being equivalent to a return by way of interest on the anticipated Contract Sum.

d. There are two methods of estimating the value of Liquidated & Ascertained Damages/Delay Damages for a Project:

i. Where the loss of amenities is not a significant feature of a Project the estimated value of the damages may be assessed by estimating the additional costs, direct losses and expenses.

ii. Where the loss of amenities is significant feature of a Project, consideration should be given to using the following approach that has been used on NHS Capital Investment Projects:

Contract sum x 5%* /365 days (calendar year) = £/calendar day. For example on a £10m scheme this would equal a sum of £1,370 per calendar day.

(Note * – the 5% shown above is provided to illustrate the approach and provides a starting point for consideration on a specific project. When considering using this approach for a specific project it is important that an NHS Client attempts to undertake and assessment what actual losses they believe they might incur and undertake a sensitivity analysis of the in the event of a delay and compare this with the result of this calculation. This will assist them in avoiding identifying a level of costs that could be interpreted as an arbitrarily fixed penalty. Consideration could perhaps be given to using the Bank of England base rate associated with this calculation. Those working with the NHS Client to provide professional advice should be involved in this process).

iii. It is important to note that that the loss of amenities method is an alternative to estimating direct costs, losses and expenses and NHS Clients should ensure

that they take account of any special circumstances or factors affecting specific contracts if they are using this method.

e. When estimating the value of Liquidated & Ascertained Damages/Delay Damages to be included in any contract as a specific sum of money per period of delay, the NHS Client's Director of Finance should be consulted to ascertain if there are any special circumstances or factors of a Project which would affect the estimate, regardless of the method used to calculate the damages value.

f. It is important to understand when calculating the value of Liquidated & Ascertained Damages/Delay Damages that an arbitrarily fixed "penalty" (i.e. it is not a genuine pre-estimate of the loss) is may be deemed unlawful by the Courts and would not be enforceable. Therefore NHS Clients should endeavour to use the methods described above to calculate the value that they insert into any contract, to ensure – as far as possible – that it is a genuine pre-estimate of the loss which is likely to be occasioned by the relevant breach.

g. When calculating the value of an NHS Client's Liquidated & Ascertained Damages/Delay Damages, consideration may be given to the value of the damages reducing during the period of any delay. This could result from the completion and handover of facilities for occupation and use by the NHS Client during a period of delay thereby mitigating the impact of the delay on both the NHS Client and Contractor.

4.0 Recovery of Liquidated & Ascertained Damages/Delay Damages by NHS Clients

NHS Clients seeking to recover Liquidated & Ascertained Damages/Delay Damages should note the following:

i. All variations/compensation events to a contract should be agreed between the NHS Client and the Contractor in respect of time and cost implications in accordance with the contract provisions prior to any decision being made by an NHS Client to recover Liquidated & Ascertained Damages/Delay Damages.

ii. The NHS Client's Contract Administrator/Project Manager must issue notification of a failure to complete by the completion date to the Contractors in accordance with the particular contractual provisions being used.

iii. The inclusion of Liquidated & Ascertained Damages/Delay Damages in the contract does not necessarily require that and NHS Client will seek recovery of these sums in the event of a delay by the Contractor- this is a commercial decision that will need to

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be based on to be based on the circumstances and facts at the time and appropriate professional advice should be obtained.

Appendix G

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that the project achieved its key delivery objectives and 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 the project achieved its key delivery objectives and 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 the project achieved its key delivery objectives and 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 the project achieved its key delivery objectives and 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

Covid-19 Mass Vaccination Programme

Advisory Review Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents

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Executive sign off:	Hayley Thomas, Director of Planning & Performance
Distribution:	Amanda Edwards, Assistant Director – Innovation and Improvement (Programme Director), Julie Rowles, Director of WOD and Support Services, Jamie Marchant, Director of Primary, Community and Mental Health Services, Jacqueline Seaton, Chief Pharmacist, Jenny Spreafico, Immunisation Co-ordinator, Samantha Moss, Assistant Director of Finance, Jason Crowl, Assistant Director (Community Group), John Morgan, Transformation Programme Manager.
Committee:	Audit, Risk & Assurance Committee

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We would like to acknowledge the time and co-operation given by staff during the course of this review.

Please note:
This advisory review 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. Advisory review 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

Introduction

The onset of Covid-19 meant that the NHS in Wales faced new and unprecedented pressures in planning and providing services to the public. One key element of the national response is the implementation of a mass vaccination campaign. Since the Summer of 2020 health bodies have been directed to prepare for the delivery of vaccination services, through a Mass Vaccination Programme (MVP), to their populations pending the arrival of regulatory approved vaccines.

Towards the end of 2020 a 'second wave' of the virus saw a rapid acceleration of cases, which was deemed to be "a pandemic within a pandemic, a crisis within a crisis" by the Welsh Government (WG). By 19th December 2020 the incidence of Covid-19 had risen and alert level four restrictions leading to a third lockdown. The rollout of the Covid 19 vaccine started on 8th December 2020 and represented the biggest mass vaccination programme in history of NHS Wales.

The success of the programme has meant that by mid-May 2021 restrictions had eased to Alert level 2. Powys Teaching Health Board's ('the health board') Covid-19 vaccination programme is well advanced and as of 17th May 2021 had reached 99,800 (94%) of the target population with first doses and 51,600 (62%) with a second dose, leading the way across Wales.

Background

By mid-summer 2020, positive news had emerged that Covid-19 vaccines were in development. An All-Wales Covid-19 Vaccine Delivery Programme Board (CVB) was established on 4th June 2020, led by WG and including representatives from across the Welsh health and care sectors. The CVB identified 'Once for Wales' workstreams supporting key areas, including but not limited to: planning and delivery, workforce surge recruitment, vaccine storage, distribution and safety monitoring, communications and marketing; infection prevention and control (including personal protective equipment), digital solutions, consumables and vaccine efficacy.

On 13th July 2020 the Chief Medical Officer (CMO) for NHS Wales wrote to all health boards and trusts requesting the establishment of vaccine delivery groups for the delivery of Covid-19 vaccine to prioritised populations (at that point health and social care frontline staff, and the shielded extremely clinically vulnerable). In August 2020 the CMO wrote again to ask that preliminary plans be provided to Welsh Government by 3rd September 2020.

As further information on potential vaccines was received, planning was geared up and the Wales CVB requested a first draft Covid-19 Vaccine Operating Plan by 20th November 2020. The health board had been working rapidly on preparations and we understand met this deadline.

The Medicines and Healthcare products Regulatory Agency (MHRA) gave regulatory approval to the Pfizer-BioNTech vaccine on 2nd December 2020. The health board received its first supply on 7th December 2020 and the very first vaccinations in Powys took place that week. The Oxford/AstraZeneca vaccine received regulatory approval on 30th December 2020 and the health board received its first supply on 2nd January 2021 and commenced roll out on 4th January 2021. The Moderna vaccine received regulatory approval on 8th January 2021. Only limited supplies of the Moderna vaccine have been made available to Wales and no allocations of this vaccine have been made to the health board.

The WG published its Vaccination Strategy for Wales on 11th January 2021, which set out the priority groups as endorsed by the independent Joint Committee on Vaccination and Immunisation (JCVI). The health board had already established a Command and Control Structure in response to the Covid-19 pandemic, and changes were adopted to allow for the establishment of an Operational Delivery Group (ODG) to report into the Strategic Operational Group (SOG) with the purpose of strengthening arrangements to take the MVP forward. A multi-channel vaccination model was adopted for vaccination delivery to the public via three Mass Vaccination Centres', GP Practices and mobile provision to care homes and vulnerable people.

Our review was undertaken between February and early May and primarily focused on the period from December 2020 to May 2021 which is the initial period of MVP delivery. We have assessed the adequacy of the processes and systems in place within the health board for the management of the MVP in order to provide assurance to the Audit & Risk Assurance Committee that risks material to the achievement of the system's objectives are managed appropriately. Our findings are informed by discussion with the Assistant Director Innovation & improvement (Programme Director), members of the Mass Vaccination Strategic Operational Group and Operational Delivery Group as well as a desktop review of documentation provided. Detailed testing of controls has not been undertaken. The objectives, scope and a summary list of key documentation reviewed can be found within the appendices of this report.

2. EXECUTIVE SUMMARY

Main Observations

The health board's Mass Vaccination Programme (MVP) is governed by the Command and Control Structure, which was initially implemented during the early stages of the Covid-19 pandemic and subsequently strengthened through the autumn as the vaccination mobilisation gathered pace. The key elements of the MVP structure are a Gold Command supported by a Mass Vaccination Strategic Oversight Group (SOG) and an Operational Delivery Group (ODG) that oversees 9 core MVP workstreams. Allied to this the health board adopted a programme management approach that provides a robust and flexible structure for operational delivery of the Delivery Plan.

The health board's Covid-19 Vaccination Delivery Plan Phase 2 (was presented to the Board on 27th January 2021. The Delivery Plan is aligned to guidance released by the independent Joint Committee on Vaccination and Immunisation (JCVI) and WG and provides a coherent strategic framework for the vaccination programme. A set of models underpins the Delivery Plan. The Board receives updates on MVP progress at all meetings.

Performance monitoring is ongoing through the governance structure being driven by a dashboard that continues to develop as the MVP progresses.
A library of Standard Operating Procedures is in place, covering the MVP activity and are subject to review and update as the activities develop.

We recognise that the MVP has posed significant challenges to all health bodies due to the speed and extent of the workload involved in its execution. The health board reconfigured its management and operational arrangements in response to these challenges. We consider that the governance structure adopted has allowed effective and agile decision-making whilst maintaining overall control of the Delivery Plan.

