Audit, Risk & Assurance Committee

Tue 14 September 2021, 10:00 - 13:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_14Sep21.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 12 July 2021 for approval

ARA_Item_1.3_Minutes_12 July 2021.pdf (12 pages)

1.4. Matters arising from previous meeting

1.5. Committee Action Log

ARA_Item_1.5_Action Log_14 September 2021.pdf (2 pages)

10:00 - 10:00
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2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

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

2.2. Updated Financial Control Procedures:

ARA_Item_2.2_Updated FCPs.pdf (3 pages)

2.2.1. Covid-19 Decision Making & Financial Governance

ARA_Item_2.2a_Appendix 1_Updated FCPs.pdf (20 pages)

2.2.2. Updated FCP Budgetary Control Procedure

ARA_Item_2.2b_Appendix 2_Updated FCPs.pdf (25 pages)

10:00 - 10:00
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3. ITEMS FOR DISCUSSION

3.1. Audit Recommendation Tracking

ARA_Item_3.1_Audit Recommendations.pdf (10 pages)
ARA_Item_3.1a_Appendix D - IA Outstanding.pdf (12 pages)
ARA_Item_3.1b_Appendix E - IA Complete.pdf (5 pages)
ARA_Item_3.1c_Appendix F - IA Not Yet Due.pdf (4 pages)
ARA_Item_3.1d_Appendix G - EA Outstanding.pdf (2 pages)

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- ARA_Item_3.1e_Appendix H - EA Complete.pdf (4 pages)
- ARA_Item_3.1f_Appendix I - EA Not Yet Due.pdf (2 pages)
- ARA_Item_3.1g_Appendix J - LCFS Not Yet Due.pdf (1 pages)

3.2. Internal Audit

3.2.1. Progress Report 2021-22

- ARA_Item_3.2a_PTHB AC A&A Progress Report September 21.pdf (9 pages)

3.2.2. Internal Audit Reports, 2021-22: i. Access to Systems (Reasonable Assurance)

- ARA_Item_3.2bi_PTHB2122.13 Access to Systems Final report.pdf (11 pages)

3.3. External Audit Progress Report 2021-22

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

3.4. Welsh Health Specialised Services Committee Governance Arrangements

3.4.1. Audit Wales Report

- ARA_Item_3.4a_WHSSC-Eng.pdf (32 pages)

3.4.2. WHSSC Management Response

- ARA_Item_3.4b_WHSSC mgmt response.pdf (16 pages)

3.5. Position Statement on the progression of the Fire Safety Improvements

- ARA_Item_3.5_Fire Audit Update.pdf (8 pages)
- ARA_Item_3.5a_Fire Safety Audit Report.pdf (24 pages)

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4. ITEMS FOR INFORMATION

4.1. Committee Work Programme

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

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5. OTHER MATTERS

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

5.2. Any other urgent business

5.3. Date of next meeting: 16 November 2021

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POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 14th SEPTEMBER 2021
10.00 AM – 12.00 PM
VIA MICROSOFT TEAMS

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 12 July 2021	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 12 July 2021	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Application of Single Tender Waiver	Attached	Director of Finance and IT
2.2	Updated Financial Control Procedures: • Covid-19 Decision Making & Financial Governance • Updated FCP Budgetary Control Procedure	Attached	Director of Finance and IT
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Recommendation Tracking	Attached	Board Secretary
3.2	Internal Audit a. Progress Report 2021-22 b. Internal Audit Reports, 2021-22: i. Access to Systems (Reasonable Assurance)	Attached	Head of Internal Audit
3.3	External Audit Progress Report 2021-22	Attached	External Audit
3.4	Welsh Health Specialised Services Committee Governance Arrangements a. Audit Wales Report b. WHSSC Management Response	Attached	External Audit & PTHB Chief Executive Officer
3.5	Position Statement on the progression of the Fire Safety Improvements	Attached	Chief Executive Officer & Director of Workforce & OD
4	**ITEMS FOR INFORMATION**		
4.1	Committee Work Programme	Attached	Board Secretary
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: 16 November 2021 at 10:00 am, Microsoft Teams		

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Key:

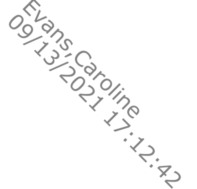
	Governance & Assurance
	Internal & Capital Audit
	External Audit
	Anti-Fraud Culture

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

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MINUTES OF THE MEETING HELD ON MONDAY 12 JULY 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
Mel Davies	Independent Member – Vice Chair

In Attendance:

Carol Shillabeer	Chief Executive
Rani Mallison	Board Secretary
Pete Hopgood	Director of Finance and IT
Matthew Evans	Head of Local Counter Fraud Services
Wayne Tannahill	Assistant Director of Estates
Anne Beegan	Audit Wales
Ian Virgil	Internal Audit
Jayne Gibbon	Internal Audit
Sarah Pritchard	Head of Financial Services
Kirsty James	Local Counter Fraud Services
Felicity Quance	Internal Audit
Hayley Thomas	Director of Planning and Performance

Committee Support

Caroline Evans	Head of Risk and Assurance

Apologies

Matthew Dorrance	Independent Member – Local Authority

ARA/21/34	**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.

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ARA/21/35	**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/21/36	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 8 June 2021 were RECEIVED and AGREED as being a true and accurate record.
ARA/21/37	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/21/38	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/21/29: 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: A meeting between Executives and Audit Wales to discuss lessons learned will be arranged at a mutually convenient date. 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 attended pre-meeting of the Committee on 12th July 2021, to provide an overview of the PPV service. Action complete. ARA/20/100: The health board is writting 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. Action complete. ARA/21/8: Appendices have been expanded within the report presented to the Committee today. Action complete. ARA/21/8: Update included on agenda, item 3.3. Action complete.
ARA/21/39	**APPLICATION FOR SINGLE TENDER WAIVERS (STWs)**

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	Sarah Pritchard presented the previously circulated report, seeking the Committee's ratification of STW requests made between 1 March 2021 and 31 May 2021.

Sarah Pritchard advised that there were three STW requests made between 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

Sarah Pritchard advised the Committee that going forward, appendices will be circulated as a separate document under confidential cover, due to the potential for commercially sensitive information.

Caroline Evans confirmed that the confidential appendices will be available via AdminControl going forward.

Action: Head of Risk and Assurance

The Committee RATIFIED the approval of the STWs.

ARA/21/40

IMPLEMENTATION OF AUDIT RECOMMENDATIONS

Caroline Evans presented the previously circulated report, which provides 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.

Caroline Evans advised that the overall summary position in respect of overdue 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

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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**

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**

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

Rani Mallison advised that as the organisation moves back into normal activity, timescales for future audits will not be prioritised as services should be realistic of their commitments and take ownership of their timescales.
Carol Shillabeer stated that this will be kept under review, and that focus will be on reducing the overall level of risk associated with the recommendations.

The Committee RECEIVED and NOTED the progress in respect of the implementation of audit recommendations.

ARA/21/41

LOSSES AND SPECIAL PAYMENTS REPORT

Pete Hopgood presented the previously circulated report, which sets out the Losses and Special Payments for the period 1st April 2020 to 31st March 2021. 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.
Pete Hopgood advised the Committee of the following losses and special payments for the period: -

	No. of payments/Receipts	No. of cases	£

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Clinical Negligence /Personal Injury (Payment)	13	7	£191,773.20
Redress Payments	9	5	£6,570.00
Redress Receipts	1	1	800.00
Other Special Payments	2	2	£535.69

The Committee RECEIVED and NOTED the Losses and Special Payments report.

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FIRE SAFETY UPDATE

Carol Shillabeer provided a verbal update to the Committee, advising that a limited assurance Internal Audit report was received in October 2020. Carol Shillabeer stated that two issues highlighted by the report remain outstanding: -

1. Review and deployment of the Fire Safety Policy
2. Site Management arrangements

Executives are progressing work on these issues, and a report is being discussed at Executive Committee this week to confirm the revised approach.

Mark Taylor asked what systems are being put in place to support these actions.

Carol Shillabeer stated that a position statement will be presented to the Committee once these arrangements have been confirmed.

Action: Chief Executive

Ian Virgil advised that a follow-up review of this audit is built into the Audit Work Programme for 2021/22.

ARA/21/43

EXTERNAL AUDIT UPDATE

a. PROGRESS REPORT 2021-22

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

Anne Beegan advised that the following audit work 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	Report due to be presented to Audit, Risk

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		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.	and Assurance Committee September 2021
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 – Completed and report presented to ARAC in July Phase 2 - Fieldwork underway. Due to report September 2021.
Review of Unscheduled Care	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

b. STRUCTURED ASSESSMENT PHASE 1: OPERATIONAL PLANNING

Anne Beegan presented the previously circulated report, which 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.
Anne Beegan advised that overall, Audit Wales 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.

Hayley Thomas stated that work is in progress to establish mitigating actions to ensure delivery of the Annual Plan, as advised within the report.

Ian Phillips congratulated officers for maintaining control and adequate planning throughout the pandemic, which is reflected by the lack of recommendations within the Structured Assessment Phase 1 report.

The Committee RECEIVED and NOTED the External Audit update and Structured Assessment Phase 1 report.

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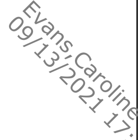

ARA/21/44	**LOCAL COUNTER FRAUD SERVICE, PROGRESS UPDATE**

Matthew Evans presented the previously circulated paper, which provides key areas of work undertaken during 2021/22. Resource was utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards as outlined:

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

Matthew Evans advised that an exercise to explore the current procedure around the identifying and rectification of overpayments within Powys Teaching Health Board (PTHB) was undertaken in response to an identified risk, to establish compliance with the FCP 009 Debtors procedure.
The exercise concluded that 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. Three recommendations for improvement were identified.

Matthew Evans stated that overpayments are largely due a lack of understanding of the process by Managers.
The Committee Chair questioned whether the impact of overpayment on pensions is explored where overpayments are identified.
Matthew Evans confirmed that the process is explored in its entirety, which includes pension contributions.
Carol Shillabeer stated that LPF identified that some processes are challenging, and that staff side is keen to work with the health board on these issues.
Mark Taylor questioned if a gateway process could be included in respect of leavers.
Matthew Evans stated that staff are paid unless a positive action is instigated to stop payment, and that the first line of defence in responding to overpayments is to increase communication.
Pete Hopgood thanked Matthew for the report, and stated that along with internal audit, these reports help to give an indication in respect of our

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	systems of internal control and highlight areas where thay can be improved. The Committee RECEIVED and NOTED the Counter Fraud Update.
ARA/21/45	**INTERNAL AUDIT PROGRESS REPORT 2021-22** Ian Virgil introduced himself and Jayne Gibbon to the Committee, with this being their first meeting with Powys, having taken over responsibility for this area from Helen and Osian. Ian Virgil presented the previously circulated report, which provides 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. Ian Virgil advised that 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, and the full versions of these reports are included in the committee's papers as separate items. 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

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 &

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	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 The Board Secretary has requested that the advisory audit review of Site Management be postponed from Q1 to Q4 due to the on-going review of Executive and Management responsibilities. The Committee Chair questioned if the audit of 'Safeguarding – Midwifery Supervision' would review the service from a clinical perspective. Carol Shillabeer stated that this non-clinical review will focus on Provider Services, testing the statutory supervision process to ensure that a high standard of practice is maintained. The Committee RECEIVED and NOTED the Internal Audit Progress Report 2021-22.
ARA/21/46	**INTERNAL AUDIT REVIEWS, 2020-21:** **a. LLANDRINDOD WELLS PROJECT (LIMITED ASSURANCE)** Felicity Quance presented the previously circulated report, which outlines the results of the review that was undertaken to assess Powys Teaching Health Board's processes, procedures, and operational management of the current stage of the Llandrindod Wells County War Memorial Hospital reconfiguration project. 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 Health Board Costs incurred as a result of the AHU compliance issues were being explored at the time of the audit. The Health Board 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). Felicity Quance advised that the scope and remit of the current audit included: • Follow up – review of the status of previously agreed management actions • Governance – the adequacy of project governance arrangements including the linkage with the THB Board / Committees, structures, accountability, roles and responsibilities etc.

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	• 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. The follow-up review identified five medium- and one low-priority recommendations. The Committee Chair questioned if we are able to seek additional Welsh Government funding if a capital project incurs significant overspend. Pete Hopgood stated that we maintain regular dialogue with Welsh Government in respect of our capital plan. Hayley Thomas stated that a number of issues arose within this project, and it is important that we harness the learning from these issues to inform future capital projects. Mark Taylor requested that the Committee is sighted on the lessons learned from this project. Hayley Thomas confirmed that the post-Project evaluation and lessons learned from the previous Machynlleth Project will be presented to the Committee at a future date. **Action: Director of Planning and Performance** Ian Phillips stated that we need to confirm our approach in respect of delay damages for future projects. Wayne Tannahill stated a concern that the inclusion of delay damages within a contract can potentially invite contractors to increase their tender price. Hayley Thomas stated that we need to look individually at each project at the merit of inclusion of delay damages. Going forward we should develop a general set of principles for delay damages, to enable us to identify the benefits and risks going forward. Felicity Quance stated that Powys is an outlier across Wales in respect of not including delay damages within the contract. **b) Mass Vaccination (Advisory)** Ian Virgil presented the previously circulated report, which provides the outcome of a review that 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. The review 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 that risks

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	material to the achievement of the system's objectives are managed appropriately. Ian Virgil advised that 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. Hayley Thomas stated that the team was pleased to receive the report, which was a boost to staff morale. The Committee Chair congratulated everybody involved in the work of Mass Vaccination. The Committee RECEIVED and NOTED the Internal Audit reports.
ARA/21/47	**COMMITTEE WORK PROGRAMME** 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/21/48	**ROLLOUT OF THE COVID-19 VACCINATION PROGRAMME IN WALES** Anne Beegan presented the previously circulated report, which 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. Anne Beegan advised that 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. The Committee RECEIVED and NOTED the External Audit report.
ARA/21/49	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES**

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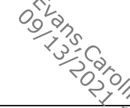

	The Committee Chair requested that the Board is appraised of the changes for monitoring outstanding audit recommendations.
ARA/21/50	**ANY OTHER URGENT BUSINESS** There was no other urgent business for discussion. The Chair declared the meeting closed at 12.10 pm.
ARA/21/51	**DATE OF NEXT MEETING** 14 September 2021, 10:00 am, Microsoft Teams

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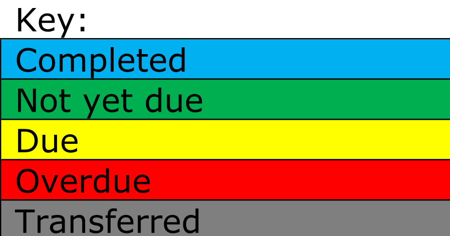

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(September 2021)

Minute	Date	Action	Responsible	Progress	Status
ARA/21/46	12 July 2021	Machynlleth Post-Project Evaluation and Lessons Learned reported to the Committee	Director of Planning and Performance	Action transferred to Delivery and Performance Committee	
ARA/21/42	12 July 2021	Position Statement on progression of the Fire Safety Work	Chief Executive Officer	Included under agenda item 3.6	Complete
ARA/21/39	12 July 2021	Single Tender Waiver confidential appendices to be uploaded to AdminControl	Head of Risk and Assurance		Complete
ARA/21/29	8 June 2021	Management Response to be formulated for External Audit review of WHSSC Governance Arrangements	Board Secretary	Included under agenda Item 3.5b	Complete

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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	Audit Wales and Management met on 7th September 2021. A development session with the Audit, Risk & Assurance Committee will be arranged to reflect on the Annual Accounts process. This will be scheduled for Q4, 2021/22.	
ARA/19/115e	9 March 2020	The Machynlleth Hospital Primary & Community Care Project recommendation 6 (lessons learnt) would be shared with the Committee, once available.	Board Secretary	Action transferred to Delivery and Performance Committee	

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Agenda item: 2.1

Audit, Risk and Assurance Committee	Date of Meeting: 16 September 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

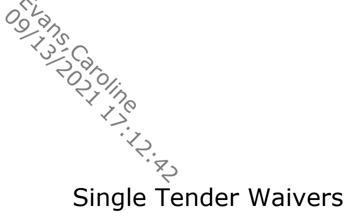
PURPOSE:

To seek the Audit, Risk and Assurance Committee's RATIFICATION of Single Tender Waiver requests made between 1 June 2021 and 31 August 2021.