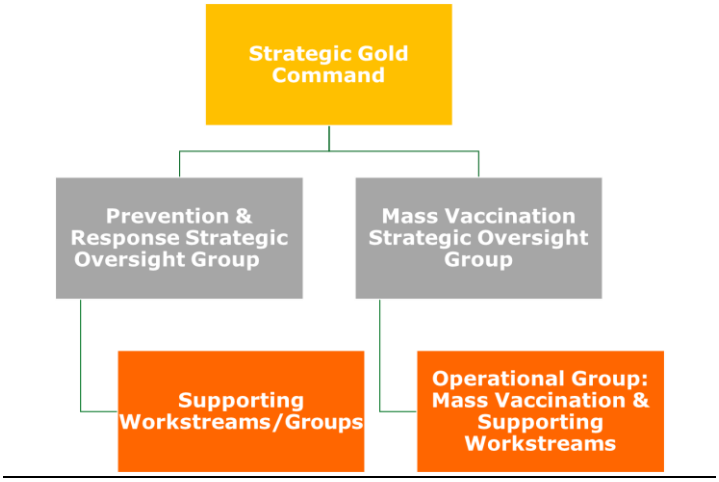
As part of this review we gathered a range of strategic and operational documents that evidenced that the MVP framework and control environment are robust and flexible, facilitating delivery of the programme effectively. During the progress of the review we evidenced that the control framework responded and developed as the MVP progressed. Notable examples being the Mass Vaccination Modelling Spreadsheet that was enhanced to provide improved operational data and provision of 24-hour security at MVCs. On a more operational basis security around disposables was improved due to the associated risks. Other matters also arose, some of which are mentioned in the report, and we are satisfied that the framework was operating sufficiently to identify and address these.

3. DETAILED REPORT

This section sets out the detailed findings of the review, under the headings of programme planning and programme governance. Each section provides commentary on the arrangements put in place. The detailed objectives of this review are provided in Appendix One.

Organisational Structure for the Vaccination Programme

The health board rapidly established a temporary hierarchy of command to progress actions / decisions during the initial phase of the pandemic (March to June 2020). The command structure established by July 2020 comprised of a Gold Command together with three Strategic Operating Groups for Care Homes, TTP and Operational Services. The structure was aligned to that recommend the World Health Organisation (WHO) with the aim of co-ordinating the Winter Pressures Plan with the WG operating framework, a dual track approach. The governance structure of the programme has been updated as it moved from planning to delivery and from December 2020 took the following shape:



The Mass Vaccination Strategic Oversight Group is Chaired by the Executive Director of Planning & Performance as the Senior Responsible Officer of the Mass Vaccination Programme. The MV SOG will provide strategic oversight of the delivery of the Mass Vaccination Programme. The supporting workstreams are:

- Clinical delivery and logistics
- Venue and site logistics
- Supply/waste/transport logistics
- Booking and documentation
- Workforce
- Primary Care

- Cohort specific Task & finish
- Care homes
- Strategic model

We note that the Chief Executive Chaired SOG until early January 2021 to reinforce continuity across the structure. The governance structure is reviewed quarterly.

3.1 Sufficient, trained persons are available to support delivery

What we found

Our review identified the following:

- The Mass Vaccination Delivery Plan (MVDP) contains a workforce plan providing an overview approach of recruitment, skill mix, training, competency and volunteers. The workforce model has been full costed.
- The Vaccine Administrative Model (VAM) for MVC applies clinical model principles. The model draws together all the aspects of MVC administration from the process, journey, lines of accountability, and more granular workforce details around MVC staffing levels and surge scenarios, recruitment needs and rostering. In January 2021, this was extended to include health care support workers (HCSWs) as vaccinators. The VAM is subject to regular review and update. Based on the model, a range of staffing requirements were initially identified in early January 2021 primarily across clinical, pharmacy, administrative and call centre staff which were duly authorised for recruitment.
- Staffing requirements for each MVC are derived from the VAM modelled capacity scenarios based on the anticipated supply of vaccines. Whilst the position is kept under review by SOG as the number of supplied vaccines can vary at short notice so impacting on staffing plans accordingly. MVC management teams keep the position under daily rolling review and are able to respond as the situation dictates as when appointments were brought forward at short notice when bad weather was forecast
- E-rostering was being introduced at MVC sites as a means to streamline and improve the staff scheduling process.
- A training programme ensures that vaccinators have the required competencies, especially in respect of the Patient Group Directions (PGDs) and national protocols. Progress on staff completing competencies is regularly monitored and checked as part of staff's

first attendance at MVC and reinforced by Standard Operating Procedures.

3.2 All potential patients are identified within each priority group and offered vaccination

What we found

Our review identified the following:

- The Welsh Immunisation System (WIS) is used for scheduling and recording all vaccination data. WIS is developed and distributed by the NHS Wales Informatics Service (NWIS).
- Cohort delivery is based on guidance issued by the Joint Committee on Vaccination and Immunisation (JCVI). The WIS patient cohort data is preloaded from the Welsh Demographic System (WDS) which is based upon data held within GP practice clinical systems.
- A specific workstream was established to oversee vaccinations for a range of vulnerable groups in care homes, inpatients, housebound and front-line staff. We note that there were issues with the reconciliation of residential home vaccination data to WIS records due to some coding issues that were addressed with NWIS.
- VDP incorporates an approach for vaccinating transient and non-registered populations.

3.3 Records are made of patients to whom vaccinations are administered, and missed appointments followed-up

What we found

Our review identified the following:

- WIS is prepopulated with core patient details. Procedures require staff at MVC's to verify patient details and update the WIS record with vaccine type, dose, batch number and expiry date. The record also captures patient consent and the details of the staff member administering the vaccination.
- WIS-Web is an internet-based application available to support the system use and contains user guides. The health board has developed several Standard Operating Procedures (SOPs) to complement these. The SOPs are succinct and cover the spectrum of activity including bookings, cancellations, bookings count and reserve list. In the event of WIS not being available, paper records

are maintained, and a process has been put in place to ensure that WIS is subsequently updated.

- Patient non-attendance is recorded on WIS as a 'Did Not Attend'. A procedure was put in place that the person should be contacted to offer another appointment.

3.4. Where patients do not attend scheduled appointments, or cancel, arrangements are in place to make use of the time slot and vaccination

What we found

Our review identified the following:

- The Delivery Plan identified a 5% booking contingency rate and maintenance of a reserve list to mitigate against vaccine waste as a consequence of non-attendance. If a patient does not attend an appointment it is recorded within WIS.
- The booking contingency rate has been varied to accommodate fluctuations in attendance caused by media attention to issues such as the rare risk of clots associated with the COVID-19 vaccine AstraZeneca.
- The public can register on-line for the reserve list if eligible. If MVC management consider that the reserve list is needed to ensure all slots are filled, to avoid vaccine waste, the booking centre identifies eligible patients from the same cohort/priority group.
- The Performance Dashboard provides detail on DNAs and we understand that further updates by NWIS will include trend analysis against day of the week and hourly slots.
- We understand that there has been a rise in DNAs as the programme has moved through the priority groups which appears to be a trend across Wales.

3.5 Second doses, where required, are scheduled and managed appropriately

What we found

Our review identified the following:

- The MVDP scheduled vaccinations in line with JCVI guidance to residential care home residents, staff and health and care staff (stage 1) and then to cohorts/priority groups 1-4 (stage 2). Stage three includes the expansion of first vaccinations to

cohorts/priority groups 5-9 and the scheduling of second doses for those within stage 1 & 2.

- WIS has inbuilt controls that assist in scheduling second vaccinations based upon vaccine type and dose interval period. The health board determines the nature of sessions to be booked (e.g. 1st or 2nd doses only) and the system populates slots informed by data recorded of doses already administered.
- The Vaccination Supply Model identifies planned immunisation figures per vaccine type, first or second dose by day and MVC location.
- The ODG receives details of vaccination related incidents as part of its monitoring functions. Few reporting incidents have arisen, which are reported to Welsh Government.

3.6 Vaccines are stored appropriately, and stock use recorded

What we found

Our review identified the following:

- The Delivery Plan stipulates that vaccine delivery and handling will be in line with national and vaccine specific guidance. Medicines Management have developed stock control SOP's from ordering and receipting, distribution, storage, security and temperature monitoring, stock checks and waste management. SOPs are kept under review and updated as necessary.
- A main pandemic stockroom was set up at Bronllys to handle the AZ vaccine which supports the MVC stock rooms that are staffed by Medicines Management teams. Pfizer vaccine is sent to MVC's directly due to storage requirements.
- The Pandemic stock is recorded on a vaccination spreadsheet whilst WIS is used as the on-site system for recording of vaccine stocks, wastage, transfers and fridge temperatures.
- MVC site security arrangements, including vaccination storage, have been reviewed in conjunction with Dyfed Powys Police. We note that Security SOPs and Security Plan consider physical security, but they do not include information governance/security.
- Fridge temperatures, including at GP surgeries, are recorded in WIS and checked daily within minimum and maximum limits, being evidenced on a monitoring spreadsheet. An initial problem with the temperature of one GP fridge was identified from monitoring and addressed.

- Wastage levels are low and are recorded on the stock system with explanations and monitored by Medicines Management staff and reported at ODG.

3.7 There is appropriate communication with the local population and other stakeholders

What we found

Our review identified the following:

- The VDP identifies that strong public communications had been determined as critical to the success of the vaccination rollout and contains a Communications & Engagement Plan across the whole range of stakeholders. Target groups include public, councils, staff, primary care, local media, third sector organisations with communication employing a range of media routes including broadcasts, website, social media and various bulletins.
- The website contains extensive information including vaccination performance and key messages geared to address the impact of DNA's and reassurance to combat vaccine hesitancy with the aim of maximising take-up. The site also contains links to national information on related policy and public health issues.
- Stakeholder engagement and involvement is evidenced through a number of initiatives. For example, PAVO (Powys Association of Voluntary Organisations) have been able to supply volunteers to assist at MVC's and Powys County Council have provided telephonists for the booking process. There are other numerous examples of stakeholder involvement and assistance, including from the military who are represented at Gold command.

3.8 Key milestones are documented

What we found

Our review identified the following:

- The workstreams supporting the ODG ensured that the Milestone 1 relating to care home residents, front line staff and vulnerable adults over 70, that commenced in December 2020, was completed by the target date of mid-February 2021
- Welsh Government published its Vaccination Strategy for Wales on 11th January which included milestone targets for mid-February (cohorts 1-4) and spring (cohorts 5-9). An updated version was

issued in February following achievement of the first milestone with additional clarity on targets within cohorts 5-9.

- As a standing agenda item, SOG reviews progress against the milestones at every meeting in consideration of the forecast of vaccine supply, which can vary significantly, and of the overall national picture. At these meetings issues around short dated vaccines and DNAs are identified and addressed.

3.9 Planning has been enhanced in response to feedback on early plans

What we found

Our review identified the following:

- A Phase 2 update was provided to the WG in July 2020 which was in line with the WG framework and contained an Operational Implementation Plan (OIP). The OIP continued to be developed and was updated at the October Board Meeting containing a detailed section on the MVP that embraced all key activity such as various models, workforce as well as clinical elements.
- In December 2020, SOG reviewed progress on the Implementation Plan and workstream leads started to populate the detail as a means to move to operational delivery.
- At an operational level a feature of the programme management approach is that it identifies lessons learned that can be used to develop the operational plans. Many of these have been around the working of MVCs, for example from identifying the need of additional support for people with sensory impairment through to revision of the facilities management structure.
- In January 2021 as part of the 60-day review process, the Board integrated a thirteenth objective, Planning Ahead, into its strategic approach as a means to map a transition path out of the pandemic.

PROGRAMME GOVERNANCE

Our review considered whether there is appropriate governance over the delivery of the plan, in particular:

3.10. The plan has been approved appropriately

What we found

- Whilst our work focused on the period from December 2020 onwards, a brief review of Board minutes identified that the initial Operational Plan built around the four harms, one of which is 'Harm From Covid Itself' that also recognised the importance of partnership working. A Phase 2 update of the Delivery Plan was provided to the Welsh Government on 9th July 2020.
- The Winter Protection Plan that went to the October 2020 Board clearly defines the MVP approach based on JCVI guidance. The plans address clinical, operational, technical, and logistical considerations, as well as details in respect of the workforce and the training requirements. Each of these areas is underpinned with more specific detail, for example on priority groups, modelling, vaccine stocks and staffing requirements.
- Drawing on the ongoing preparation work on the Implementation Plan was carried on in line with events and leading to the Mass Vaccination Delivery Plan being adopted at the January 2021 Board meeting after approval by Gold Command.
- WG's Vaccination Strategy for Wales (January 2021) recognised that if Wales were to deviate away from the recommended priority approach of the JCVI, residents would be vulnerable to harm and be at greater risk of exposure to the virus. Therefore, all health boards were required to follow and implement JCVI guidance as part of their local plans. Our review highlighted that the health boards approach conformed to guidance and that subsequently there is continuous monitoring of the MVDP progress at all levels of the governance structure.

3.11 Progress against plan and the JCVI priority list is monitored and reported regularly

What we found

Our review identified the following:

- Gold Command receive weekly Highlight Reports from SOG that keep it updated with on MVP progress. The scope of the information provided to GOLD Command has increased to reflect the complexity of the service provided by the programme. Such information includes performance, funding posts, clinical workstream matters, and issues on short date vaccine supply and

DNAs Gold Command either endorses or ratifies SOG business as necessary.

- SOG monitors progress against milestones and receives Weekly SitRep and exception reports that cover all main workstream activity
- A Covid-19 Vaccinations Dashboard is in place and updated regularly throughout the day. Information contained includes performance data, cohort, location, dose, and vaccine type. We understand that the information details reported have been extended and will include 'Did Not Attends' (DNAs).

3.12 Appropriate financial arrangements are in place

What we found

Our review identified the following:

- The Board receives financial reports that specifically identify all Covid-19 expenditure. At month 11 it was projected that a balanced plan would be achieved and so the health board remain be within the WG funding envelop of £26.5m.
- As noted in our advisory report 'Governance Arrangements During Covid-19 Pandemic' issued in August 2020, Covid-19 related expenditure is separately identified through dedicated cost centres and monitored as part of the budgetary review process.
- The Scheme of Delegation was reviewed in November 2020 with the Interim Financial Control Procedure for Covid-19 (approved by the Board's Audit, Risk and Assurance Committee), detailing the financial management responsibilities.
- Single tender actions are reported through to the Board as part of the finance report. Procurement have been involved in tender exercises such as the providing of 24-hour security cover for MVCs. Such costs are approved at SOG.

3.13 Risk management processes identify actions needed to address issues

What we found

Our review identified the following:

- The health board adopted a two-tier approach to risk management with the Corporate Risk Register to capture strategic risks. Complimenting this is a specific Covid-19 Vaccination Programme

Risk Register overseen by SOG and reported to the Board. Risks range from those around emergency care issues, second doses, vaccine supply to GPs and workforce resilience. A major review of risks was completed in late February 2021 and reported through.

- At operational level the workstreams have their own integrated project risk registers that are kept under rolling review by ODG
- Overall, this structure provides a suitable risk management framework as it covers the spectrum of MVP activity.

3.14 Lessons learned' are identified and form part of a feedback loop

What we found

Our review identified the following:

- A review, New Ways of Working, was agreed in the January Board meeting of 2021 to identify how the organisation changed and adapted in response to the pandemic. The detailed results were reported at the March 2021 Board and incorporated in to the 2021/22 Interim Plan. Relevant areas covered redeployment, streamline governance and IT critical support.
- A formal Lessons Learned log is maintained at ODG level that identifies actions necessary as well as the owner and completion status. The log is monitored by SOG.
- At MVC level spot check audits, for example around the completion of WIS entry, are undertaken on site and with any lessons learned fed back as necessary.
- Lessons learned are also identified and captured from ad hoc initiatives, such as the pop-up clinic in Ystradgynlais.
- SOG also receive feedback from a variety of National Groups, including from Healthcare Inspectorate Wales, that are considered for lessons learned. We note from SOG minutes that the three issues identified from HIW site visits have been picked up part of the Action Plan.

Appendix One – Scope and Objectives

Provision was added to the 2020/21 audit plan for additional work on the management of the Covid-19 pandemic. The advisory review assessed the arrangements in place to manage the key risks associated with the roll out and implementation of the Mass Vaccination Programme.

This review focused on the following:

Programme Planning

- a clear plan is in place for the delivery of vaccinations to each priority group in respect of arrangements needed to ensure that:
    - sufficient, trained persons are available to support delivery;
    - clear and concise operating instructions, in line with regulations, are issued to all stakeholders;
    - all potential registered patients are identified within each priority group and offered the vaccination and can be identified to schedule for the second dose;
    - patient records are properly maintained on Welsh Immunisation System and missed appointments followed up;
    - where patients do not attend scheduled appointments or cancel, arrangements are in place to make use of the time slot and vaccination;
    - vaccines are stored appropriately, and stock use recorded or subject to full stock control processes, including of wastage and disposal of items;
    - there is appropriate communication with the local population and other stakeholders;
    - key milestones are documented;
    - planning has been enhanced in response to feedback on early plans.

Programme Delivery Governance

- there is appropriate governance over the delivery of the plan, in particular:
    - the plan has been approved appropriately;

- progress against plan and the Joint Committee for Vaccination and Immunisations (JCVI) priority list is monitored and reported regularly;
- appropriate financial arrangements are in place;
- risk management processes identify actions needed to address issues; and
- 'lessons learned' are identified and form part of a feedback loop.

The potential risks considered in this review were as follows:

- weaknesses in the planning process could reduce the efficiency or effectiveness with which the programme addresses all the necessary priority groups;
- weaknesses in the oversight of delivery could compromise the achievement of the delivery programme.

Appendix Two – What we did

We undertook the following review activity:

- Reviewed agendas, papers and minutes of the Board on the Pandemic and Governance.
- Reviewed papers and minutes from the Strategic (Gold) Group.
- Reviewed papers, minutes and action log from the Mass Vaccination Strategic Operational Group (SOG) and Operational Delivery Group (ODG).
- Reviewed and discussions of the Delivery Plan.
- Reviewed and discussed workforce and vaccination models.
- Reviewed the Covid-19 Vaccination Bulletins on the health board's website
- Reviewed the interim advice and subsequent updates on the priority groups for Covid-19 vaccination from the Joint Committee on Vaccination and Immunisation (JCVI).
- Reviewed iterations of the Welsh Government's Vaccination Strategy for Wales.