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 2 items during the period of 1 June 2021 and 31 August 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 June 2021 meeting which covered the period from 1 March 2021 to 31 May 2021.

A summary of the use of Single Tender Action from 1 June 2021 and 31 August 2021 is as follows:

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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
POW2122002	TENDER	British Pregnancy Advisory Service (BPAS)	Provision of Termination of pregnancy and Vasectomy for Powys Patients	Absence of viable NHS Supplier. Continuation of arrangement until national framework for these services is in place which is anticipated to be Autumn 2021.	15/07/2021	£148,920	12 Months or earlier if alternative provision implemented	Part - Retrospective	A1
POW2122005	TENDER	Network of Staff Supporters	Counselling Services for Staff	Extension of previously tendered contract as interim measure while formal procurement is undertaken	25/08/2021	£39,363	8 Months	Prospective	A2

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.

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AGENDA ITEM: 2.2

Audit, Risk & Assurance Committee	Date of Meeting: 14 September 2021
Subject :	**Updated Financial Control Procedures: Covid & Budgetary Management**
Approved and Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Sam Moss, Deputy Director of Finance
Other Committees and meetings considered at:	Executive Committee, 25 August 2021

PURPOSE:

The purpose of this paper is to seek the approval of the committee on the:

- Updated FCP Covid-19 Decision Making & Financial Governance
- Updated FCP Budgetary Control Procedure

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee is requested to:

- APPROVE the latest version of Covid-19 policy (Update#7) presented to Audit, Risk & Assurance Committee
- APPROVE the latest version of Budgetary Control Procedure (Update#6) presented to Audit, Risk & Assurance Committee

Approval/Ratification/Decision	Discussion	Information
✓		

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Summary FCP Changes

Covid-19 Decision Making & Financial Governance Appendix 1:
Since the introduction of this policy at the start of the Covid-19 pandemic in 2020 there have been regular updates to the document to ensure it remained fit for purpose.

Version 6 and 7 of the document have been updated and full details are provided in the Version Control section of the document but in summary the changes include:

- New cost centres for Recovery & Renewal programme
- Changes to working practices including commencement of IBG process, LTA blocks in 2021/22, and ongoing reporting requirements
- Current WG Adult Social Care payment process for 2021/22
- Revised dates/timescales for the publication of the accountability letters.
- Process expenditure and funding flows in 2021/22
- References to Gold Meetings replaced by Exec Meetings

FCP 21 Budgetary Control Procedure Appendix 2:
Last updated approximately 2 years ago this is a key document on the principles and processes of the day to day management of the Health Boards Budgets and the summarised the responsibility of Budget Holders and the Finance Department in this process. There are a number of changes to the document to reflect working practices, along with other changes with are summarised below:

- Now contains a reference to Covid-19 Decision Making & Financial Governance policy
- Updated on reflect process reporting Reserves
- Updated in line with the IBG process that went live in April 2021
- Updated to reflect the new process from 2021/22 linked Efficiency Programme
- Changes in meeting arrangements and communications linked to agile working
- Includes reference to Finance Academy Good Practice Guide on Reporting
- Outlines the position regarding WG allocations and budget virements

Recommendations

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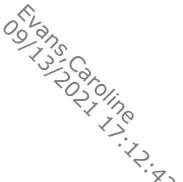
The Audit, Risk and Assurance Committee is requested to:

- APPROVE the latest version of Covid-19 policy (Update#7) presented to Audit Committee
- APPROVE the latest version of Budgetary Control Procedure (Update#6) presented to Audit Committee



FCP COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

Document Reference No:	PTHB / FCP INTERIM	
Version No:	7 (Q2 Update 21/22)	
Issue Date:	April 2021	
Review Date:	n/a	
Author:	Deputy Director of Finance	
Document Owner:	Finance Department	
Accountable Executive:	Director of Finance	
Approved By:	Execs	
Approval Date:	July/Aug 2021	
Document Type:	Policy	Non-clinical
Scope:	PTHB wide (including Hosted Services)	

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

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

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Version Control

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

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	Signatory Forms as per PtHB standard operating processes. Addition = Section 15 Capital: to ensure there is clarity on the management and approval of capital expenditure which may need to vary from the approach used for revenue	
6	Update # 5 Revision = update on commencement of standard BC processes pending launch of new IBG process. Revision = additional cost centres added since August Revision = section Gold Reporting Revision = Reimbursement Section New = Adult Social Care Section Revision = LTA payments to simply FCP and refer to general principles only Revision = TRACs process Revision – 2 Way Matching linked to updates by NWSSP and All Wales P2P	January 2021
7	Update #6 Removed = section on Investment Benefit Group as this will go live in May 2021. Removed = section on Budget Holder Meetings and changes to FCP 21 as this no longer applicable in 2021/22. Updated = section 3 on covid expenditure and the processes to be followed Updated = section 4 to reflect how funding flows in 2021/22, which is different to the process in 2020/21. Updated = section 5 to reflect new guidance issued at end March in relation to 2021/22. Updated = section 7 to reflect ongoing reporting requirements to WG. Updated = section 8 to reflect savings plan for 2021/22 as per Annual Plan. Updated = section 9 to reflect LTA contract payment process agreed between WG and NHSE	Not taken to AC

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	Updated = section 10 to reflect changes in IMTP process for 2021/22 Updated = section 14 linked to extension of 2way matching process by All Wales P2P	
8	Update #7 Updated = new cost centres for Recovery & Renewal Updated = Section 5 on Adult Social Care payment process for 2021/22 Updated = Section 10 dates for the publication of the budget letters. Update = Reference to Gold meetings replaced by Exec Meetings	

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ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

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

Circulated to the following for Consultation

Date	Role / Designation

Evidence Base

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IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	Adverse	Differential	Positive	
Age	√				
Disability	√				
Gender	√				
Race	√				
Religion/ Belief	√				
Sexual Orientation	√				
Welsh Language	√				
Human Rights	√				

Risk Assessment Summary
No risks identified
No Information Governance issues identified
No Training or Resource implications identified

1 Policy Statement / Introduction

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

This procedure needs to be read in conjunction with the documents listed below. The documents listed remain valid and no changes have been made to these. However this FCP may override certain elements of listed documents where changes are necessary to address the pace of change required for COVID-19.

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

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

2 Objective

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

3 Definitions

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

4 Responsibilities

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

4.1 Staff Group or Specific Role

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

4.2 Other staff

5 Monitoring Compliance, Audit & Review

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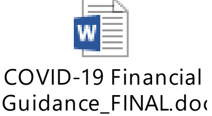
Monitoring compliance will take place regularly as part of the financial monitoring process laid down by WG and may be supported by internal audit and external audit reviews.

This document will be valid for the period the COVID-19 outbreak and during this time may be updated to reflect the pace of change. All changes to this FCP will be approved by Executive Team (Execs) as required.

6 References / Bibliography

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



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FINANCIAL CONTROL POLICY

COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

1. Introduction

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

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

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

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

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2. Interpretation

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

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

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

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

In line with the WG requirements PTHB continue to capture and understand the additional financial commitments made as a result of COVID-19. PTHB has established a number of COVID-19 cost centres (B259, B452-B459, B811-B820) to capture all additional expenditure.

The approval limits for these dedicated cost centre will be noted on the Approved Signatory Forms as per PtHB standard operating processes. All orders over £25,000 will be approved by Execs along being signed by the relevant Budget Holder, Director, CEO or Chairman as required and in line with the SFI. This will happen at start of the purchase or retrospectively.

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

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

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

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

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<u>Non Pay (Revenue):</u>

- All dedicated COVID-19 expenditure needs to be raised against the relevant cost centres set up to support Covid-19 and its component parts as per the full list provided under the pay section below.
- The approval limits for these dedicated cost centre will be noted on the Approved Signatory Forms as per PtHB standard operating processes. Orders between £25,000-£50,000, should be presented to Execs as part of the monthly Finance Report, once informed. All orders over £50,000 must first be approved by Execs before being signed by CEO and Chairman as required and in line with the SFI.
- Requests to commit expenditure will need to be supported by either a small summary or an email detailing the key information in Appendix B. An example of information needed is included in template found in Appendix B. It is the responsibility of the Director for that service area to ensure that the Finance Team are provided with Appendix B or other schedule/business case, completed and approved as per the directions on the form. Where the appendix or supporting information is not submitted directly from a Director there must be a sufficient audit trail to ensure it is clear that the Director has approved this request.
- Using the received Appendix B's or other information including data from the Financial Ledger, the Monthly Covid report to Execs will include:
  - Those orders already raised on the system. This list will be updated monthly so the Health Board can see the total value of services and goods ordered placed since the start of the Financial Year.
  - Orders Over £5k as per the ledger system as some of these may have used the exemption in section 6.
  - Summary of all WHS charges allocated to Covid-19, using the data from the WHS feeder file.
  - List of requests received that require approval from Exces. And where deemed helpful the appendix B forms or other supporting information submitted will be embedded into the report should Exec members require full details on the expenditure requested.
- This report will ensure expenditure is both captured and reported and approved by Execs. It is the intention that all expenditure is approved in advance, but where this is not possible this report will ensure that all expenditure not approved in advance is approved retrospectively in a timely manner and included in one of the categories reported on above.
- From Mth 1 Reporting 2021/22 only expenditure from 1st April 2021 will be included in the report. All previous expenditure is captured in 2020/21 reports.
- It will be the responsibility of the Director of Finance to update the Finance Team on the decisions made by Execs.

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Pay:

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

- Temporary staff (Cost Centre B454)
- Students (Cost Centre B453)
- Returning from Retirement (Cost Centre B455)
- Bank (Cost Centre B452)
- Test, Trace & Protect (Cost Centre B456)
- PPE (Cost Centre B457)
- RPB Covid-19 Funding (B458)
- Mass Vaccinations (B459)
- Recovery & Renewl (B811-B820)

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

Shared Services will also be using these codes to report the spend to date directly to Welsh Government.

For variable pay costs such as overtime, costs will initially be allocated to the cost centre where the substantive post holder is paid. In addition PTHB has historically committed expenditure for overtime, bank and agency to support 'standard non COVID' service provision. Therefore it is proposed that apportionment of expenditure for these areas to COVID-19 will be based on the increase above in year monthly spend, using the monthly average from the last financial year. So for example the variable pay costs for Mth 1 in 2021/22 attributable to COVID-19 =

Total Variable Pay Costs Mth 1 21/22
less average of the variable pay cost in 19/20 **=** COVID-19 Variable Pay Cost in Mth 1 21/22

This will be provided to Execs via the standard WG reports after each month closedown, which are embedded within the report. As well as being reported directly to WG as per the WG Monthly Monitoring Return (MMR) process.

COVID-19 Exec Reporting Summary:

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

- Summary of orders by non pay subjective for goods and services paid on B259-B820 both within the month and from 1st April 2021
- The report will also include a summary of the Covid spend to date and forecast.

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

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

The funding for Covid (Revenue & Capital) will be provided via in year allocation adjustments and will be managed and controlled as per the standard processes within the overall management of the financial position, building in the additional controls outlined in this FCP.

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

In 2020/21 WG issued guidance and funding to support care homes. In April 2021 WG issued an updated guidance for Q1 of 2021/22 and this will be reviewed further updated during the year by WG.

On receipt of the guidance from WG the Finance Department will review and action the guidance provided and ensure the funding is transferred to the Care Homes as quickly as possible.

Where further approval may be required from the Execs a paper will be completed, but as this is the 2nd year of the process this would only happen in exceptional circumstances.

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

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

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

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

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

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

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

WG will require PTHB to provide enhanced financial information via the MMR and accompanying narrative on covid-19. The monthly reports will be shared retrospectively with the Board and the Executive Team.

8. Savings

Recognised in the 2021/22 Annual Plan it is assumed that savings will not commence delivery until start of Q3 due to the ongoing worked linked to the pandemic. From April 2021 savings delivery will be overseen as part of the HB wide Efficiency Framework.

Reporting of savings will be in line with the Efficiency Framework and Welsh Government requirements.

9. Changes to LTA Payments - (Change SFI)

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

However since the start of the pandemic the payments have been made on a Block arrangement, with various caveats agreed between NHSE and WG.

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All Wales block arrangements are presented and approved at All Wales DOFs, via DDOFs, and at these meetings are representatives from WG. The approvals made at All Wales DOFs will then drive the payment/recovery/performance monitoring for PTHB, which will be consistent across Wales. Payments to English providers will be driven by formal agreements between WG and NHSE.

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

FCP 21 states that the letter of Accountability will be issued 28 days after approval of the IMTP. In 2021/22 there is no IMTP but an annual plan, which will be finalised and submitted to WG on 30th June.

Therefore, the approach will be to issue letters to the Directors during Q2 to establish the baseline position and for these to be returned within 4 weeks of being issued.

11. Procurement Hierarchy

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

12. Changes TRACs Approval Process

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

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

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

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

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Where additional resources are required linked to COVID-19 this will need to be approved by Execs as per the process detailed in section 3 above.

13. Capital

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

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

Then will be presented for retrospective approval at the next available Executive Meeting.

As WG increase the HB Capital Resource Limit to reflect Covid-19 requirements the Financial Accounting team will be responsible for monitoring and reporting on the capital spend as required by WG and Board, in line with the management of the standard Capital Resource Limit.

14. Two Way Matching

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

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

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

In September 2020 the process was changed. And the key points were as follows:

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

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

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At the end of March All Wales P2P and DDOF agreed for the two-way matching process to continue to operate until 30th September 2021. However further work will be undertaken by NWSSP and the All Wales P2P Group to look at options.

15. Advanced Payments

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

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

A copy of the guidance is provided below:

Advance Payments - Guidance FINAL.pdf

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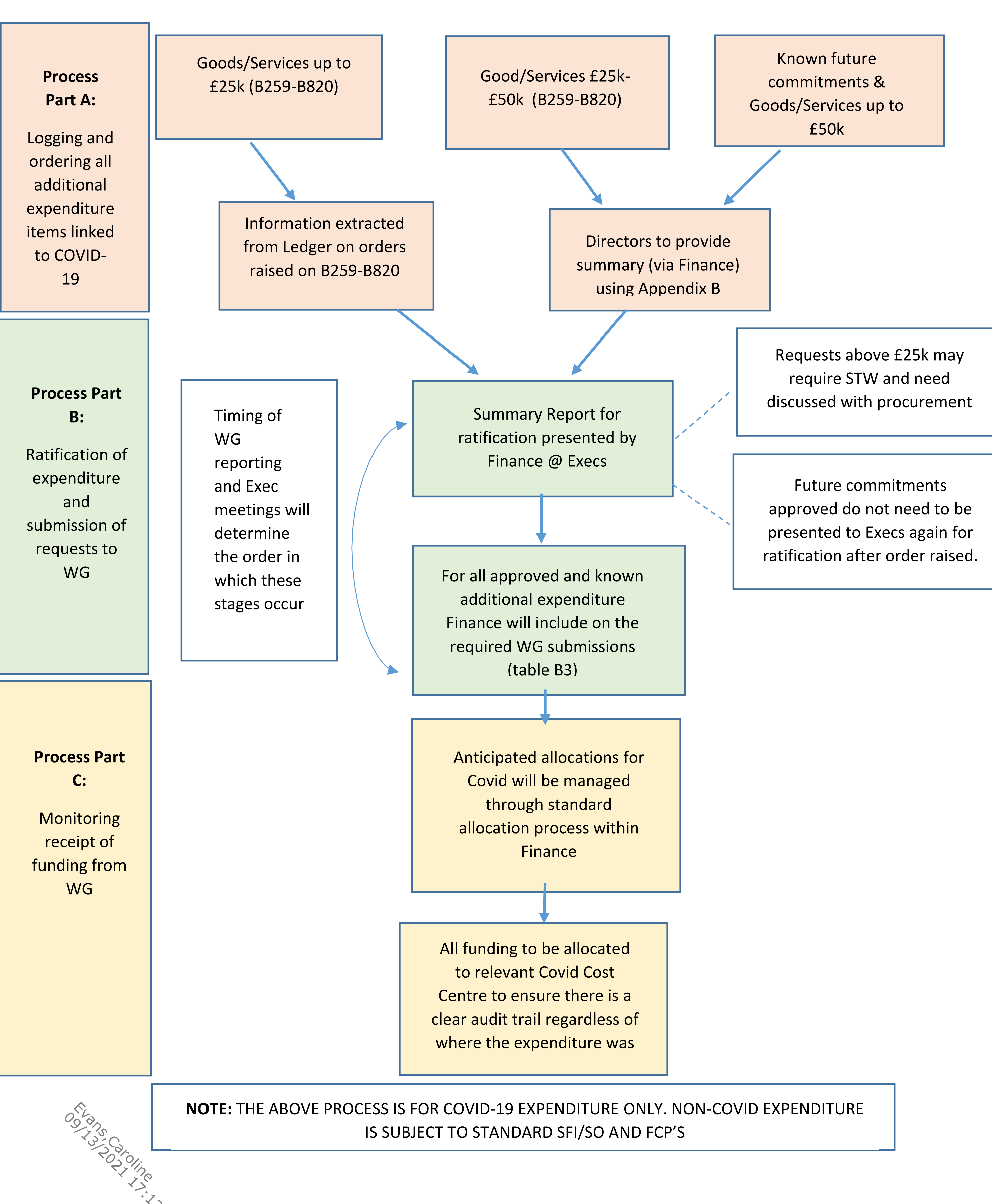
APPENDIX A – PROCESS MAP COVID 19 REVENUE EXPENDITURE NON PAY



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

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APPENDIX B – FUNDING REQUEST TEMPLATE

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

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FCP021 BUDGETARY CONTROL PROCEDURE

Document Reference No:	PTHB / FCP021	
Version No:	6	
Issue Date:	September 2021	
Review Date:	September 2024	
Author:	Deputy Director of Finance	
Document Owner:	Finance Department	
Accountable Executive:	Director of Finance, Information & IT Services	
Approved By:		
Approval Date:		
Document Type:	Policy	Non-clinical
Scope:	PTHB wide (including Hosted Services)	

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

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

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Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Sep 2011
2	Review	Sep 2013
3	Review	Jul 2015
4	Review	Aug 2017
5	Reviewed and updated to reflect key changes on: • Timescales for accountability letter • IBG Process & Business Cases • IMTP & Budget Setting process • Revised Virement Process • Unallocated funds held in reserves will be reported within the Risks & Opportunities section of the Board Report	Jan 2020
6	Updated – include reference to Covid FCP policy and new SFI's Section 7.3 updated on reserves Section 8.4 updated with revised IBG process that went live in 2021/22 Section 10.3 updated to reflect new process from 2021/22 linked Efficiency Programme Section 11.2 – added section on c/f on non recurrent funding Section 12.3 – added reference to email evidence and that meeting may be via MS Teams Section 14.1 – added reference of Finance Academy Good Practice Guide Section 15.3 new to reflect additional staff appointments linked to IBG cases. Section 16.11 updated to clarify position regarding WG allocations and budget virements Section 20.1 updated to expand No PO No Pay Appendix C updated so virement forms can be done via Email	August 2021

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ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Finance Directorate
Budget Holders

Circulated to the following for Consultation

Date	Role / Designation
Various	Audit Committee
Various	Shared on Intranet for Staff Access

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Evidence Base

IMPACT ASSESSMENTS

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

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1 Policy Statement / Introduction

This procedure describes how to ensure that the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented within the Powys tHB, including those services hosted by the Health Board.

This procedure needs to be read in conjunction with the following documents: The Board has approved Standing Orders and Standing Financial Instructions which include instructions on financial management.

- Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- Other Financial Procedures

2 Objective

This procedure prescribes the responsibilities of Budget Holders in how to maintain sound financial management and the minimum procedures needed to ensure this. It also sets out the duties that Budget Holders must discharge in order to ensure the effective control of their financial activities. This procedure is relevant for all staff including those within the hosted bodies.

3 Definitions

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

4 Responsibilities

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

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	4.1 Staff Group or Specific Role Budget Holders are required to review procedures for financial management to ensure that they meet the standards laid down and must comply with the directions and guidance contained within this financial control procedure.
	4.2 Other staff

5 Monitoring Compliance, Audit & Review

Monitoring compliance will take place regularly as part of the financial monitoring process within PTHB and supported by regular internal audit review.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

6 References / Bibliography

Note – during the Covid pandemic this policy will need to be read in conjunction with the Covd -19 FCP, which is updated quarterly.

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FINANCIAL CONTROL POLICY FCP021 BUDGETARY CONTROL PROCEDURE

1. Introduction

1.1. This procedure describes how to ensure that the financial management responsibilities placed upon the Chief Executive and Director of Finance are discharged and implemented within the Powys tHB, including those services hosted by the Health Board.

1.2. This procedure needs to be read in conjunction with the following documents: The Board has approved Standing Orders and Standing Financial Instructions which include instructions on financial management.

- Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- Other Financial Procedures

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

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

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

1.6. This procedure prescribes the responsibilities of Budget Holders in how to maintain sound financial management and the minimum procedures needed to ensure this. It also sets out the duties that Budget Holders must discharge in order to ensure the effective control of their financial activities.

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2. Interpretation

2.1. Any queries regarding the interpretation of any of the guidance set out in this document should be addressed to the Director of Finance.

2.2. The following expressions used within this document shall have meanings as shown below:

2.3. **"Principal Budget Holder"** means the level below the Chief Executive where the main responsibility rests and includes, for the purpose of this procedure, the following posts

- Director of Primary, Community & Mental Health
- Medical Director
- Director of Therapies and Health Science
- Director of Planning and Performance
- Director of Public Health
- Director of Nursing
- Director of Workforce and OD
- Director of Finance, Informatics and IT Services

2.4. **"Delegated Budget Holder"** means the budget holder nominated by the Principal Budget Holder to hold budgetary responsibilities.

2.5. **"Budget Holders"** means all Budget Holders

2.6. **"Finance Directorate"** means the Director of Finance or any officer authorised by the Director of Finance

3. Financial Control

3.1. Paragraph 1.3.1 within the THB's Standing Financial Instructions make the following reference:

"The financial provisions and obligations for LHBs are set out under sections 175, 176 and 177 of the NHS (Wales) Act 2006 (C.42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources."

[Note - this will need to be checked and updated once revised SFI have been approved by the Board]

3.2. This translates into the requirement of the THB to ensure that its operating costs remain within the annual resource allocation provided by the Welsh Government (WG).

3.3. The preparation and maintenance of the Annual Financial Plan and annual revenue budgets is undertaken with this objective in mind.

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3.4. The production and interpretation of timely and accurate budgetary control information is an essential ingredient of the management of the THB. The balance between speed of production and greater accuracy of information should be reviewed on a regular basis.

3.5. Employees of the THB, and especially those involved with the budgetary process, have a responsibility to the Board for identifying all possible opportunities to make savings or to use THB resources more effectively.

3.6. The budgetary process requires adherence to particular timescales for the performance of routines and duties. As the timescales will change periodically they are not included here. An overview of the key timescales linked to the budgetary process are summarised below:

- The Financial Planning timescales will be directed by WG as part of the IMTP planning process, which will also determine the publication of the letters of accountability;
- All timescales for formal reporting to WG for the Monthly Monitoring Reporting will be prescribed by WG;
- All Board reporting will be in line with the Health Boards requirements;
- Budget Holder Dashboard will be available once the financial period has been closed and all Budget Holders will receive an email confirming when the information is available.

It is the responsibility of all Budget Holders concerned to adhere to any timetables and to inform the Director of Finance of any reasons preventing the achievement of a specific deadlines.

3.7. The Finance Directorate will periodically re-assess all functions of the THB that incur financial consequences and ensure that the responsibility for exercising budgetary control for each and every function is delegated to the appropriate Principal Budget Holder, in line with the requirements of the Board.

3.8. Each Principal Budget Holder will, from time to time review the range of delegated functions and make recommendations to the Director of Finance on a scheme for further delegating the budgetary responsibilities pertaining to those functions to appropriate Delegated Budget Holders. Account shall be taken of the scope and approximate value of resources and the seniority and management potential of a prospective Delegated Budget Holder.

3.9. The THB Board, acting upon the advice of the Director of Finance, will periodically review and approve the income and expenditure limits within which Budget Holders may operate. These limits will be laid down in the Schedule of Authorised Signatory Limits.

4. Financial Plan

4.0. It is the responsibility of the THB, under the guidance of the Director of Finance, to produce on an annual basis a 3 year Integrated Medium Term Plan (IMTP). The plan should ensure that the THB is geared to meeting:

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- External statutory targets
- Internal targets determined by the THB

4.1. The IMTP should demonstrate that the THB is exercising good stewardship in its use of public funds and in particular demonstrate the principles of:

- Probity
- Value for Money
- Minimising Risk

4.2. Robust financial planning and budgetary control are central to the THB in meeting its financial and non-financial performance targets and achieving its prescribed / agreed targets and goals.

5. All Budget Holders

5.1 Budgets may be delegated by the Chief Executive to Principal Budget Holders, who shall be the designated budget holders for the specified services.

5.2 All Principal Budget Holders are accountable to the Chief Executive for their performance in managing their delegated budgets.

5.3 Day to day management of those budgets, and the authority to commit expenditure against them, may be delegated to officers subject to the THB's SOs and SFIs.

5.4 All Delegated Budget Holders are accountable to the appropriate Principal Budget Holder for their performance in managing their delegated budgets. The Principal Budget Holder may, in the event of unsatisfactory budget performance, remove the status of budget holder. In such circumstances the funds shall revert to the control of the Principal Budget Holder.

5.5 All Budget Holders should be encouraged to demonstrate efficient and effective use of resources whilst considering the overall financial health and priorities of the THB.

5.6 The Chief Executive, acting on advice from the Director of Finance, will ensure that Principal Budget Holders are notified in writing of their budget and the accountability linked to this was a 'Letter of Accountability, which will have a clear definition of:-

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- The functions/services for which the budget is provided
- The amount of the budget and savings requirement
- The planned levels of activity/service provision (if known)

5.7 The issuing of the Letter of Accountability will be undertaken within 28 days of the formal confirmation from WG of the IMTP approval.

5.8 The Principal Budget Holder will be required to sign off the Letter of Accountability within 28 days of receipt of the letter, thus allowing any issues or concerns to be discussed with CEO or Director of Finance.

5.9 Delegated Budget Holders must restrict budgetary and spending activity to within the limits of delegated authority and purpose for each budget and may not further delegate any aspect without the approval of the appropriate Principal Budget Holder.

5.10 Budget Holders must provide an approved signatories (with specimen signatures) to the Finance Directorate. This list must be reviewed regularly and updates provided to the Finance Directorate as a matter or urgency, where changes are needed.

6. Allocations and Other Income

6.1 The majority of the THB's income is received via allocations from the WG. The Finance Directorate are responsible for ensuring all allocations due are received and ensuring the appropriate cash management in calling funding down from WG.

6.2 The THB receives its Financial Allocation from the WG under a number of headings, some of which have restrictions placed upon them. These restricted allocations are referred to as "ring fenced"

6.3 In cases where individual Budget Holders have bid for and received specific funding, it is the responsibility of the Budget Holder to inform the Finance Directorate that this income is due to the THB.

6.4 It is the responsibility of the Budget Holders to ensure that all income due to the Health Board is notified to the Finance Directorate.

6.5 The Finance Directorate will maintain a register of all specific funding due to the THB.

6.6 The Finance Directorate will ensure that all income due to the THB is properly invoiced within the requisite timescales and that there is an adequate system for pursuing late payments.

7. Reserves

7.1 The Director of Finance, on behalf of the Chief Executive, will endeavour to create such reserves as are deemed necessary to secure the ability of the THB to meet its financial targets. Reserves may include sums to cover future pay awards, price inflation, unforeseen contingencies, non-recurrent

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spending and other specific items as yet not allocated to individual budgets.

7.2 The Director of Finance, with the agreement of the CEO, and or, the Executive Team, may partly or wholly allocate general reserves directly to the Principal Budget Holders or subsequent allocation to specific budgets.

7.3 Where the Health Board is holding reserves that are not for a known future use or are not currently part of the wider Health Board Financial position/forecast and are therefore an unallocated opportunity then the impact of their utilisation on the management of the wider Health Board position, will be highlighted to the Board. This will be contained in the 'Risks and Opportunities' section of the Finance Board Paper.

8. Investments and Business Planning

8.1 Budget Holders, when developing service change plans or business cases, should take account of the nature of costs and funding associated with a particular scheme:

- Non recurring capital costs
- Non Recurring revenue costs
- Recurring revenue costs

8.2 The Finance Directorate must be fully involved in the preparation and appraisal of any business case or other proposal requiring investment or disinvestment. Their role will be to provide expert financial advice on proposals under consideration and where internal expertise is not available, the directorate will work with the locality/directorate leading the business case to secure support where required.