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AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2021-22

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 2021-2022						
		29 April	08 June	12 July	14 Sept	16 Nov	20 Jan	22 March
Governance & Assurance:								
Approach to 2021-22 Annual Accounts	DF&IT							✓
Annual Accountability Report 2020-21	BS	✓	✓					
Annual Accounts 2020-21, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit of COVID-19 Governance Arrangements	BS	✓						
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Charitable Funds Annual Report and Accounts 2020-21	DF&IT					✓		
Losses and Special Payments Annual Report 2020-21	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 2020-21	HoIA	✓						
Internal Audit Progress Report 2021-22	HoIA	✓	✓	✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2021-22**						
Internal Audit Plan 2022-23	HoIA							✓
External Audit:								
External Audit Annual Report 2021	EAO						✓	

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-2022						
		29 April	08 June	12 July	14 Sept	16 Nov	20 Jan	22 March
External Audit of Financial Statements 2020-21	EAO		✓					
External Audit Plan 2022	EAO						✓	
External Audit Progress Report 2021-22	EAO	✓	✓	✓	✓	✓	✓	✓
External Audit Review Reports	EAO	**In line with External Audit Plan 2021-22**						
External Audit Structured Assessment	EAO					✓		
Welsh Health Specialised Services Committee Governance Arrangements	EAO				✓			
Anti-Fraud Culture:								
Counter Fraud Annual Report 2020-21	HoLCF		✓					
Counter Fraud Update	HoLCF			✓			✓	
Counter Fraud Workplan 2022-23	HoLCF							✓
Post Payment Verification Annual Report 2020-21	PPVO		✓					
Post Payment Verification Workplan 2021-22	PPVO		✓					
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2021-22	BS		✓					
Development of Committee Annual Programme of Business	BS	✓						
Review of Committee Programme of Business	BS		✓	✓	✓	✓	✓	✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-2022						
		29 April	08 June	12 July	14 Sept	16 Nov	20 Jan	22 March
Local Counter Fraud Team				✓			✓	
Post Payment Verification			✓	✓				

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

Archwilio Cymru
Audit Wales

Rollout of the COVID-19 vaccination programme in Wales

Report of the Auditor General for Wales

June 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Key messages

Context

1 The COVID-19 pandemic has affected everyone. The vaccination programme is a key strategic tool to fight the virus and help reopen the economy and wider society.

2 The purchase and supply of the vaccines is the responsibility of the UK Government. The vaccination programme in Wales is the responsibility of the Welsh Government and NHS Wales.

3 This report considers the rollout of the vaccination programme in Wales. In it, we discuss the shape of the programme, how it is performing, the factors that have affected rollout to date, and future challenges and opportunities. **Appendix 1** describes our audit approach and methods.

4 There are many vaccines in development globally, and the UK government has signed contracts for vaccine supply with eight major pharmaceutical providers (**Appendix 2**). At the time of our fieldwork, three vaccines were approved by the Medicines and Healthcare products Regulatory Agency (MHRA): Pfizer-BioNTech, Oxford-AstraZeneca and Moderna. All three vaccines require two doses to maximise effectiveness.

Key findings

5 Overall, the programme has delivered at significant pace, with local, national and UK partners working together to vaccinate a considerable proportion of the population who are at greatest risk. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy have provided a strong impetus to drive the programme. To date, the Welsh Government's milestones have been met.

6 The Welsh Government has adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation (JCVI). A national group in Wales provides additional guidance where further clarity on prioritisation is required. The guidance has generally been followed, but the process of identifying people within some of the nine priority groups (**Appendix 3**) has been complex.

7 The organisations involved in the rollout have worked well to set up a range of vaccination models which make best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

8 Overall vaccine uptake to date is high, but there is lower uptake for some ethnic groups and in the most deprived communities. There are also increasing concerns about non-attendance at booked appointments, although health boards to date have been able to minimise vaccine waste.

9 The dependency on the international supply chain is the most significant factor affecting the rollout. Limited stock is held in Wales, primarily to allow for second doses and short-term supply to sites. This means that shortfalls in supply can seriously impact the pace of rollout. However, increasing awareness of future supply levels is allowing health boards to manage the calling of individuals effectively.

10 In the short-term, the workforce supporting the vaccination programme has been meeting the demands placed on it and many staff have been working ‘above and beyond’. The current programme is unlikely to complete all second doses until September 2021, and an autumn booster programme is being discussed. This will offer little respite for key vaccination staff in an environment where workforce resilience is vital.

11 Early observations from military partners identified some sites were more efficient than others. Some vaccination sites may become unavailable in coming months as partner organisations look to reopen venues over the summer.

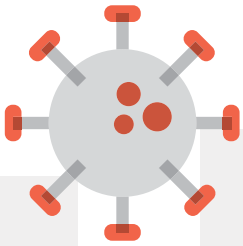
12 As Wales maintains its focus on delivering against existing milestones, there is a need now for the Welsh Government and NHS Wales to develop a longer-term plan for vaccine rollout. This needs to include sustainable workforce models which can respond to supply, whilst also responding to demands as other services are restarted.

13 Consideration also needs to be given to the longer-term estate requirements to support autumn boosters, with a focus on ensuring that vaccination models are cost effective. Strategies to minimise waste need to be maintained and increased action taken to encourage uptake as the programme moves to the remaining population.

14 More broadly, there is much to be learnt from the positive way in which the vaccine programme has been rolled out to date. The Welsh Government and NHS Wales should be looking to apply that learning to wider immunisation strategies and the delivery of other programmes.

> Wales has made great strides with its COVID-19 vaccination programme. Key milestones for priority groups have been met and the programme is continuing at pace with a significant proportion of the Welsh population now vaccinated. This is a phenomenal achievement and testament to the hard work and commitment of all the individuals and organisations that have been involved in the vaccine rollout to date.
>
> However, the job is far from over. A longer-term plan is needed that moves beyond the existing milestones and considers key issues such as resilience of the vaccine workforce, evolving knowledge of vaccine safety, the need for booster doses, and maintaining good uptake rates - especially in those groups that have shown some hesitancy in coming forward for their vaccinations.
>
> **Adrian Crompton**
> Auditor General for Wales

Key facts



3.3 million

Vaccinations given in Wales

0.4%

Percentage of all vaccines considered unsuitable for use

91.5%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a first dose

£29.4 million

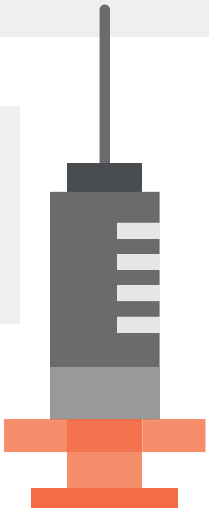
Costs for 2020-21 (excludes redeployed staff and the cost of vaccines)

84.4%

Percentage of the 2.66 million eligible adults who have received a first dose

66.1%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a second dose



Vaccinations being delivered in:

54 mass vaccination centres

346 general practice locations

30 hospital locations

11 pharmacies

18 mobile team units

As of the end of May 2021

Source: Public Health Wales and the Welsh Government

Main report

How the programme is set up

15 Public sector partners across the UK have worked together since the beginning of the pandemic to explore the potential for a COVID-19 vaccination. The programme in Wales was first established in June 2020 to enable an appropriate infrastructure to be put in place before any vaccinations came online.

16 The programme is based around the principle of local autonomy for vaccine deployment through health boards. Supply policy and guidance is nationally coordinated:

a the UK government's Department for Business, Energy & Industrial Strategy (BEIS) led on UK-wide arrangements for research, purchase, and coordination of the national vaccine supply[1] working with the UK Vaccine Taskforce. Responsibility for the Vaccine Taskforce is now shared between BEIS and the UK Department of Health and Social Care. Welsh Government officials engage with the Vaccine Taskforce to streamline vaccine supply and anticipate upcoming issues.

b the Welsh Government is leading on vaccine deployment in Wales. It developed the national Vaccination Strategy for Wales[2] and formed a national programme structure (including Stakeholder and Deployment Boards, and an operational delivery group). The Vaccine Clinical Advisory and Prioritising Group (VCAP) considers clinical developments in vaccination against COVID-19 infection. The group advises the programme and partners on the implementation of the national vaccination programme, interpreting the priorities as outlined by the JCVI for the Welsh context. Collectively, these national groups provide policy and guidance, support financial resourcing, and have facilitated the Primary Care COVID-19 Immunisation Scheme[3] for commissioning primary care.

1 The UK Government Vaccine Taskforce (VTF): 2020 achievements and future strategy report provides an overview of UK level progress

2 The Vaccination Strategy for Wales was first published in January 2021 and formally updated in February, March and June 2021.

3 The Primary Care COVID-19 Immunisation Scheme sets out requirements and reimbursement for Primary Care providers that have signed up to the scheme.

c health boards are responsible for local vaccination plans, set up of mass-vaccination sites through collaborative working with local partners, and aspects of training and staffing. They are also responsible for securing vaccination centres in primary care and outreach/mobile services, with the Welsh Immunisation System (WIS) working to identify those in the priority groups using information on GP and hospital-based IT systems.

d Public Health Wales provides expert advice, surveillance data, vaccine effectiveness and safety monitoring, and public and patient information and reporting. It also assists in the development of training policy, patient group directions (PGDs) and tools.