8.3 The appraisal of business cases will be in line with the Health Board's IBG process. For the NHS there is a finite amount for resources available and so every investment or change in service could potentially increase the costs for the Health Board and needs to be undertaken in a manner that allows the organisation to make the right decision for the patients both in terms of commissioning and providing services. Furthermore investing in one service in one part of the organisation may prevent investments in other areas and so the decision has to be clear, transparent and based on the accurate and relevant information both financial and clinical.

8.4 As per the guidance issued and Terms of Reference for IBG Panel, the IBG process is to support the Executive Team in overseeing the effectiveness of the arrangements for the management of investment business cases (revenue) and bids for external investment in line with the board's strategic goals and corporate objectives. The main aim will be to assess business cases for quality assurance, governance and value for money. The group will provide assistance and advice to service leads for the preparation of business cases.

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9. Budget Setting Process

9.1 The THB will set annual budgets, in line with the agreed IMTP, which will relate to the Financial Year beginning 1st April.

9.2 The provisional IMTP Financial Plan will be presented by the Director of Finance to the THB Board for approval in line with the All Wales IMTP timescales and prior to the start of the financial year, at which time it will become the formally adopted budget.

9.3 Following Board approval the IMTP is submitted to WG for sign off. Only when this IMTP is officially agreed by WG can it the budgets for the new financial year be finalised.

9.4 Principal Budget Holders will then be informed of the budget proposals for the ensuing year, via the Letter of Accountability.

9.5 All budget proposals/plans will consider the following:

- WG Allocation letter
- Expenditure/income trends in the current and previous year
- Proposed service plans and developments, workforce plans, commissioning intentions, cost improvement targets and guidelines laid down by the Board

9.6 The accurate phasing of planned expenditure in each budget is key to maintaining in-year financial control. This is the responsibility of the Budget Holder, supported and advised by the Finance Directorate. Each budget must have clearly defined phasing representing planned expenditure. This can take many forms, twelve equal monthly payments, month by month specific amounts, quarterly payments, or one single lump sum payment.

9.7 Any in year amendments to these budgets will be discussed with the Budget Holders, and confirmed by the Finance Directorate as per the virement process outlined in section 16.

9.8 The Finance Directorate will monitor progress on performance against budgetary limits throughout the year and report accordingly to the Executive Team, Board and other relevant committees.

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10. Savings / Financial Recovery Plans

10.1 The Chief Executive, after taking advice from the Director of Finance, will decide how much is required from saving schemes for the year ahead. Factors affecting that level will include:

- Impact of the annual resource funding from WG
- Specific directives from WG
- Internal requirement to balance overspending functions
- Board approved savings strategies
- Local disinvestment decisions taken to fund local initiatives aligned to the IMTP.

10.2 Savings may take the form of recurrent or non-recurrent schemes. However, the latter should be replaced with schemes that generate recurring savings in future years.

10.3 From 2021/22 the delivery, oversight and reporting will be in line with the agreed Efficiency Programme. Where necessary there will be up to 4 programmes each lead by a Director to drive the efficiency agenda of the Health Board , which will contribute to the savings requirement. Progress on the performance and delivery of savings will be reported monthly as part of the standard finance performance papers.

10.4 The Finance Directorate will monitor, measure and report progress on achievement of savings targets throughout the year and report accordingly to the Board and Welsh Government in accordance with the prescribed monitoring arrangements.

10.5 Reporting on progress against savings will take place in a timely manner, enabling the THB to determine which cost improvements are likely to deliver their planned target and those where slippage is likely to occur. The THB can then take necessary action to ensure the overall budget and IMTP finances aren't compromised.

10.6 The accurate phasing of planned savings for each area is key to measuring progress and maintaining in-year financial control. This is the responsibility of the Efficiency Programme, supported and advised by the Finance Directorate. This can take many forms, twelve equal monthly payments, month by month specific amounts, quarterly payments, or one single lump sum payment.

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11. Recurring and Non Recurring Budgets

11.1 A recurring budget is one that is available for the Budget Holder to utilise on a rolling basis year on year. Budget Holders will be informed at Budget Holder meetings which elements of their budgets are recurring and non-recurring by the Finance Directorate. The Finance Directorate will consult Budget Holders if a recurring budget is no longer available for their use, and a course of action agreed.

11.2 A non-recurring budget is a budget available for the Budget Holder to use over a fixed period of time agreed with the Finance Directorate. If a non-recurring budget/funding is not used in the agreed time period as per accounting guidance it cannot be carried forward to future years as the Health Board is not allowed in most cases to hold deferred income. Changes from this approach would need to be agreed with the Health Boards External Auditors. However where expenditure has been committed which has yet to be paid by the end of the financial year in which the funding expires then an accrual can be undertaken, with the appropriate audit supporting papers.

11.3 It is the responsibility of Budget Holders to ensure that they do not enter into recurring commitments (for example appointing a permanent member of staff) using a non-recurring budget.

11.4 If any doubt exists regarding the status of a budget allocation it should be referred to the Finance Directorate.

12. Budgetary Control

12.1 It is the responsibility of budgets holders to ensure that budgetary control is exercised over the budgets that they are responsible for managing. The Finance Directorate will provide advice and support to ensuring budgetary control is established and maintained.

12.2 Budget Holders will be given the names and contact numbers of Finance Directorate staff to whom they may address any queries they have regarding their budgets.

12.3 The Director of Finance will ensure that there are regular, evidenced, meetings (which may be undertaken via Teams) between Budget Holders and the Finance Directorate. It is expected that these meetings would take place, as a minimum, at least quarterly (APPENDIX B). Evidence can be as simple as summary to the Budget Holder via email of the meeting and the queries raised.

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12.4 At these meetings any significant variances will be discussed with the Budget Holder, the reasons they have arisen ascertained, and plans to address any overspends formulated. Where necessary these plans will be reported back to the Director of Finance.

13. Reporting Periods

13.1 Reporting periods will consist of calendar months running from April (Period 1) to March (Period 12) each year.

13.2 In addition to this there may be a year-end reporting period that will be designated Period 13.

14. Reporting

14.1 The Director of Finance will be responsible for reporting to the Board the financial performance of the THB each time they meet. The report will contain as a minimum the requirements set out in the Standing Financial Instructions and the NHS Wales Good Practice Guidance, including current and projected (year-end) performance against statutory and other financial targets.

14.2 The Director of Finance will ensure that the THB Board of Directors receives a report updating them about the financial performance of the THB on a monthly basis.

14.3 Principal Budget Holders will receive monthly reports. These will be viewed via on-line systems (currently Qlikview, whilst transitioning to Power B.I.) and budget holders will be notified via email when the information is available for review.

14.4 Budget Holders with responsibility for managing delegated budgets will receive reports regarding the performance of the budgets they manage on a monthly basis, together with reports analysing their staffing costs, as per 14.3 via Qlikview/Power BI.

14.5 Budget values reported in the statements should take into account, wherever possible, all known adjustments to budget and all reasonably anticipated future adjustments. Proportions of budget applied to the report month and the accumulated period to date should take account of appropriate start and finish dates of functions or value variations, seasonal fluctuations and irregular spending patterns.

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14.6 Where the terms of an allocation, or grant income, from the WG stipulate that the Budget Holder has to send expenditure reports to the WG in

accordance with an agreed format, and to an agreed timetable, it is the responsibility of the Budget Holder, in consultation with the Finance Directorate, to ensure that these reporting requirements can be met.

14.7 After preparation of the budget reports, the Finance Directorate will discuss any significant variances displayed in the resulting financial data with Budget Holders, and, where necessary, agree, and document, any recovery plan.

15. Appointment of Staff

15.1 All permanent staff, at all levels of the organisation will be appointed via the TRACs process, for which there is a approval process including Workforce and Finance.

15.2 Principal Budget Holders may agree appointments at all other levels providing the costs are within the agreed budget or are covered by approved virement.

15.3 Where investments have been agreed as part of the IBG process the agreement to support cases will be notified to the Finance Directorate. The financial value of these agreed investments will be also recorded on the IBG Tracker.

16. Virement

16.1 For the purposes of this document virement is the authorised transfer of a budgetary allocation.

16.2 Budget Holders must be able to respond to overspends or under spends if the variations are due to activity and workload, or as the result from external factors influencing expenditure.

16.3 In order for virement to be considered the budget holder must demonstrate that all the budgets managed by the budget holder will not be overspent at the year-end.

16.4 Virement may be temporary or permanent. A temporary virement will be non-recurring and apply only to the financial year in which the virement is approved.

16.5 Virements will also be required where in year funding is received from Welsh Government increasing the allocation income, which will result a corresponding increase in expenditure budgets.

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16.6 A permanent virement will be recurring and will need to be reflected in the THB's rollover Financial Plan.

16.7 In general Budget Holders will not be allowed to retain savings arising from factors outside of their control. Utilisation of unplanned savings or fortuitous gains will be jointly agreed between the principal budget holder and the Director of Finance.

16.8 Planned savings may be retained and used for the purposes of virement to other budget heads in consultation with the Finance Directorate.

16.9 To support the Virement Process a standard template will need to be completed by the Finance Directorate and approved by the relevant Budget Holder for approval. This can be undertaken via email, with the audit trial being the email (APPENDIX C).

16.10 Where virement relates to an allocation which will be held initially in reserves then approval can be provided from within the Finance Directorate as there will be evidence from WG to support the transaction.

16.11 Where an allocation is received directly from WG for a specific service development or investment approval can be provided from within the Finance Directorate to allocate the funding to a Cost Centre as WG will issue various letters/communication to the relevant Director/Service.

17. Overspending

17.1 A budget is overspent when the expenditure that has been charged against the budget is more than the funds allocated to the budget.

17.2 The Director of Finance in conjunction with the Chief Executive shall determine the value of any variance that constitutes a material variance. This variance may be applied at Directorate level or at an individual cost centre which in itself may not result in an overspend at Directorate level. The value of the variance deemed to constitute a material variance will vary across the organisation and will need to be assessed based on a variety of performance indicators including budget variance, actual spend levels and savings delivery. This assessment will be undertaken as part of the month end closedown process, whereby all areas of the financial position will be reviewed by the Finance Team, and areas of concern can be escalated either linked to a specific cost centre, overarching trend e.g. variable pay or service area/directorate.

17.3 Budget areas that report a material variance may activate a formal recovery process. So where there is no current forum to discuss overspends a recovery process may be required. A recovery process would result in:

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- The Director of Finance establishing a review forum which will normally involve at least one other Executive Director and the principal budget holder in question.
- The forum to identify and record the causes of the material variance.
- The Locality/Directorate management team to develop savings plans in order to rectify the overspend and ensure a breakeven position.

17.4 In circumstances of persistent or deliberate non-compliance with budget holder responsibilities, the Director of Finance will refer to the Chief Executive who may, after considering the circumstances take remedial action which could include the removal of principal budget holder status.

18. Under-spending

18.1 A budget is under spent when the expenditure that has been charged against the budget is less than the funds allocated to the budget.

18.2 Under-spending can be grouped into two categories:
- recurring
- non-recurring

18.3 Recurring under-spending may be used to alleviate savings requirements in the current financial year and may be offset against savings targets in year. Budgets will be realigned during the budget setting process, to take account of recurrent underspends and these may be included in the rollover Financial Plan.

18.4 Non - recurring under-spending may be used to alleviate savings requirements in the current financial year. These will be excluded from the rollover Financial Plan.

18.5 Where the Budget Holder has achieved all savings targets any under-spending may be utilised in accordance with Section 16 of this procedure.

19. Coding and Authorisation of Transactions

19.1 It is the responsibility of the Budget Holder with the support of the Finance Directorate, where necessary, to ensure that vouchers and invoices relating to budgets that they control are:
- properly authorised
- charged to the correct budget

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19.2 The Finance Directorate will maintain a register of officers who are authorised to charge expenditure against budgets in conjunction with Budget Holders.

19.3 Any problems regarding coding should be referred to the Finance Directorate.

19.4 It is the responsibility of Budget Holders to ensure that any changes to the authorised signatory list are notified to the Finance Directorate so that the lists may be updated to reflect these changes.

20. Ordering of Goods and Services

20.1 All goods and services that are ordered for use in the THB should be supported by an official order and authorised by an officer on the official list of signatories. The No PO No Pay supports the use of Orders in all situation unless they fall under one of the recognised exemption categories.

20.2 Budget Holders must refer to the Shared Services Procurement Department any request for quotes, tenders or a waiver for services (including clinical services) which involve the private sector in line with Standing Financial Instructions.

21. Service Agreements

21.1 All service agreements with other bodies should be supported by a service level agreement or a long-term agreement as appropriate. These service agreements should be signed by both parties in accordance with the agreed process for Service Level and Long Term Agreements.

21.2 In the case where a Partnership Agreement is entered into with another body this should be supported by a partnership agreement.

21.3 LTA and SLA's for clinical services between NHS bodies must comply with the Executive Committee agreed format and process.

22. Equality Impact Assessment

22.1 Following assessment, this procedure is not felt to be discriminatory or detrimental in any way with regard to the following equality strands: Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights

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APPENDIX A

List of Abbreviations

THB	-	Teaching Health Board
SOs	-	Standing Orders
SFIs	-	Standing Financial Instructions
WG	-	Welsh Government
IMTP	-	Integrated Medium Term Plan
SLA	-	Service Level Agreement
LTA	-	Long Term Agreement
IBG	-	Investment Benefits Group

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APPENDIX B

Summary Meeting Schedule

	Frequency Meetings	Meet With*
Principal Budget Holders:		
• Primary & Community	Quarterly	FBP/MA/AMA
• Corporate Functions	Quarterly	FBP/MA/AMA
Delegated Budget Holders		
• Primary & Community	Quarterly	FBP/MA/AMA
• Corporate Functions	Quarterly	FBP/MA/AMA

Key	
Director of Finance	DoF
Deputy Director of Finance	ADoF
Finance Business Partner	FBP
Management Accountant	MA
Assistant Management Accountant	AMA

**Where appropriate the DOF and DDOF may also meet with Budget Holders on an ad hoc basis.*

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APPENDIX C

Virement Process

- Where Budget Virement is required a standard form must be completed. The form must be approved by the Budget Holder and the email can be used as the audit trail.
- To support agile working this can also been completed via email. The email should contain the basic information as per the form and the email for the Budget Holder is their authorization.
- The standard template to be used is provided below.
- Where the virement is linked to new allocation from WG and/or the funding is to be held in reserves then approval can be provided from within the Finance Directorate as there will be evidence from WG to support the transaction

Financial Value of Virement	£
Is Virement Income or Expenditure	Income / Expenditure
Transferring From Budget Code	
Transferring To Budget Code	
Reason for Virement:	
Please detail reason here -	
Approved by Budget Holder	
Name	
Date	

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Approved by Finance	
Name	
Date	
Finance Section Only: Actioned in Ledger by	
Name	
Date	
Jnl Reference	

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AGENDA ITEM: 3.1

AUDIT, RISK & ASSURANCE COMMITTEE	DATE OF MEETING: 14 SEPTEMBER 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, 25 August 2021 Risk and Assurance Group, 8 September 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 a result of the Health Board's response to the COVID-19 pandemic, capacity to implement audit recommendations across services was inevitably previously reduced. To ensure a balance between managing capacity pressures and challenges presented by the COVID-19 pandemic and managing the 'business as usual' issues and risks, services previously reprioritised their outstanding audit recommendations according to the level of risk associated with delayed implementation, and in line with delivery of the Quarter 3 & Quarter 4 Winter Plan. As the organisation transitions back into normal activity, timescales for the implementation of future audit recommendations have not been re-prioritised and remain as that determined by Internal Audit. This is in recognition that services will agree realistic timescales for implementation of recommendations, in light of current commitments and capacity.

INTERNAL AUDIT

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

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

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

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

Overdue Internal Audit Recommendations							
Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21		TOTAL OUTSTANDING
	Number	Number	Number		Number		Number
Priority 1	0	0	0	**High**	1		1
Priority 2	5	2	14	**Medium**	7		28
Priority 3	1	0	15	**Low**	4		20
Not Yet Prioritised	0	0	1				1
TOTAL	**6**	**2**	**30**		**12**		**50**

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

EXTERNAL AUDIT

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

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

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

LOCAL COUNTER FRAUD SERVICES

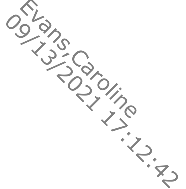
The overall summary position in respect of **overdue** local counter fraud services recommendations is: -

Local Counter Fraud Services Recommendations		
	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 J – Local Counter Fraud Audit Recommendations NOT YET DUE for implementation

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.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2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1							✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	2							✓
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0							✓
171806	Risk Management	Limited	2	1	0	2	1	0							✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0							✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0							✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0							✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1							✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1							✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0							✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1							✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0							✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1							✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3							✓
171817	Policies Management	Reasonable	0	4	2	0	0	1	0	4	1	0	5	0	×
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3							✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1							✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4							✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2							✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3							✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1							✓
171824	General Ledger	Substantial	0	0	1	0	0	1							✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1							✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1							✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	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
			H	M	L	H	M	L	H	M	L	1	2	3	
181901	IMTP – Joint Planning Framework	Reasonable	0	1	1	0	1	1							✓
181902	Dental Services: Monitoring of the General Dental Services Contract	Limited	2	2	0	2	2	0							✓
181903	ICT Infrastructure	Reasonable	0	1	2	0	1	2							✓
181904	Podiatry Service	No Assurance	7	1	3	7	1	3							✓
181905	Recruitment and Retention	Reasonable	1	2	0	1	2	0							✓
181906	Environmental Sustainability Reporting	Reasonable	0	1	0	0	1	0							✓
181907	Commissioning – Primary Care (Advisory)	Not Rated	2	2	0	2	2	0							✓
181908	Asbestos Management	Reasonable	0	4	4	0	4	4							✓
181909	Occupational Therapy Service	Reasonable	0	6	0	0	5	0	0	1	0	0	1	0	×
181910	Health and Safety	Limited	1	6	1	1	6	1							✓
181911	Section 33 - Governance Arrangements	Limited	2	1	1	2	1	1							✓
181912	Annual Quality Statement	Substantial	0	1	0	0	1	0							✓
181913	Departmental Review - Catering	Limited	3	3	1	3	3	1							✓
181914	Capital Systems	Reasonable	0	6	1	0	6	1							✓
181915	Temporary Staffing Unit	Reasonable	0	4	1	0	4	1							✓
181916	Cyber-Security Follow-up of Stratia Report	Reasonable	0	2	2	0	2	2							✓
181917	Putting Things Right – Lessons Learned (Midwifery)	Reasonable	0	1	3	0	1	3							✓
181918	Single Tender Waivers	Reasonable	0	3	0	0	3	0							✓
181919	Business Continuity Planning	Reasonable	1	2	2	1	2	2							✓
181920	Information Governance: General Data Protection Regulation (GDPR) - Compliance	Reasonable	0	1	2	0	1	2							✓
181921	Risk Management	Limited	2	1	0	2	1	0							✓
181922	Procurement of Consultant and Agency Staff Follow Up	Reasonable	0	3	1	0	3	1							✓
181923	Medicines Management (Patient Group Directions) Follow-Up Review	Limited	3	3	0	3	3	0							✓
181924	Estates Assurance Follow Up	Reasonable	0	6	4	0	6	4							✓
181925	Capital Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
181926	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1							✓
181927	Engagement with Primary Care Providers Follow-up	Limited	1	2	1	0	2	1	1	0	0	0	1	0	×
TOTAL			**25**	**70**	**32**	**24**	**69**	**32**	**1**	**1**	**0**	**0**	**2**	**0**	

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	Not Yet Prioritised	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	1	0								✓
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1								✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0								✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3								✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3								✓
192006	Records Management	No Assurance	6	0	0	3	0	0	3	0	0	0	3	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3								✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	2	0	0	1	0	0	0	1	0	×
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2								✓
192010	111 Service	Reasonable	2	3	0	1	0	0	1	3	0	0	4	0	0	×
192011	Catering Services Follow-up	Reasonable	0	3	2	0	3	2								✓
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	1	2	0	0	3	0	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	0	3	0	1	0	1	0	1	1	0	×
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	1	0	0	1	0	0	0	1	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	1	3	0	0	0	3	1	×
192023	Estates Assurance Follow Up	Reasonable	0	1	2	0	1	1	0	0	1	0	0	1	0	×
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1								✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0								✓
192026	Risk Management and Board Assurance	Limited	2	3	0	2	0	0	0	3	0	0	3	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	2	1	0	0	3	0	×
TOTAL			**23**	**63**	**32**	**14**	**47**	**27**	**9**	**16**	**5**	**0**	**14**	**15**	**1**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0										✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	1	2	0	1	3	0	4	0	0				✗
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	1	1	0	1	0	0	2	1	0	1	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	1							✗
202107	GP Access Standards	Substantial	0	0	1	0	0	1										✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	1	0	0	0	1	1				2	0	0	✗
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	0	0	0	1				0	0	13	✗
202110	Freedom of Information Follow Up	Substantial																✓
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	0	2	0	0	0	0	0	0	0				0	2	0	✗
202112	Grievance Process	Reasonable	0	1	0	0	1	0										✓
202113	Safeguarding during COVID-19	Reasonable	0	1	1	0	1	0	0	0	1							✗
202114	Implementation of digital solutions	Reasonable	0	3	0	0	0	0	0	0	0				0	3	0	✗
202115	Winter pressures and flow management	Reasonable	0	3	1	0	0	0	0	1	0				0	2	1	✗
202116	Llandrindod Wells Project	Limited	0	5	1	0	4	1	0	1	0							✗
202117	Covid-19 Mass Vaccination Programme	Not Rated																✓
TOTAL			**5**	**26**	**25**	**2**	**11**	**6**	**1**	**7**	**4**	**4**	**2**	**1**	**2**	**8**	**15**	

APPENDIX B

2018/19 External Audits

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

2019/20 External Audits

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

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	2	3	Not Yet Prioritised		
202151	Effectiveness of Counter-Fraud Arrangements	3	2	1	0	0	0	1		×
202152	Structured Assessment 2020	11	7	1	0	1	1*	2*	3	×
202153	Audit of Accounts	6	5	1	0	0	0			×
TOTAL		**20**	**14**	**3**	**0**	**1**	**1**	**3**	**3**	

***Not Yet Due**

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Not Yet Due	All Audit Recs implemented
202181	Pre-Employment Checks	3	3			✓
212281	Overpayments	3	0	0	3	×
TOTAL		**3**	**3**	**0**	**0**	

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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-21	Mar-20	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-21		38	#NUM!	Jul-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-21	Mar-20	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-21		38	#NUM!	Jul-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-21	Mar-20	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-21		38	#NUM!	Jul-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-21	Mar-20	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-21		39	#NUM!	Jul-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-21	Mar-20	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-21		38	#NUM!	Jul-21	26/02/2019

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171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	Director of Primary, Community and Mental Health	Chief Pharmacist	R4	The Health Board should introduce a formal policy which clearly sets out the process of prescribing medicines. This should include the following: • roles and responsibilities • monitoring and reporting arrangements • processes for processing and approving changes to the formulary • circumstances where follow up action should be taken Once approved, the policy should be appropriately communicated to all relevant staff.	Concise collation of advice for practitioners from professional guidance, and contractual arrangements that they should already be working to, may be a helpful reminder.	Apr-18	Sep-20		Overdue	3	Partially complete		Medicines Policy has been delayed until January to be approved by Med Safety and Governance Group. The advice will be attached as an appendix. New Chief Pharmacist appointed May 2020. Although the Medicines Policy has been updated and is in the final stages of approval, it does not include all of the audit recommendations. Work is needed to establish robust governance arrangements for medicines/prescribing decision making. As soon as this work has been undertaken, the Medicines Policy will be updated.	Chief Pharmacist new in post and needs time to understand/amend governance arrangements to ensure that when Medicines Policy is updated, it accurately reflects HB approved processes	Reminder, and links, send to HB employed prescribers on GMC advice	Sep-20		39	10	Jul-21	27/03/2019
181909	Occupational Therapy S	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-21	Nov-19	Deadline Revised	2	Partially complete		A revised Records Management Framework is being developed.	Impact of COVID-19 on the IG team	IG advice and support is provided to the organisation when requested.	31-Dec-21		27	#NUM!	Jul-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		Following national review of clusters and a commitment to a new Accelerated Cluster Development (ACD), a new governance framework is being developed nationally. Powys cannot act outwith of that framework.	National work on ACD now developing this	All financial commitments are reviewed and authorised, as appropriate, by the DPCCMH	not able to specify as national work		24		Jul-21	30/05/2019

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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		16	7	Jul-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		15	#NUM!	Jul-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		15	#NUM!	Jul-21	14/11/2019

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192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R2	The Occupational Health service has recently upgraded its case file software 'Cohort' which should provide the service with on demand reporting. This should be used to monitor or identify trends with stress related referrals with appropriate action being taken where trends are identified and whether this can be used to identify missed opportunities where stress related absenteeism could have been reduced or avoided. The health board should improve management and monitoring of stress, including, where appropriate, earlier interventions / referral to Occupational Health services, triage, treatment / support and modifications to improve the likelihood that staff remain in work, or if not return to work sooner.	The recently upgraded software is due to be able to interface with ESR; this in turn will provide management reports relating to referrals and absence reasons. A stress steering group will be set up that seeks to monitor information, and data. The group will monitor data relating to types of stress (internal / external) Male / Female / Directorates etc – Data will also be triangulated with Datix incidents /accident – for example; Violence and Aggression incidents; this will inform where any specific interventions / follow up are required. We will promote adopting the therapeutic recommendation from the new Attendance at Work policy which includes inviting staff who are off on sick leave to team meetings. Provide rapid access telephone support for Managers and Staff through OC Mental Health Registered Nurse. We will develop a business case to increase resources; seeking funding for 2 Health Intervention Coordinators 1x physical health and 1 x emotional and mental health. Pending above: • Recruit x 2 Health Intervention coordinators; and • Design and plan the rollout of early intervention and support programme. Continue to promote the use of the mindfulness APP offered through Velindre	Apr-20	Aug-21		Deadline Revised	3	Partially complete		Bi-directional ESR/Cohort interface not yet progressed and no date confirmed by Medgate. Rapid access available for managers and staff through OH Mental Health Registered nurse and EAP Counselling services. Also access to SilverCloud CBT on line programme available. Business case to develop 2 Staff Wellbeing roles not progressed to date due to unavailable funding. 16/8/21: We are one-directional and expecting to be bi-directional by end of August. Medgate are in the process of finishing a final release following a data cleanse by all Health Boards and which will need to be applied. Once this is available (expecting no longer than a week), Medgate will get the upgrade schedule to us. We will expect to	Bi-directional interface expected to be available mid August 2021.	Clinical psychologist working alongside OH Registered Mental Health Nurse in developing on-line Mental Health awareness tools during Covid-19. Increased volume of referrals to EAP service accommodated by telephone appointment.	Unable to provide date for bi-directional interface at this stage, the work will resume in Q2.		15	#NUM!	Jul-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. Data received into PTHB and data quality check completed. reports currently being prepared to establish end to end report ing by the end of Q2 2021	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		17	#NUM!	Jul-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		16	#NUM!	Jul-21	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	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		18	#NUM!	Jul-21	

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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		17	#NUM!	Jul-21	
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R1	(a) That the health board progresses its discussions with Welsh Government to ensure all parties are aware of the practical inconsistencies between the historic Welsh Government Hosting Agreement and the reality of the relationship between CHC and the health board, with the aim of agreeing an accepted form of Accountabilities Statement amongst all parties. (b) That the health board raises any concerns over the legal status of staff engaged on HCRW activities with the Welsh Government.	(a) and (b) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to inform arrangements for other hosted arrangements, including HCRW.	Apr-20			Overdue	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however the work did not progress due to COVID19 outbreak. Any final agreement will be mirrored as a template for Healthcare Research Wales.	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		15	1458	Jul-21	
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability framework and governance systems for HRCW. (c) The health board ensures that the Welsh Government Hosting Agreements, and any signed replacement agreements, for the hosted functions are shared with all those health board staff managing and monitoring services provided to these hosted functions.	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to inform arrangements for other hosted arrangements, including HCRW.	Apr-20			Overdue	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however the work did not progress due to COVID19 outbreak. Any final agreement will be mirrored as a template for Healthcare Research Wales.	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		15	1458	Jul-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		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required.			Sep-21		7	#NUM!	Jul-21	

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192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent 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		Overdue	2	Partially complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart	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		15	0	Jul-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		16	3	Jul-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		Following national review of clusters and a commitment to a new Accelerated Cluster Development (ACD), a new governance framework is being developed nationally. Powys cannot act outwith of that framework.	National work on ACD now developing this	All financial commitments are reviewed and authorised, as appropriate, by the DPCCMH	not able to specify as national work		15	#NUM!	Jul-21	
192015	Primary Care Clusters	Reasonable	Director of Primary, Community and Mental Health	Director of Primary, Community and Mental Health	R5	We recommend that clusters conduct a review of patient information resources and that up to date cluster newsletters and other documents covering cluster service developments and achievements are provided on cluster and health board web pages.	This will be considered by the clusters and factored into their work programme for 2020/21. Prioritisation of this may vary across the 3 clusters and thus the deadline set allows that local flexibility.	Sep-20	Mar-22		Deadline Revised	3	Partially complete		Due to covid implications and deployment of former cluster manager to the mass vaccination programme this work has been delayed. A new cluster manager commences in post in September. this work will be considered as part of the national work on Accelerated Cluster Development (ACD).			Mar-22		10	#NUM!	Jul-21	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and monitored.	The Executive Directors will develop detailed objectives and actions that will enable the achievement of the key priority deliverables within the Organisational Development Framework. For each action there will be action owners or leads along with defined timescales which will ensure the ability to monitor and evaluate progress against each action.	Mar-20	Sep-20		Overdue	3	Partially complete		Objectives and actions aligned to the Framework have been put on hold due to Covid-19	Covid-19 work superseded this piece of work	This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		16	10	Jul-21	