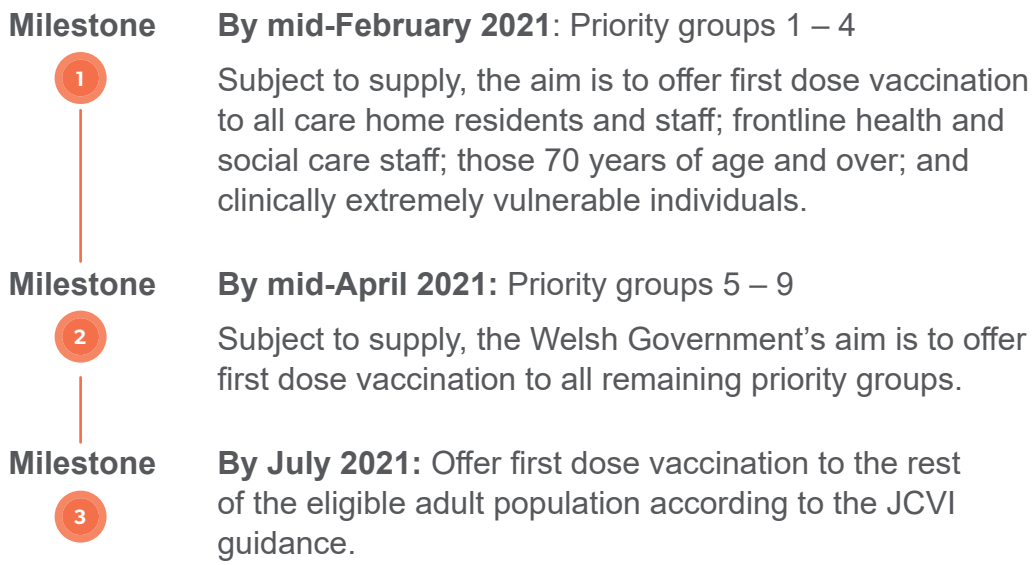
e other partners are responsible for logistics:

- NHS Wales Shared Services Partnership and the Welsh Blood Service are responsible for supporting the pharmaceutical co-ordination team for consumable and storage logistics.
- Digital Health and Care Wales has led the design, test and rollout of the WIS that enables identification and coordination of priority groups and related appointment booking, vaccination recording and clinical quality assurance such as vaccine batch control. The system also provides performance data.

17 The Vaccination Strategy for Wales provides a high-level framework setting out the expectations for prioritisation and delivery of the COVID-19 vaccine. The Welsh Government has adopted the Joint Committee on Vaccination and Immunisation: advice on priority groups (**Appendix 3**). The national strategy focusses on developing the infrastructure for vaccine deployment, and communication about progress.

18 The first version of the strategy provided a clear milestone for the first four priority groups. In February 2021, the updated strategy provided target dates for the remaining milestones (**Exhibit 1**), with the aim of achieving 75% uptake for priority groups 5-9. This approach has continued to focus all partners on the time-critical aims of the vaccination programme as it continues to roll out.

Exhibit 1: Current key milestones for the vaccination programme



Source: Welsh Government

19 Programme oversight and monitoring take place at national and local levels receiving significant and regular officer level scrutiny as well as ministerial oversight. Public Health Wales and the Welsh Government publish regular updates[4]. Public Health Wales also undertakes enhanced surveillance, including analysis on vaccination uptake by deprivation, age, ethnic background and gender.

20 Vaccination delivery models vary by health board, predominantly based on geography and population density. Mass vaccination sites are being used in areas of higher population density, but in rural and hard to reach areas some health boards have adopted smaller local site models which enable vaccines to be delivered closer to the communities that they serve. Some health boards also depend more on primary care than others. Irrespective of geography, health boards are using outreach models to vaccinate in care homes and have set up temporary and mobile hubs (such as the Swansea Bay UHB Immbulance service).

21 Workforce planning is largely a delegated responsibility for health boards. A national workforce group has created policy and guidance providing high-level productivity modelling and has developed role descriptors for recruitment.

4 Public Health Wales vaccination updates are available on their interactive dashboard. Welsh Government updates are published each week.

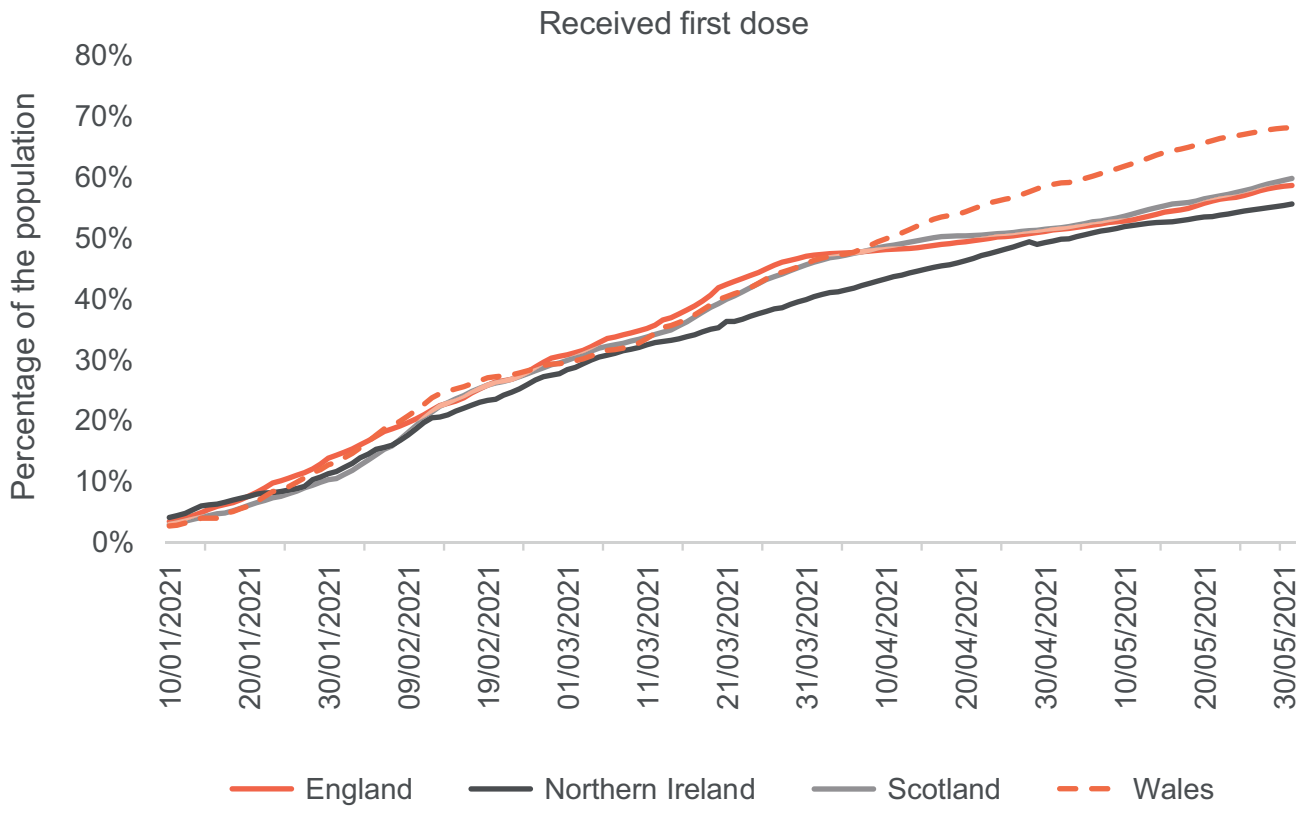
22 To date, vaccine procurement costs have been met by the UK Government in full. The Welsh Government funds the transport, storage, and additional local deployment costs in Wales. It provisionally estimated these costs at £34.9 million for 2020-21, including an estimated cost of £7.8 million for personal protective equipment (PPE). At the end of March, the actual costs for 2020-21 were reported as £29.4 million, as a result of costs associated with PPE largely being funded through existing PPE budget allocation. . Of the £29.4 million, £10.8 million has been spent on additional staffing, £9.54 million on the Primary Care COVID-19 Immunisation Scheme and £0.2 million on capital costs. Some staff are redeployed from within their organisations at no additional cost, although this has potential workforce implications for the part of the business where they originally worked.

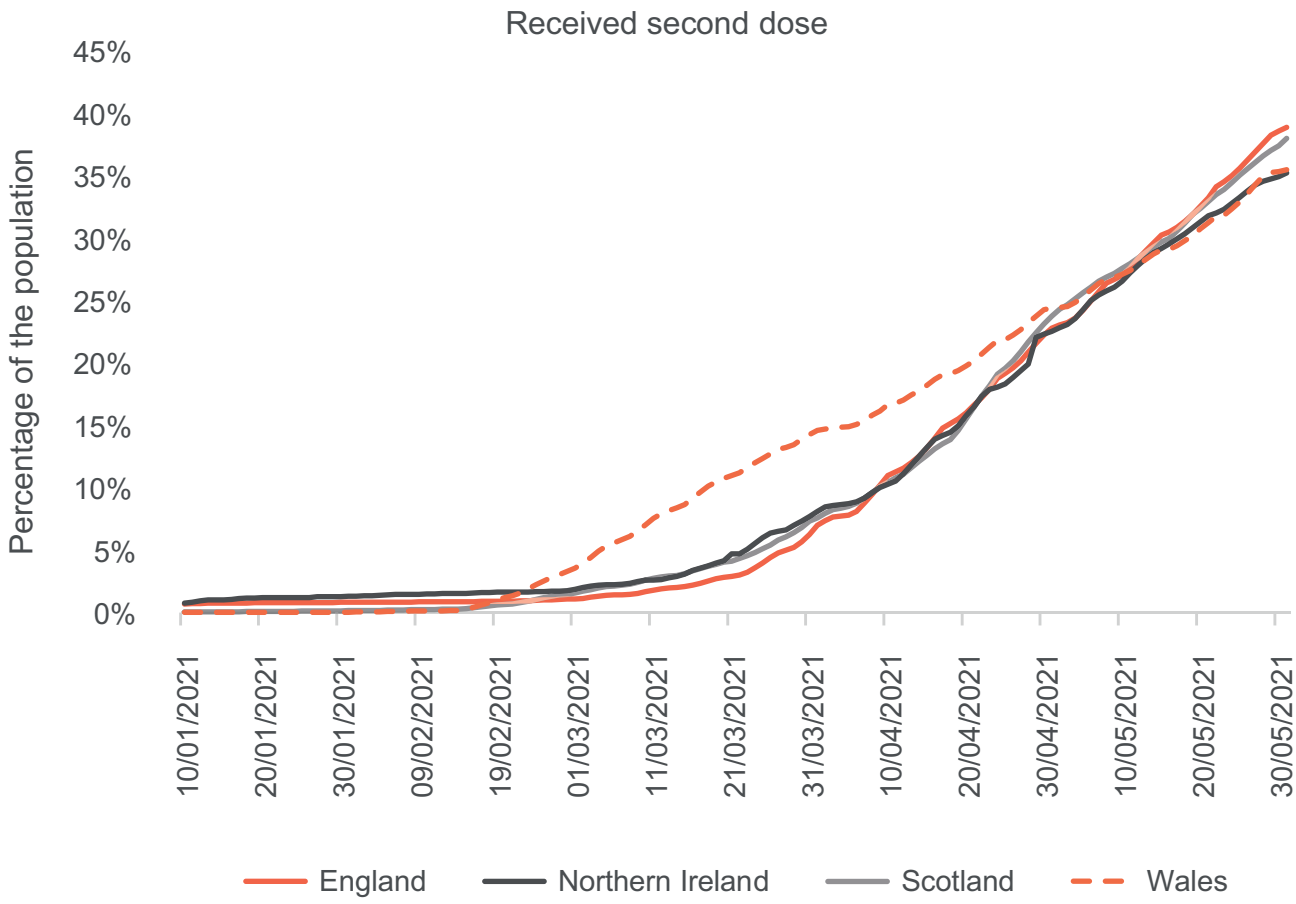
23 Other non-pay costs include transportation, site venue hire, personal protective equipment and syringe packs, security, and communications material. We understand that some vaccination sites are provided to the programme at no additional revenue cost. This is likely to change if local authority or other partners require the return of their facilities and health boards need to relocate to alternative accommodation which may come at a cost. The forecast costs of the programme for the first three months of 2021-22 (April to June 2021) are £31.5 million.