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192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	Director of Planning and Performance	Assistant Director of Estates & Property	R6	A lessons learnt exercise should be undertaken in consultation with appropriate parties and reported to Board. (O)	Accepted. As PTHB develops a major project pipeline, it is important that the organisation employs a lessons learned regime. A review will be undertaken of the project at Machynlleth from inception to the point of the FBC resubmission.	Sep-20	Aug-21		Deadline Revised	3	Partially complete		Lessons learnt framework complete and due to be presented at Innovative Environment Group (IEG) August 2021	Delayed due to covid	Lessons learnt have been implemented in real time through continual improvement	Aug-21		10	#NUM!	Jul-21	
192020	Welsh Risk Pool Claims Management	Substantial	Director of Nursing & Midwifery	Assistant Director Quality & Safety	R1	Management should consider reviewing the reporting mechanisms on compensation claims to ensure that all claims are captured. For example, the format could be enhanced to distinguish between new claims, ongoing claims and closed claims from one period to the next.	The recommendation is accepted. Future claims reports will distinguish between new claims, ongoing claims and closed claims from one period to the next.	Oct-20			Overdue	3	Partially complete		The reports scheduled September 2020 onwards will be set out in the described way. This will then enable readers to distinguish between new claims, ongoing claims and closed claims from one period to the next.	None	Information relating to claims is categorised and recorded to support differentiation between new, ongoing and closed claims.	Oct-20		9	1458	Jul-21	
192022	Outpatients Planned Activity	Reasonable	Director of Primary, Community and Mental Health		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access Policy within the health board will be developed that details roles and responsibilities and sets out the general principles and rules for managing patients through their elective care pathway. WG are currently reviewing national waiting times standards (RTT) in light of Covid 19 and the impact of new ways of working e.g. digital appointment solutions like Attend Anywhere. The Patient Access Policy will be updated in line with the revised WG guidance once published.	Mar-21	28/03/2022		Deadline Revised	3	No progress		this work has been delayed due to covid but also now needs to be considered in line with national guidance on pathways and the Powys renewal priorities. This will take until end of the year.			Mar-22		4	#NUM!	Jul-21	26/09/2020
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							4	1458	Jul-21	26/09/2020

192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R3	The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This should include reference to anomalies that might be caused by potential variations in the types of clinical treatments, availability of certain specialist consultants (including, for example, the number of sessions delivered by speciality against the number of sessions required).	The CAF report sets out the RTT position for Powys patients in each of the different providers attended (due to geography) even though the waiting times are different. The waiting time differences are recorded in the public domain. Audit recommends showing that Powys patients are being treated the same as the other patients in those health boards and NHS Trusts by showing the overall performance of those organisations. However, this would not offer assurance as a small number of Powys patients attend some of the specialities provided in a provider. The Powys specific figure would not be the same as the overarching RTT performance figure for the provider. Our English providers report as organisations against the English targets. Recommendation partially accepted. We will review the mechanisms in place but not the specific suggested action regarding comparison with the providers' overarching RTT performance figures. Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Dec-21		Deadline Revised	3	Partially complete		As reported to EQS and P&R committees the CAF has been partially reinstated. Work is underway to ensure information about follow-up.	Periods of suspension of elective activity due to COVID. Block contracts continuing due to COVID. Modernisation of follow-up including See on Symptom and Patient Initiated Follow-up is leading to accelerated change in the delivery of follow-up.	Follow-up is discussed in CQPRMs.	Dec-21		4	#NUM!	Jul-21	26/09/2020
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R4	Continue to work with the commissioned health boards and trusts in Wales and England to enhance the reporting of commissioning services data to include Powys outpatient follow-up appointments waiting times and to discuss exceptions with them.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Dec-21		Deadline Revised	3	Partially complete		As reported to EQS and P&R committees the CAF has been partially reinstated. Work is underway to ensure information about follow-up.	Periods of suspension of elective activity due to COVID. Block contracts continuing due to COVID. Modernisation of follow-up including See on Symptom and Patient Initiated Follow-up is leading to accelerated change in the delivery of follow-up.	Follow-up is discussed in CQPRMs.	Dec-21		4	#NUM!	Jul-21	26/09/2020
192023	Estates Assurance Follow Up	Reasonable	Director of Planning and Performance	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		Jan-21	Aug-21		Deadline Revised	3	Partially complete		Management Plan updates complete and for formal review by Asbestos Group in August 2021	COVID-19 delays	Changes to Management Plan are well understood by management team with strengthening of structure in place with appointee to Deputy Asbestos Manager role	Aug-21		6	#NUM!	Jul-21	26/09/2020
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	Nov-21		Deadline Revised	2	Partially complete		a. Complete b. The toolkit is currently under development c. Complete					10	#NUM!	Jul-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	Dec-21		Deadline Revised	2	Partially complete		a. Complete b. Committee Risk Registers are currently under development, in line with the new committee structure.					7	#NUM!	Jul-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	Dec-21		Deadline Revised	2	Partially complete		High level work has been initiated to outline the framework and principles.			It is anticipated that the fully populated BAF will be in operation by December 2021.		4	#NUM!	Jul-21	26/09/2020
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: • the roll of out awareness sessions, keeping records of attendance; • increasing the frequency and content of internal communications; and • the Standards included as a standing agenda item at Directorate and service level meetings to ensure progress against action plans is monitored. Consideration should be given to developing a communications strategy to ensure staff are familiar with the Standards, understand its impact on their roles and the support and resources available to them to comply.	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to record staff training. Opportunities to deliver this training session virtually will be explored in order to reach as many staff as possible across the health board. In addition, the health board will look to increase opportunities to raise awareness of the Standards to all staff across the organisations via a range of communication methods. The health board will continue to liaise with the Assistant Director of Communications to develop and promote a new Communications Guide for staff across the health board which includes guidance on complying with the requirements of the Welsh Language Standards and will offer examples of best practice. A communication strategy will form part of the overarching Welsh language action plan as outlined in the response to recommendation 2 above.	Mar-21	Mar-22		Deadline Revised	3	Partially complete		Work is ongoing. Covid-19 has disrupted implementation, particularly around staff training and developing a communication strategy. Virtual WL Awareness Sessions continue to be offered to staff which has been added to ESR in order to record staff training. A detailed WL Standards guidance document has been developed and promoted to all staff. WL Standards are promoted regularly via emails, Powys Announcements and staff social media networks. New Corporate Communications Style Guidance for staff has been developed and promoted which includes guidance on complying with the requirements of the Welsh Language Standards and offers examples of best	Lack of resources to fully implement the WL Standards. Additional funding requirements for translation costs. Conflicting priorities and workload pressures due to COVID-19. SIM for WL is moving to another post in Oct 2021. Vacant post in the recruitment process but not guaranteed to be filled. Likely risk that the cross-over period will result in further delays to implementation in the short term.	Regular monitoring and reporting via the Executive Lead for WL. Additional resources requirement assessment undertaken in Jan 2021. Funding secured for 2 additional posts 1 x WTE Band 5 Translator (Permanent) 1 x WTE Band 6 Officer (Fixed Term). Recruitment to SIM for WL post underway to replace existing staff member. Increased budget for translation costs. Access to additional external translation companies.	Implementation will be ongoing		4	#NUM!	Jul-21	26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R1	The deed of variation to the Overarching Agreement requires completion and signing to demonstrate agreement by both the health board and county council of the amendments proposed during 2019/20. The Reablement agreement needs to be brought up to date and signed ASAP. This also applies to any other unsigned current year scheme agreements. The health board should to continue work with the county council to instigate the timeline defined in the Overarching Agreement to ensure future scheme agreements are agreed and signed off in advance of the start of that financial year.	There has been an inevitable impact on the signing of 2020/21 S33 Agreements by April 2020, in light of the COVID-19 Pandemic. 2020/21 Agreements will therefore be signed later in the year. PTHB will therefore work towards ensuring signed agreements for 2021/22 in April 2021. The Overarching Agreement Deed of Variation will be addressed in 2020/21.	Apr-21			Overdue	3	No progress							3	1458	Jul-21	26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R2	The health board should continue strengthening the arrangements in place to ensure it receives the assurance it needs over the governance of the Section 33 agreements in place. This could be achieved by: • working with the county council to establish the Joint Officers' Group to ensure effective oversight of the operation of Section 33 agreements, and • ensuring that relevant information is reported to the JPB in line with the requirements of the Section 33 Agreements.	The remit and constitution of JPB will be revisited and will be articulated through the Overarching Agreement Deed of Variation (linked to Finding 1). S33 Oversight by JPB and Board Committees will continue to be strengthened throughout 2020/21 as far as possible, recognising the impact of COVID-19.	Apr-21			Overdue	3	No progress								1458	Jul-21	26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R3	There is a need for a further final accuracy check of the Section 33 Agreements before they are signed.	A Quality Check process will be established in advance of the signing of agreements.	Apr-21			Overdue	3	No progress								1458	Jul-21	26/09/2020

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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	Sep-21		Deadline Revised	1	Partially complete		The Fire Safety Policy has been reviewed against, and is consistent with WHTM 05-01; the fire safety management structure has now been agreed and is incorporated into the updated policy.	Policy approval to be mapped through appropriate governance route.	Statutory Maintenance activity continues. Fire evacuations have been undertaken.	Sep-21		6	#NUM!	Jul-21	
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		This item was discussed during the January Fire Safety Group and is ongoing.	The fire safety policy is due for review in August and has already been reviewed against current WHTM's. The document cannot be completed until the responsible issue is resolved.				6	1458	Jul-21	
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							6	1458	Jul-21	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R5	Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed	The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	Jul-21			Overdue	1	Partially complete		Site Coordinators appointed and training for Fire Incident Coordinators and Fire Wardens underway; training will include use of local fire management folders	In progress	Fire evacuation drills have been continuing.			0	1458	Jul-21	
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		Overdue	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 improveme nt 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 Health & Safety Group on 16th August. The H&S Policy HSP001 – Will be going to the H&S Group meeting on the 16th August 2021 for approval, the current H&S policy is still in-date so "current". Other policies going before this meeting include the new Contractor Management Policy and the reviewed and revised First Aid at Work policy for approval and submission to Executive Committee at the end of August 2021.	1 outstanding policy	Policies were extant whilst being reviewed.	Anticipate sign off of the Corporate Health & Safety Group in June 2021.	Health & Safet	4	1	Jul-21	
202106	Capital Systems	Substantial	Director of Planning and Performance	Assistant Director of Estates & Property	R2	The change control process defined within the Capital Procedures should be reviewed and clarified to ensure it reflects actual process and is not left open to interpretation		Jun-21	Sep-21		Deadline Revised		Partially complete		Minor amendment to Capital procedures to clarify the purpose of the change control process. Amendments to be presented at Capital Control Group in September 2021	Delays due to COVID	Updated proceedures only to clarify existing process	Sep-21		1	#NUM!	Jul-21	

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202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Assistant Director Mental Health	R2	Responsibilities for delivery and arrangements for monitoring and reporting on implementation of specific actions within the Together for Mental Health delivery plan should be formally documented and mapped to the delivery plan. This will enable the Mental Health Planning & Delivery Partnership Board to maintain oversight of and gain assurance in respect of the delivery of the plan as a whole.	The (reviewed) National Together for Mental Health Delivery Plan (2019-2022) released in October 2020 is undergoing significant focus and preparation to reflect a Powys regional perspective. This re-vision needs to also align with related new regional plans, such as Housing. Welsh Government have not clarified monitoring and reporting for priorities within the T4MH Delivery Plan, as yet. We are progressing on drafting a detailed iteration of the Powys plan, clearly identifying priorities/milestones, responsible partner, strategic/responsible leads (by name) for the March 2021 Partnership Board meeting. Governance, monitoring and reporting arrangements will be communicated/aligned as soon as information is released from Welsh Government.	Jun-21	Sep-21		Overdue		Partially complete		To be considered by Live Well MH Partnership for potential approval in Sept 21			Sep-21		1	#NUM!	Jul-21	
202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Assistant Director Mental Health	R4	Membership of the MH Planning & Development Partnership Board should be reviewed to ensure appropriate representation from each partner organisation and the terms of reference updated accordingly.	It has always been the intention, upon receipt of the reviewed T4MH Delivery Plan, to adjust membership if this was needed to align with new priority areas and gaps. The majority of partner agencies and members remain unchanged. New areas may warrant further discussion/agreement, such as Education, Housing and Employment. The intention is to agree any final adjustments to the TOR's and Membership once the draft Delivery Plan is presented to the MH Partnership Board in March 2021.	Jun-21	Sep-21		Overdue		Partially complete		Live Well MH Partnership considered ToR at meetings in March and June. Members are to confirm representation by Spetember meeting for formal sign off.			Sep-21		1	#NUM!	Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R1	The organisation should maintain oversight of the extent to which IM&T satisfies obligations (regulatory, legislation, common law, contractual), internal policies, standards and professional guidelines. A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for reporting status upwards via the appropriate committee.	The Informatics team structure has recently been strengthened and this will support the development of a formal register. The Informatics team will work and liaise with the Information Governance team and other departments as needed to identify the best way to implement and maintain.	Jul-21			Overdue		No progress							0		Jul-21	
202113	Safeguarding during COVID-19	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	R1	The health board should ensure that compliance rates for safeguarding statutory and mandatory training is at an acceptable level for all relevant modules across all directorates so that the target rates can be achieved and maintained.	There is a safeguarding training plan in place with a rolling programme of training packages available to professionals. PTHB will continue to produce Safeguarding Newsletters to support professionals with their independent learning. PTHB will continue to be represented at the Regional Safeguarding Training Group and share multi agency training opportunities with PTHB professionals. Safeguarding training compliance reports will continue to be presented and monitored at the Operational and Strategic Safeguarding Group.	Jun-21			Overdue		Partially complete		28.07.2021 Rolling programme of MS Teams training and online packages in place, safeguarding training compliance reported each quarter to the safeguarding strategic and operational group. Managers Training compliance from WOD recommenced as a reminder to managers. Email sent to HoS asking for assurance Safeguarding Training Improvement Plan in place within the service.					1		Jul-21	