How is the programme performing?

24 Overall, as of 31 May 2021, the percentage of the adult population to have received the vaccine in Wales is higher than in the other UK nations (**Exhibit 2**). Wales made particularly good progress delivering second doses in March, although England and Scotland have now accelerated the delivery of second doses.

Exhibit 2: Percentage of the adult population to have received first and second doses of COVID-19 vaccination by country, as at 31 May 2021

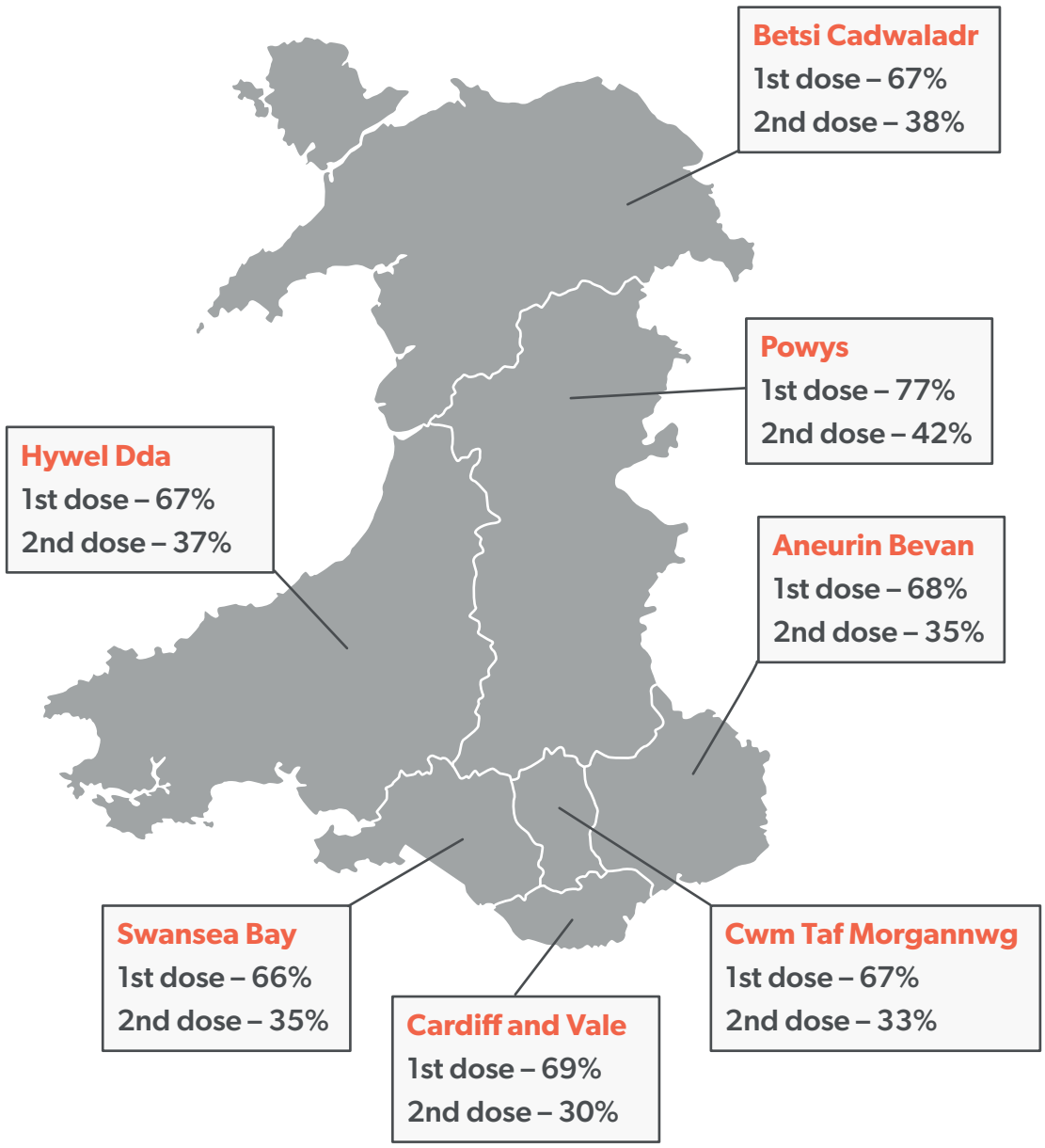




Source: UK Coronavirus Dashboard

25 There is some variation in the progress across health boards, most notably for Powys Teaching Health Board which is making the greatest progress (**Exhibit 3**). This is due to a combination of factors in Powys including a greater proportion of an older population and a higher level of supply per population as a result of batch sizes.

Exhibit 3: Vaccine doses given by health board as a percentage of the adult population as at 31 May 2021



Source: COVID-19 Vaccination Enhanced Surveillance Report, Public Health Wales

26 On 12 February 2021, the Minister for Health and Social Services announced that Milestone 1 of the vaccination strategy had been met. The Minister also announced on 4 April, that Milestone 2 had been met. Both milestones focus on the offering of an appointment for a vaccine. It is not possible to know if everyone eligible within the priority groups 1-9 were identified in the booking process. However, Welsh Government and health board officials took steps to help verify the position, such as contacting care homes to ensure all staff and residents had been offered a vaccination. At 31 May, around 95.5% of those in Milestone 1, and 87.9% of those in Milestone 2 had received their first dose.

27 While the programme has moved ahead to focus on Milestone 3, the Welsh Government and health boards are operating a ‘no one left behind’ policy. This means that anyone eligible in previous groups who has not yet had a vaccine for any reason can inform the relevant health board and make an appointment.

28 Public Health Wales surveillance reports show that influenza vaccine uptake is typically around 70% for those aged 65 and older. So far, the overall COVID-19 vaccine uptake for priority groups 1-9 is 91.5% which reflects positively in comparison. Reasons for not achieving 100% uptake include for example, people that are too unwell to receive the vaccine and the minority, to date, that have chosen not to have the vaccine. At the time of reporting, 66.1% of the priority groups 1-9 had received their second dose, and good progress was being made with vaccine rollout to younger age groups.

29 **Exhibit 4** shows some variation on uptake of first doses against the prioritisation groups by health board, particularly for priority group 6. We have observed extensive national-level discussion to respond to the challenges of identifying relevant population datasets. This included identifying all those aged 16-64 years clinically at risk where definitions of clinical conditions have needed to be clarified, and information about individuals is contained on different systems. There have also been challenges identifying unpaid carers who have previously not been recorded on any system. This indicates some of the difficulty in using a complex vaccination prioritisation model in the environment where no single centrally maintained population dataset exists for this purpose.

Exhibit 4: Percentage of first doses given by priority (P) group, at 30 May 2021

Priority Group		Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
P1.	Residents of care homes	97.5	98.6	98.0	96.4	98.2	96.8	98.8
P2.	80 years +	96.3	96.0	94.3	95.9	96.1	97.2	96.2
P3.	75-79 years	97.0	96.5	95.9	97.1	96.6	97.2	97.3
P4.	16-69 years clinically extremely vulnerable	94.2	93.8	93.2	94.7	93.9	95.7	94.4
P4.	70 – 74 years	96.6	95.6	95.4	96.5	95.7	96.2	96.6
P5.	65-69 years	94.9	94.5	93.5	95.4	94.3	95.0	95.5
P6.	16-64 years clinically at risk	88.6	86.5	88.1	88.2	86.7	90.4	87.8
P7.	60-64 years	93.6	91.6	91.5	93.7	92.2	91.6	93.3
P8.	55-59 years	91.6	89.4	89.3	91.9	90.0	89.4	91.1
P9.	50-54 years	89.7	87.7	86.5	90.1	87.5	88.1	89.0

Note: P2, P3 and P4 also includes data for those in the respective age groups who are also residents of care homes. Frontline health and care staff, as well as unpaid carers are not explicitly identified at health board level but instead included within the relevant age groups.