202115	Winter pressures and flow management	Reasonable	Director of Primary, Community and Mental Health	Senior Manager Unscheduled Care	R1	1.1 The PFCU business cycle document should: i. cover all meetings and reporting requirements, including internal team and external stakeholder meetings; and ii. clarify whether formal minutes and/or action logs are required for each type of meeting. Given the nature of the process, we recognise the level of formality will vary depending upon the type of meeting. At a minimum, we recommend key meetings with external stakeholders should have decision / action logs. 1.2 The PFCU SOP should include the business cycle and be formally approved within the directorate. 1.3 PFCU and CTC meetings and support mechanisms should remain active throughout future waves of the pandemic. 1.4 PFCU management may wish to engage team members to identify other potential methods that would help them to feel supported whilst working as a small team across a wide geographic area.	1.1 Business cycle process will sign off end of July with a determination on each to reflect actions & formal minutes 1.2 Draft SOP completed, will consult & sign off by end of June 1.3 Completed, more frequent team meetings booked on a fixed basis with drop-in sessions for more complex case discussions – remote & face to face meetings in place. CTC's have had a consultation and felt this would improve support 1.4 Completed, more frequent team meetings booked on a fixed basis with drop-in sessions for more complex case discussions – remote & face to face meetings in place	Jul-21	Aug-21		Deadline Revised		Partially complete		1.1 Completed 1.2 SOP completed and sent to CSM for approval 1.3 Completed and ongoing 1.4 Completed and ongoing			31/08/2021	Yes	0		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R3	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.	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.	Jul-21	Aug-21		Deadline Revised		Partially complete		Lessons learnt framework complete and due to be presented at Innovative Environment Group (IEG) August 2021	Delayed due to covid	Lessons learnt have been implemented in real time through continual improvement	Aug-21		0		Jul-21	

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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?					
192001	Deprivation of Liberty Safeguards	Limited	Director of Nursing & Midwifery		R3	The health board should put in place a formal agreement (for example, a Service Level Agreement) with the LA for the services provided by the Powys DoLS Team. This should include: I. clear details of the service provided, including who is responsible/liable for each aspect of the process; II. a performance monitoring process, including input, performance and output key performance indicators; III. information governance considerations, such as data security, integrity, maintenance, transfer and ownership (i.e., who is the data controller); IV. the provision of DoLS management information, including required information and format; V. access to training opportunities; and VI. monitoring and audit of compliance with the Code.	Agreed.	Oct-19			Complete	3	Complete		A Memorandum of Understanding has been developed in partnership with PCC and is for final ratification with the Information Governance Team. There is a local infrastructure overseeing the plans for implementation of the LPS which reports to Executive Committee.			1 month		21	1458	Jul-21	10/07/2019
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		Complete	2	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		17	7	Jul-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		Complete	2	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		17	7	Jul-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	R1	The health board must approve, promote and publish the new Policy and Toolkit. Line Managers should be provided with adequate training in line with the requirements of the 'Stress Management and Wellbeing in the Workplace Policy' on how to identify, manage and where possible, reduce stress within the workplace and be made aware of the requirement to complete the 'Stress Management Risk Assessment questionnaire'.	The Stress Management Policy and Toolkit was approved on October 23rd 2019. It was agreed that the policy and toolkit will be reviewed in 9 months (July 2020) to ensure approaches are current and fit for purpose. Approved Policy to be published on Intranet. Promotion of approved policy and toolkit through: • Powys Announcements; and • Health and Well-being roadshows x 7 November to end of January. To include information on the stress risk assessment toolkit as part of the managing attendance at work training. As part of the new mandatory Management Development Programme being rolled out for managers (224 in total) the following 1 day training will be delivered as part of the Managing a Healthy and Safe Environment module: Stress and resilience management for managers.	Jul-20	Dec-21		Complete	3	Complete		We will be monitoring stress levels and discussing it in caseload meetings. The stress management toolkit is part of the absence training. A pulse survey was sent out in May which has provided information on stress levels during the COVID-19 pandemic. Wellbeing survey was delivered but was specific to COVID-19 situation rather than general stress. Found that Anxiety (getting COVID and being redeployed), Isolation (for home workers) and technolofy issues were common negative factors. However, people reflected that they were coping by getting outside, doing exercise and staying connected with others. This forms part of the mangement development programme, which has recommenced.		Work on COVID-19 has prevented progress. Mass Vaccination roll out has had an impact on the capacity of the OH service. Staff wellbeing initiatives continue to be developed and implemented to support staff. It is too early to evaluate the impact of the initiatives.	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. 15/04/2021 - End of Q3		12	#NUM!	Jul-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		Complete	2	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.		14	#NUM!	Jul-21	14/11/2019

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192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R2	In order to ensure the effective governance of the service, the health board should continue to hold the monthly Facilities Management Team meetings. The health board should also consider producing a standard agenda and method of recording for the local team meetings to ensure that updates provided to the Facilities Management Team are in a consistent format. The standard agenda items should be in line with the functions of the Facilities Management Team. We concur with the action proposed by management to review the structure of Facilities and Support Services, including the roles of the co-ordinators and supervisors to ensure there is sufficient capacity to undertake the requirements of the roles.	Agree The Department welcomes and accepts the recommendation. We will implement the recommendation to set agendas and record local team meetings in a format that reflects the Facilities Management Team (FMT) meeting. In the management review of Facilities and Support Services we will maintain the current span of control to sustain the current performance of more than 90% compliance with Personal Development Reviews.	Feb-20	Sep-20		Complete	3	Complete		Regular management teams have been suspended during Covid 19 escalation, as reported to the Board Secretary in March 2020. Hotel Services team meeting north and south established. Fixed items to reflect SSMT and to include SSMT feedback. FMT meetings resumed in July 2020. The Support Services Management Team meet monthly. There are local team briefing documents which provide a summary of themes and issues which arise, these are consistent across all sites and are co-ordinated by Support Services centrally.	Covid 19 escalation.	During Covid 19 Escalation there have been thrice weekly briefings between the Assistant Director and his direct reports. FMT meetings will resume from July 2020 onwards.	Jul-20	Yes	17	10	Jul-21	
192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R5	We concur with management intentions, that regular spot checks of PADRs should take place to ensure; • all PADRs are completed to the required standard; • all staff are using the correct form to ensure consistency across the team; and • 90 day reviews are scheduled and are used as an opportunity to discuss compliance with statutory and mandatory training.	Agree. The department welcome's the auditor's confirmation that PADR compliance has been sustained at above the health board's target of 80%. The department is happy to confirm our commitment to sustaining and improving on this level of performance. We accept the recommendation to sample PADRs to ensure the quality of reviews as well as the frequency; and to ensure compliance with 90 day reviews.	Mar-20	Sep-20		Complete	3	Complete		PADRs have resumed and the percentage of compliance is good. This will continue to improve as completed PADRs are uploaded onto ESR.	Covid 19 escalation.	Action has resumed following Covid 19 escalation.	Sep-20	Yes	16	10	Jul-21	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R2	We recommend that the health board either seek to incorporate all of the OD Strategic Framework priority themes in the health board's existing performance monitoring framework or consider implementing a dedicated framework to manage the delivery of the OD Strategic Framework priority themes and related actions. Typical features of such a framework would be as follows: • task level actions; • action target dates and individual delivering the action; • action RAG status; and • regular reporting to management oversight group / committee / board.	Agreed Executive Directors will report progress against actions through the following performance monitoring governance mechanisms: • IPR reporting where appropriate • Directorate performance reviews • Performance and Resources Committee	May-20	Dec-20		Complete	3	Complete		Performance reporting aligned to the OD Framework put on hold due to Covid-19. Refreshed and reviewed, agreed at Board Meeting, this action is now superceded by the new arrangements.	Covid-19 work superseded this piece of work	This will be reviewed as part of the re-introduction of BAU	end of Qtr 3		14	7	Jul-21	
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			Complete	2	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.					7	1458	Jul-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			Complete	2	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.					7	1458	Jul-21	26/09/2020
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R6	Sample checks should be made during Fire Safety Adviser site visits to ensure folders are being completed as required	A checklist will be added to the folders for officers [either Fire Safety Advisers / Estates Officers / Responsible Persons] to provide a signature to confirm appropriate completion.	Jul-21			Complete	1	Complete		Site Coordinators and Fire Safety Advisors will check the folders and sign to signify the check has been undertaken.	Programme and logistics for training roll out pan-Powys	Fire SAFETY manager routine visits			0	1458	Jul-21	

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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			Complete	1	Complete							3	1458	Jul-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		Complete	2	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.		2	#NUM!	Jul-21	
202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Assistant Director Mental Health	R3	Terms of reference for the amalgamated MH Officers Group / Performance Subgroup should be documented and reflect the groups responsibility for monitoring performance against the Together for Mental Health delivery plans. The Hearts & Minds: Together for Mental Health delivery plan should be monitored by the MH Officers Group / Performance Subgroup, with clear status updates on the implementation of actions within. Assurance on delivery of the plan should be reported via the MHPDP to the RPB in line with the RPB work plan.	The Mental Health Officers Group (MHOG)/Performance Subgroup is being re-engaged and the best, most efficient way of monitoring performance, as a multi-agency operational group, is being discussed with partner agencies along with timescales. The landscape has significantly changed due to Covid-19 and new multi-agency Delivery Plan(s). We are looking at possibilities of utilising technology to reduce the need for so many (monitoring/performance) meetings so as to "automate" reporting and monitor progress of linked priority areas. Our aim is to holistically satisfy a number of different inter-related Delivery Plans and oversight groups, including the Strategic Leads (Partnerships) joined up reporting within the RPB governance structure.	Jun-21			Complete		Complete		MHOG has been reinstated with first meeting held. Performacne Tracker drafted. Report on progress received by LiveWell MH Partnership 22/06/21					1	1458	Jul-21	
202112	Grievance Process	Reasonable	Director of Workforce & OD and Support Services	a) Board Secretary b) Director of WOD	R1	a) The Terms of Reference for the Remuneration and Terms of Service committee should be updated to reflect new reporting requirements for employee relations matters. b) Information reported to the Committee should include compliance with the timescales set out within the policy and the monitoring requirements i.e. trends, lessons learned. We note that the All Wales Respect and Resolution policy will be replacing the current grievance policy, and these arrangements should be reflected when considering the implementation of the suggested recommendations.	a) The Board's Committee Structure and supporting Terms of Reference are scheduled for review in Quarter 1, 2021/22. The Remuneration and Terms of Service Committee will retain responsibility for receiving updates on employee relations matters and the Terms of Reference will be updated accordingly. b) The relevant information will be included to the committee as identified.	Jun-21			Complete		Complete							1		Jul-21	

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202113	Safeguarding during COVID-19	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	R2	The health board remind staff of the importance of the requirement to complete and send the multi-agency referral form to the Local Authority within 24 hours of a verbal report to the Local Authority and complete a Datix incident form accurately. In addition, we recommend that the Safeguarding Team puts a formal mechanism in place monitor the timeliness of MARF submissions and address any underlying issues identified.	PTHB Safeguarding team will undertake an audit of Multi Agency Referral Forms following a verbal report to the Local Authority. The introduction of the Once for Wales Safeguarding Module will be set with mandatory fields when completing a Safeguarding Report.	Jul-21			Complete		Complete		28.07.2021 - audit undertaken and no issues identified in relation to timeliness of reports being submitted. MARF Tracker now in place that is completed by Lead Nurses for Safeguarding which enable the lead to follow the report progress, the Tracker is reviewed monthly by Senior Nurse for Safeguarding.				Yes	0		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R1	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.	The terms of reference will be updated at key junctures and meetings will consistently record when the meeting is not quorate for future projects.	Phase 2 / future projects			Complete		Complete		Terms of reference updated to reflect current project activity and signed off at Project Board	N/A	N/A	Complete		#VALUE!		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R2	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.	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.	During Phase 2 / at future projects			Complete		Complete		Implemented as per current procedures	N/A	N/A	Complete		#VALUE!		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R4	Cost reports should reference any discrepancies between costed risk values and available contingency funds.	Cost consultancy reports will reference any discrepancies between risk value and contingency.	At future projects			Complete		Complete		Audit finding shared with consultants to ensure that this is captured on future schemes.	N/A	N/A	Complete		#VALUE!		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R5	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).	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.	At future projects			Complete		Complete		Delayed damages suitably assessed with professional advice and shared at appropriate management level for approval for implementation (undertaken at Machynlleth)	N/A	N/A	Complete		#VALUE!		Jul-21	
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R6	Cost reports should include sufficient information to facilitate THB scrutiny and cost management.	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.	At future projects			Complete		Complete		Implemented for current project activity	N/A	N/A	Complete		#VALUE!		Jul-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	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?					
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Health & Safety Team	R3	The health board should resume the roll out of health and safety training sessions once practicable, in particular the programme of accredited IOSH Working Safely courses to ensure managers have a full understanding of their roles and responsibilities and those of their employees.	IOSH working safely one day programme will run in conjunction with managers development programme. Programmes scheduled quarterly. Delivery will be through the Health & Safety Team. First course due to commence in October 2021 (pending Covid situation).	Oct-21			Not yet due	3	No progress							#NUM!	1458	Jul-21	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R4	• The health board should review the terms of reference of the Health and Safety Group, including confirming who should be in attendance. • Attendance of members at the group should be monitored and where a member of the Group is unable to attend, an alternative representative should attend in their place. If a member continually fails to attend then an alternative representative should be identified. • The health board should continue to review the effectiveness of the revised reporting structures to manage health and safety arrangements, including the coordination of oversight and assurance reporting across each of the subject matter areas.	• Terms of Reference for the Health & Safety Group to be drafted and approved, via the Executive Team and Health & Safety Group. • Attendance of members of Health & Safety Group to be tracked and monitored. • The reporting structures that manage health and safety arrangements will be reviewed.	Sep-21			Not yet due	2	No progress							#NUM!	1458	Jul-21	
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R1	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes. A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21			Not yet due		No progress							#NUM!	1458	Jul-21	
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R5	Arrangements for reporting assurance to the Health Board on the effectiveness of the Live Well: Mental Health partnership need to be determined.	Reporting arrangements will be reviewed and clarified through the Partnership Governance Framework development and ongoing implementation. This reporting mechanism will also need to reflect existing reporting arrangements to Welsh Government and the RPB in order to reduce duplication.	Sep-21			Not yet due		No progress							#NUM!	1458	Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R2	Consideration should be given to providing reports identifying risks that are not scored to escalation level due to low likelihood, however contain a severe worst case scenario. In doing so, this shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.	The Directorate maintains a local risk register (that captures lower level risks as referenced) and this is held within the department and reported up via the risk process for the Health Board. The current register will be reviewed and consideration given to how worst case scenario identification and potential impact can be included as needed.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R3	The organisation should consider assigning the responsibility of CCIO.	There is a Clinical Informatics Lead Nurse who is part of the Informatics team. The potential for a CCIO role will be reviewed and an options paper prepared for the Executive Committee to consider how best to establish within current establishments.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	