Source: Weekly COVID-19 coverage report, Public Health Wales

30 Equality considerations are a growing concern. Public Health Wales data shows clear variation in uptake among different ethnic groups with uptake lower particularly within the Black community (**Exhibit 5**).

Exhibit 5: Percentage uptake of first dose of COVID-19 vaccine by age and ethnic group as at 5 May 2021

Ethnic group	White	Black	Asian	Mixed	Other
80+ years	97.2	80.7	87.3	93.1	82.5
70-79 years	96.6	79.9	87.3	88.0	83.4
60-69 years	94.4	76.8	86.6	84.5	78.9
50-59 years	91.3	71.9	84.3	79.4	71.7

Source: Monthly enhanced surveillance report, including analysis on equality of coverage, Public Health Wales

31 As part of their analysis, Public Health Wales also found lower uptake in deprived communities. Although the differences are not as great as for ethnic groups, uptake between the least and most deprived areas for some age groups varies by up to 5.3%. Analysis of COVID-19 positive cases over the last 12 months has indicated that case prevalence and severity have been higher in Black, Asian and Minority Ethnic groups as well as in some of Wales' most deprived areas, with Merthyr Tydfil experiencing the highest number of cases per head of population. In March 2021, the Welsh Government published its Vaccination Equity Strategy for Wales. The Vaccine Equity Committee met for the first time in April 2021 and is preparing a vaccine equity plan.

32 Vaccine wastage (known as vaccines unsuitable for use) to date is around 0.4% of all vaccines supplied. As of 31 May, this equated to around 14,400 doses. Wastage is more prevalent for Pfizer-BioNTech with 0.8% of doses unsuitable for use. Only 0.2% of Oxford-AstraZeneca doses have been deemed unsuitable, with 0.04% reported for Moderna. In comparison, NHS Scotland has estimated that around 1.8% of COVID-19 vaccines are wasted[5]. The other UK nations do not publicly report vaccine wastage.

5 Scotland's COVID-19 Vaccine Deployment Plan – Update March 2021

33 Reasons for vaccines being unsuitable for use include doses that fail quality assurance on initial inspection, doses that fail quality assurance following preparation and vials/doses which expire during the vaccination session. Specific requirements for storage, transportation, and shelf-life of Pfizer-BioNTech once thawed have presented challenges.

34 Arrangements to minimise wastage include:

a systematic recording of temperatures during the different stages of transportation to ensure storage requirements are met from source to site storage, and then on to vaccine centres.

b using reserve lists so that people can attend at short notice at the end of the day to use any vaccine left because of people not attending booked appointments. Approaches to reserve lists vary across health boards with some making reserve lists open to all priority groups while others are targeted to specific priority groups.

c allocation of the Pfizer-BioNTech vaccine mainly to mass vaccination sites. Pfizer-BioNTech shelf-life once defrosted is shorter than the Oxford-AstraZeneca, so the allocation to mass vaccination sites helps to ensure that it is used rather than reaching the end of its shelf-life.

What have been the factors affecting rollout to date?

35 Vaccine supply is the most significant factor affecting the pace of the rollout. UK-wide supply, while agreed through formal contractual obligations, is constrained by commercial pharmaceutical supply and international demand. In general, the Welsh Government and NHS Wales are informed of the expected notional supply around one month ahead. But this can change at short notice both upward and downwards, so reliable projections are difficult beyond two weeks and are in a range, with best, realistic, and worse case scenarios from BEIS.

36 Supply challenges to date include:

a the temporary withholding of a batch of Pfizer-BioNTech vaccines, equating to 25,000 vials, because of quality control issues in January. The MHRA quality control process ensures that vaccines are safe to administer.

b a reduction in February resulting from the refurbishment of both Oxford-AstraZeneca and Pfizer-BioNTech facilities in Europe to accommodate increased production levels.

c a reduction in April owing to the reprioritisation of Indian-produced Oxford-AstraZeneca vaccine resulting in an expected four-week delay.

37 Workforce models have evolved since the beginning of the vaccination programme, with a need to remain flexible to expand or reduce services at relatively short notice in response to supply. All health boards initially used registered health staff immunisers. This was then supplemented through GP practices, which has enabled vaccination activity to be scaled up and offered close to home. Changes to UK legislation has also enabled non-registered staff to be trained to vaccinate under supervision, and over time other partners, such as the military and more recently fire and rescue service personnel, have assisted in the rollout. Plans are also in place to use community pharmacies, with the first pharmacy offering of the COVID-19 vaccine launched in April 2021 in Cardiff.

38 Support staff, clinical staff who have either previously left or retired, and volunteers are also helping at vaccination sites in a variety of roles. The Welsh Government and health boards recognise the goodwill of retired staff who have agreed to come back and assist, as well as volunteers, but we heard mixed views on how easy and beneficial making use of these groups has been in practice. We heard of cumbersome processes to bring back retired or returning staff, some volunteers were only offering to help for short periods, and there were differing views about the need to undertake mandatory training.

39 Prioritisation in line with the Welsh Government policy and guidance has been an essential element of the programme to date. Almost all (99%) of the population at most risk from COVID-19 are in priority groups 1-9. All health boards have adopted prioritisation principles set out within the national vaccination strategy. However, there have been concerns about how the prioritisation approach has varied across Wales and the risk that some (including NHS staff) may have received their vaccine ahead of their allotted priority group. This has arisen because of the desire not to waste unused vaccine and the differing approaches to manage reserve lists. Welsh Government officials have written to health boards in an attempt to standardise the approach for reserve lists. There have also been challenges defining ‘frontline’ for health and social care staff, which may have also resulted in some staff receiving the vaccine earlier than intended.

40 We found that communications relating to prioritisation for the COVID-19 vaccination at a UK, Welsh Government and health board level have been generally consistent, reducing the risk of mixed messaging. In addition, work undertaken by Community Health Councils has found that the public have generally been happy with the communication that they have received from health boards. However, there appeared to be greater concern at earlier stages of the programme from people:

a wanting to know where and when they will be vaccinated;

b not understanding why, for example, a couple could not go to the same vaccination centre on the same day; and

c feeling that some with lower priority had been vaccinated before them.

41 As the programme has gathered pace, many of those initial concerns have eased. A longer lasting issue related to the format of invite letters. These letters are produced automatically by the Welsh Immunisation System for individuals invited to attend a mass vaccination centre, and for the first three months of the programme there was little that could be done to tailor them. We heard of concerns around:

a identical letters being used for first dose and second doses. An example was given to us where an individual was called back for a second dose at the initial recommended four-week period[6], but they thought they had received a first dose letter again in error and ignored it.

b the format of the letters, with interchangeable use of English and Welsh language over several pages, affecting the clarity of the letter and how to raise a concern or rearrange the booking.

42 The format of invite letters has since been addressed in relation to the use of English and Welsh language although the need to make clearer that the invitation is for second doses remains.

6 Initial guidance from the JCVI recommended that the second dose of the COVID-19 vaccine should be administered at four weeks after the first dose. This was subsequently changed to up to 12 weeks in January 2021.

What are the future challenges and opportunities?

43 The vaccine programme in Wales has progressed extremely well but there is still some way to go. Around 4.5 million doses are needed to protect 90% of the adult population in Wales with two doses. At the current rate, and with 3.3 million doses completed as at 31 May, this could mean that second doses for the remaining adult population are not completed until September. Alongside this, there is increasing discussion of an autumn booster programme. It is likely that there will be little respite between finishing vaccinating the remaining adult population and planning a possible next phase of the programme. This all points to a need to develop a longer-term plan for vaccine rollout that looks further ahead and moves beyond the here and now.

44 Vaccine supply is likely to remain a significant challenge. While new vaccines are also becoming available, the more that are in use, the greater the challenge to coordinate their deployment. Storage, transportation, preparation, shelf-life, and training requirements differ depending on the vaccine. Changes to JCVI guidance may also present challenges. For example, the recent guidance to offer under 40s an alternative to the Oxford-AstraZeneca vaccine[7] could result in slower rollout if alternative vaccines are not available. As more vaccines come on stream in Wales, complexity will increase further as may waste and operational efficiency. The Welsh Government are aware of this risk and are working to mitigate it.

45 The current workforce model is meeting the needs of the vaccination programme. However, as other services are restarted and as the wider economy reopens, a sustainable and still flexible workforce solution will be needed for the medium to longer term. Key issues include:

a some health board staff supporting the vaccination programme have been redeployed from their normal role. As other services are restarted, there will be competing workforce pressures as staff are called back to their core roles.

b we have heard that the workforce is fatigued, with many having worked above and beyond at many stages of the pandemic. This will not be sustainable in the longer term. We also heard that as the economy reopens and COVID restrictions are eased, the supply of volunteers is reducing.

c consideration is being given to the potential to combine a COVID-19 booster programme with the routine flu immunisation programme, or whether there is a clinical need to keep them separate. Either way, there are implications for the development of the workforce to meet demand.

7 JCVI statement on Use of the AstraZeneca COVID-19 vaccine: 7 May 2021

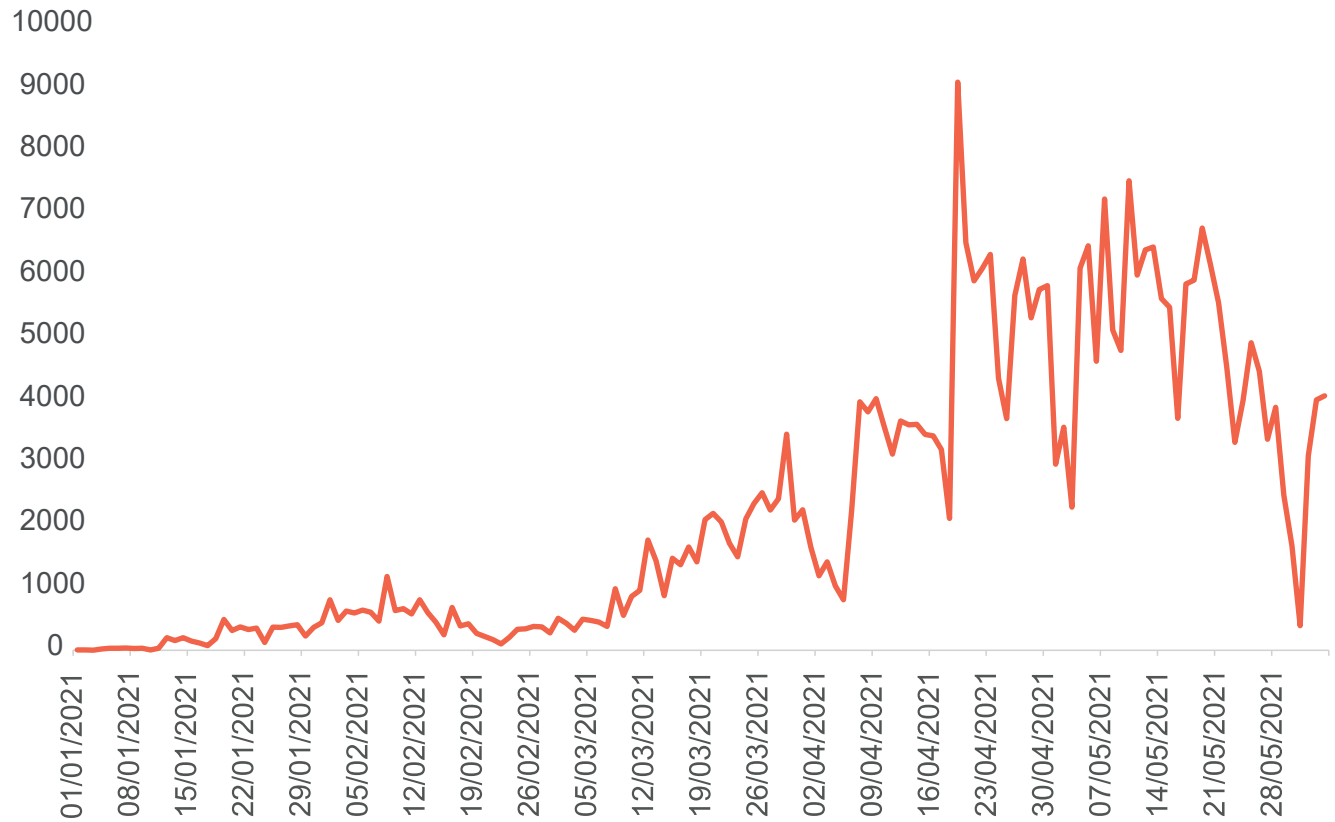
46 Sites used as mass vaccination centres have largely been made available to health boards through the goodwill of partners. Many of these venues were closed due to COVID-19 restrictions. With restrictions easing, organisations will now be looking at the potential to reopen these venues before the anticipated end of the current programme as a way of remaining commercially viable, for example, Venue Cymru in Llandudno. Health boards are likely to need to consider alternative cost-effective options for vaccination centres at relatively short notice to deliver the remainder of the current programme. They will also need to look at how to accommodate the longer-term COVID-19 vaccination programme alongside the wider immunisation programme.

47 There will always be differences in vaccination models to respond to local population needs and geography. Nevertheless, some models will be delivering greater efficiency than others. Early observations from the military partners involved in the vaccination programme identified vaccination sites were not always making the most efficient use of qualified staff and that rates of vaccination per hour per staff varied between 2.6 and 10.2. This variation in vaccination rates merits further investigation by operational officials, but the local variations will be, in part, due to supply and vaccine type. Health boards and the Welsh Government need to maintain a focus on ensuring that service models provide value for money. This will also help inform the shape of future models and programme design.

48 As the programme moves forward, there is a growing concern that the younger population are less likely to accept the offer of a vaccination. Health boards are continually assessing and adapting vaccination models to ensure they are accessible to all and working in partnership with other agencies to understand the reasons for vaccine hesitancy and to put actions in place. This has included some positive actions being taken to engage community leaders in particular ethnic communities, and members of the travelling community. Health boards and partners need to maintain this focus to build trusted relationships and improve the confidence in the vaccine programme. This is likely to be resource intensive if the Welsh Government and NHS wants to maintain its overall positive uptake rate for the remainder of the population and to ensure uptake of second doses is as high as is being achieved for first doses.

49 Having dropped at the end of March and early April, the number of individuals who do not attend for their appointment has since increased again (**Exhibit 6**). It is understood that non-attendance is greater for first dose vaccines, than second dose vaccines. Non-attendance impacts the pace of the programme and represents a cost-inefficiency as staff can end up underutilised. Arrangements to call those on reserve lists in at short notice are helping to fill empty slots, but as the percentage of the population yet to have a vaccine reduces, filling these slots will become more challenging. Non-attendance rates do vary by health board with Aneurin Bevan, Cardiff and Vale, and Swansea Bay University Health Boards experiencing some of the highest levels.

Exhibit 6: Numbers of people invited for vaccination but did not attend by day up to the end of May 2021



Source: Welsh Government

Note: the data used is intended for internal management information purposes and has therefore not been validated

50 Some of the reasons for non-attendance have included delays in invite letters being received, and problems getting through to contact numbers to rearrange appointments, as well as people not turning up because of vaccine safety concerns. Difficulties in getting time off work to attend appointment slots and clashes with holidays as society opens are increasingly likely to result in further non-attendance over the coming months. There is opportunity to reflect on the current approach for booking, with consideration to web-based systems to support self-booking of appointments. This will help provide flexibility and minimise the resource intensive process when people have to re-book or staff must find people to fit in the slots. The programme is actively working on establishing this with Digital Health and Care Wales.

51 Following a recent 'Programme Assessment Review' in March, the Welsh Government has considered future challenges and how it strengthens national programme management arrangements. To date, there has been limited additional central capacity to drive the programme at a national level, and reliance has been placed on a relatively small number of officials both within the Welsh Government and across the NHS to lead the rollout programme. Programme management arrangements during the early part of the vaccine rollout were rather unwieldy, with early oversubscribed Stakeholder Boards due to intense interest. In excess of 60 people from different professional backgrounds attended. Changes have been made to tighten up these arrangements and we understand that more changes are planned to further streamline programme management and governance.

52 Whilst the challenges outlined here need to be carefully considered as the vaccine rollout moves to its next stage, it should be recognised that the programme has moved at a scale and pace not previously seen in Wales. There is much to celebrate in that and there are many positive lessons to learn for the delivery of other programmes and the wider immunisation agenda.

Appendices

1 Audit approach and methods

Our primary focus was on the national vaccination programme and the deployment of vaccines in Wales. We drew on the vaccination deployment of three health boards to obtain an understanding of rural and urban settings. We considered the set-up of the national programme, performance of the programme, and the factors or issues that have affected rollout.

Our work excluded vaccination arrangements administered by the UK government. The National Audit Office has examined the UK government's preparations for potential COVID-19 vaccines[8]. We reviewed that report to help inform our wider understanding of procurement, contracting and vaccine costs, which are administered UK-wide.

Audit methods

We used a range of methods:

- **document review**: we reviewed national strategy, guidance, Welsh Government announcements and update reports, health board vaccination plans, local and national performance reporting. We also reviewed national vaccination stakeholder and deployment board papers and minutes.
- **observations**: we attended several national vaccination stakeholder board and deployment board meetings as observers.
- **semi-structured interviews**: we interviewed Welsh Government officials involved in the vaccination programme, selected members of the national vaccination deployment board, and senior managers from three health boards involved in the set-up of vaccination sites and the deployment of vaccines.
- **data analysis**: we reviewed available data on first and second dose vaccination progress in Wales and the other UK nations. We considered vaccine wastage and deployment costs, in relation to pay costs, non-pay costs and the extent of costs associated with vaccination in primary care settings.

It is not possible for us to present data for the same period throughout this report. Data in this report are taken from differing sources and are published at differing intervals. Detailed information on vaccine availability, stock, and utilisation by manufacturer is not publicly available for reasons of commercial confidentiality.

We completed our fieldwork between February and April 2021.

8 Investigation into preparations for potential COVID-19 vaccines, National Audit Office, December 2020

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

Vaccine	No of doses	Status
Oxford-AstraZeneca	100 million	Approved 30 December 2020 and in deployment across Wales from January 2021
Janssen	20 million	Approved 28 May 2021
Pfizer-BioNTech	100 million	Approved 2 December 2020 and in deployment across Wales from January 2021
Moderna	17 million	Approved 8 January 2021 and in deployment from April 2021 in Aneurin Bevan and Hywel Dda University Health Boards
GlaxoSmithKline/ Sanofi Pasteur	60 million	Phase 3 trials
Novavax	60 million	Encouraging phase 3 safety and efficacy data
Valneva	100 million	Phase 3 trials
CureVac	50 million (initial order)	Phase 3 trials
Total	**507 million**	

Source: Recent GOV.UK announcement, updated based on information from the London School of Hygiene and Tropical Medicine and recent GOV.UK announcement

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

Vaccine prioritisation groups	
1	People living in a care home for older adults and their staff carers
2	All those 80 years of age and older and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and people who are extremely clinically vulnerable (also known as the "shielding" group) – people in this group will previously have received a letter from the Chief Medical Officer advising them to shield
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions*, which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Source: Welsh Government

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