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202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R4	The health board should review its published ICT policies for completeness and where necessary develop or adapt and publish additional polices to provide a full suite.	This is an ongoing process. The recently established team will help to provide the ongoing focus in ensuring that relevant policies and procedures are in place, these will need to align between national (NWIS) and local as needed. A review of the existing policies to identify gaps will continue to ensure a full suite is appropriate and available.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R5	The necessary work to define and approve the strategic direction for the use of ICT within the organisation should be completed as a priority. In doing so the health board should explore opportunity for synergy and overlap of strategy with colleagues in Powys county council. This work should include an evaluation of the current position of the health board in relation to both the external environment and current ways of working in order to provide a baseline position from which to work. Once completed, to ensure the strategy is embedded within the organisation and stakeholder network (champions / leads) it should have a plan for communication which identifies target audiences, communication mechanism and schedules.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R6	The development of the strategy should consider the wider ICT strategy implications and the supporting technical infrastructure.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R7	As part of the Strategy development, work should be carried out to ensure it is fully costed and appropriate resource made available to deliver the organisations strategic ambitions with a fair and equitable system of allocating costs to the enterprise. Consideration should also be given to allocating future budget on need to ensure that the trajectory for strategy delivery is maintained.	Action already been completed in this area to ensure that the Informatics structure and establishment are as needed to meet objectives and there has been ongoing work with PCC re appropriate resource and support to be included in the S33. There is a need to manage various national development funding appropriately to support the Informatics structure (and resource). Agreed that the appropriate business cases will need to be completed to secure appropriate resource / investment to meet strategic priorities as identified.	Apr-22			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R8	A full assessment of the current skills within ICT, alongside the required resource and skills for the ICT Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics. Action already been completed in this area to ensure that the Informatics structure and establishment are as needed to meet objectives and there has been ongoing work with PCC re appropriate resource and support to be included in the S33. There is a need to manage various national development funding appropriately to support the Informatics structure (and resource). Agreed that the appropriate business cases will need to be completed to secure appropriate resource / investment to meet strategic priorities as identified.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R9	As part of the strategy development and approval the organisation should ensure the resourcing requirements are fully defined and a gap analysis is included so as to ensure the requirements are fully known and provisioned.	Action already been completed in this area to ensure that the Informatics structure and establishment are as needed to meet objectives and there has been ongoing work with PCC re appropriate resource and support to be included in the S33. There is a need to manage various national development funding appropriately to support the Informatics structure (and resource). Agreed that the appropriate business cases will need to be completed to secure appropriate resource / investment to meet strategic priorities as identified.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	

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202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R10	A suite of cyber security KPIs should be developed in order to show the status of cyber security and the progress of the team in managing issues.	Appropriate KPI's are included as part of the work to review the current S33 and is ongoing to ensure that appropriate.	Dec-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R11	The health board should encourage appropriate groups of staff to complete the all wales NHS cyber training.	This is available on ESR and all staff encouraged to complete, we will continue to explore if this can be made mandatory.	Dec-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R12	Critical assets should be identified and be subject to enhanced monitoring an assessment for risk / replacement.	Action to completed with PCC partners as part of S33 arrangements.	Dec-21			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R13	In order to ensure best value approach, differing continuity options should be defined and the differing options to deliver this assessed/ costed.	The current procedures and process will be reviewed with PCC partners to ensure up to date and different options identified if available.	Apr-22			Not yet due		No progress							#NUM!		Jul-21	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R14	The health board must ensure resource is available to deliver and report upon the ICT programme.	The 20/21 Digital Plan as presented and approved by Executive Committee included the additional resource required to support implementation (note the newly established Digital Business Manager). There are numerous national funding streams that are available to help support developments in a number of areas and any developments will include the relevant PM role as needed. Action also ongoing to improve reporting against the plan to be reported via Board committee structure and is a recognised areas for improvement.	Oct-21			Not yet due		No progress							#NUM!		Jul-21	
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R1	We concur with management and recommend that early clinical involvement in the second phase of the SPP programme is given a high priority to ensure that all clinical constraints and opportunities are taken into consideration in the development of the strategic changes to Maternity services.	As confirmed by Internal Audit the South Powys Programme Board had already identified this issue through its "Lessons Learned" process for Phase 1. As stated there was clinical membership of the Programme Board and workstreams – although the context was particularly challenging due to COVID 19. Thus, this recommendation is accepted. Clinical membership has been built into the Programme Board and Programme Workstream for Phase 2. However, frontline engagement via midwives is also built into the implementation plan. In addition, the readiness assessment will also cover frontline engagement.	Nov-21			Not yet due		No progress							#NUM!		Jul-21	
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2	We concur with management and recommend the development of a documented framework that the health board can use in future collaborative change programmes to assist in the management of the programme and to ensure the use of a consistent and controlled approach.	This recommendation is accepted and a collaborative change programme framework will be developed and considered through the PTHB Executive Group for Strategic Planning and Commissioning.	Sep-21			Not yet due		No progress							#NUM!		Jul-21	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R1	a) Guidance on the process that services need to undertake should be drafted to ensure that staff are clear on the considerations and key contacts when planning and implementing changes. Consideration should be given to include the following: - Key contacts when planning the change i.e. IG, Finance, ICT, Information and Cyber; - Governance arrangements and approval routes; - Documentation that needs to be maintained; - Staff and patient involvement / consultation; - Staff training requirements; - Funding, monitoring and ongoing costs; - Ongoing IT support and maintenance arrangements; - Documentation of outcomes and benefits, linking into patient experience; and - Lessons learned. b) The ICT governance process and above guidance should be published on the health board's intranet site to ensure service areas can find this information easily.	The recommendation will be actioned as part of the process of establishing the newly formed Digital Governance Board. Appropriate communication will be made to ensure that staff are clear on the process and route to access (clarity re process, governance and decision making). This will then be available on the Health Board Intranet site.	Sep-21			Not yet due		No progress							#NUM!		Jul-21	

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202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R2	a) The Digital Transformation Sub-Committee should be established and include oversight and monitoring of digital solutions implemented throughout the health board. b) Work to establish links and processes with the Innovation and Improvement Hub should be progressed to ensure opportunities for learning lessons from existing solutions and suitability of these are maximised across the health board.	a) Noted and agreed – Action already in place to establish the Digital Transformation Sub-Committee known as the 'Digital Governance Board' which reports into the Digital Transformation Board This group monitors and has oversight of all digital solutions to be implemented in the Health Board. b) Noted and agreed – Action already underway to ensure clear and easily understood alignment between the Innovation and Improvement hub and the Digital Transformation Board, this is in progress to ensure actions align and any learning is maximised across the Health Board.	Dec-21			Not yet due		No progress							#NUM!		Jul-21	
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Deputy Director of Finance	R3	The implementation of the Investments Benefits Group should include consistent reporting and review of benefits from changes implemented within the health board, to ensure that planned outcomes are realised. This should include a link to patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS).	One of the key actions of the IBG is the monitoring and reporting of benefits so this action is already in place. Additional action will be for IBG to require appropriate action re PROM and PREMS for all cases received.	Aug-21			Not yet due		No progress							#NUM!		Jul-21	
202115	Winter pressures and flow management	Reasonable	Director of Primary, Community and Mental Health	Senior Manager Unscheduled Care	R2	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update process.	2.1 Agree – cannot action until further consultation. Recent engagement with DU has suggested DTOC will return by end of year. If this is the case policies and procedures will need recommencing & revision if required. 2.2 Flow charts & diagrams of discharge requirements circulated to staff, placed in shared access folders and discussed in team meeting. Will be a standard agenda for assurance of understanding & interpretation by staff. 2.3 The update of any policies will be in line with Welsh Government direction on DTOC and discharge planning, so we are working within national guidelines.	Mar-22			Not yet due		No progress		Still awaiting direction from WG, which is expected November 2021			Mar-22		#NUM!		Jul-21	
202115	Winter pressures and flow management	Reasonable	Director of Primary, Community and Mental Health	Senior Manager Unscheduled Care	R3	3.1 As part of formalising the PFCU business cycles (see MA1), the health board should consider the key performance metrics for patient flow performance (including delayed transfers of care) to be used for reporting at each level within the health board and how frequently these should be reported. 3.2 The health board could refer to the 2017 Audit Wales report (Discharge Planning, Powys Teaching Health Board) in identifying metrics, recognising some of the metrics in that report are only relevant for acute care.	3.1 KPI's and pathways are in situ but "paused" whilst DTOC reporting was stepped down. When recommenced a review of pathways will be held to ensure they are in line with any revised guidelines. KPI's for delays & repatriation times will be developed once the technology supports this – incoming with electronic flow system. 3.2 The HB will focus on national guidelines for step down & step up beds as a mechanism to support the identification and development of metrics - currently working with Hywel Dda University Health Board & the NHS Wales Delivery Unit to establish a cross agency recording system which will lead to a shared data set. Metrics for discharge pathways is already established.	May-22			Not yet due		No progress		Still awaiting direction from WG, which is expected November 2021			May-22		#NUM!		Jul-21	
202115	Winter pressures and flow management	Reasonable	Director of Primary, Community and Mental Health	Senior Manager Unscheduled Care	R5	Given the impact of the Covid-19 pandemic and the ongoing development of patient flow initiatives, the health board should consider undertaking a formal demand and capacity review for staff resource for patient flow.	Seven-day working was stood up during the pandemic where a demand & capacity review was completed for weekend working. As a result, the HB established no demand for seven day working but has a plan to flip if required to seven days. Outside of this flow is managed & workload of CTC's is manageable There is sufficient evidence to support this (i.e. staff within working hours, flow adequate & ability to flex within teams). The HB will consider a demand & capacity review in its longer-term plan.	Jul-22			Not yet due		No progress							#NUM!		Jul-21	

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PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committe	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation: Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon	No. of months past agreed deadline
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		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	Dec-21		Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme 2021-22	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	31-Dec-21		21
181951	Structured Assessment 2018	Board Secretary	R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21		Overdue	3	Partially complete		Report templates and masterclasses for senior managers will be delivered in Q2.	COVID-19 arrangements have taken priority over this work.		31-Mar-21		25
192051	Structured Assessment 2019	Director of Workforce & OD and Support Services	R3	The All Wales Attendance at Work Policy was recently implemented with the delivery plan developed in partnership with Trade Unions. The Health Board should evaluate and report on how the change in approach is working in practice for staff and managers.	A review will be undertaken in partnership with Trade Unions to assess the impact of the All Wales Policy in its implementation.	Sep-20			Overdue	3	Partially complete		Union representative has been identified to work on PULSE survey.	COVID-19 work took priority.	WOD and Trade Unions held regular meetings during COVID-19 to discuss workforce issues.	The work will re-assume in Q2.		10
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.		
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							
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. 05/08/21 the oracle upgarde has been delayed on a national basis until October 2021 but on line 'video's will be avaialbe to support staff on this process before the upgrade is undertaken.			Linked to Oracle Upgrade and the training programme due to be launched along side this.	Yes	

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No. of months past revised deadline	Reporting Date	Date Added to Tracker
4	Jul-21	
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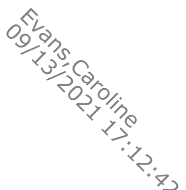
PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committe	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, 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?		
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 Operating Arrangements for the Board's Committees.	Apr-20	Mar-21		Complete	2	Complete						Yes	15
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			Complete		Complete		Proposal received to be approved and implemented from April 2021.			Apr-21		
202152	Structured Assessment 2020	Board Secretary	17	The Health Board's legacy website had a form to enable members of the public to raise questions of the Board in advance of board meetings. This form is no longer available on the new website. Given little use was made of the facility, the Health Board is considering how to improve its engagement with the public in its Board meetings in future.	To be considered in-line with the roll out of live streaming of board and committee meetings.				Complete	2	Complete							
202152	Structured Assessment 2020	Director of Workforce & OD and Support Services	30	The Medical Director retired after the first phase of the pandemic with appropriate interim arrangements secured until a permanent successor can be recruited.	• Recruitment process underway.				Complete	3	Complete							
202152	Structured Assessment 2020	Board Secretary	31	The Board is under pressure because it holds two Independent Member vacancies, while the Chair and five experienced Independent Members are due to step down during the next two years. The Public Appointments process was suspended during the pandemic but is scheduled to resume in October. To support the Board during this period of transition, one Independent Member's tenure was extended for a year. All committee meetings have been quorate, although with fewer Independent Members the risk of non-quoracy increases. It will be important to plan and prepare for the induction of new members and their impact on the culture of the Board.	• 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)				Complete	2	Complete							
202152	Structured Assessment 2020	Board Secretary	46	In 2019, we reported that the Performance and Resources Committee was unable to provide detailed scrutiny of the most up-to-date financial position prior to board meetings and recommended the schedule of meetings was reviewed to ensure the timing of meetings supports effective detailed scrutiny. While the Health Board's aspiration is for the Committee to receive the finance reports prior to board meetings, meeting cycles do not yet support this aspiration.	• Linked to 2019 Structured Assessment Actions and Update. Business Cycle to be reviewed, recognising the impact of COVID-19 during 2020.				Complete	2	Complete							



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			Complete		Complete		12/04/21Due 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 and 2021/22 contract, with the supplier moving ot a framework in summer 2021. 05/08/21 All Welsh LTA contracts were signed by the deadline set by WG for 2021/22 no contracts with English provers are required as per NHS england gudielines. For 2022/23 the HB will comply with the requires set out by NHSE and WG. Details on hte contracts signed are clearly detailed in the monthly WG Narrative report which				Yes	

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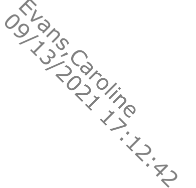

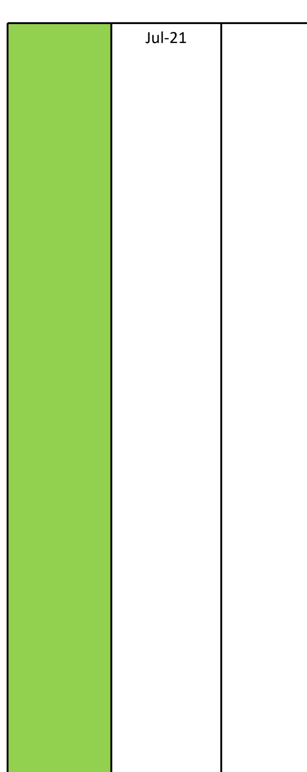

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PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committe e	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline
													Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
202152	Structured Assessment 2020	Director of Nursing & Midwifery	41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and	• Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22			Not yet due		Partially complete		Paper to Clinical QG Group and EQS next week, shows progress in some areas, and other areas affected by COVID-	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021.	Implementation overseen by QGG and EQS.			
202152	Structured Assessment 2020	Director of Nursing & Midwifery	43	The Health Board has a process for responding to national Patient Safety Alerts and Notices. A review of the system for implementation is underway and will be revised as necessary.	• Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22			Not yet due		Partially complete							
202152	Structured Assessment 2020	Director of Therapies & Health Sciences	44	The Health Board is undertaking a programme of work to refresh its patient experience framework as part of the improving clinical quality assurance framework.	• Linked to 2019 Structured Assessment actions. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22			Not yet due	3	Partially complete		The patient experience group continued to meet during the pandemic and patent experience has been	There are no dedicated staff to work on patient experience, it relies on the capacity of operational teams and	on track	Mar-22		

No. of months past revised deadline	Reporting Date	Date Added to Tracker
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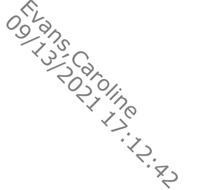

PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				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?					
212281	Overpayments	Director of Finance, Information and IT		R1	The most common reason for overpayments was down to when a manager or supervisor submits a form when a change or termination takes place. There was a very vast time difference across the cases, ranging from a couple of weeks in advance, to 9 weeks after termination. When an online ESR form is completed it is tasked to an "approver" in the chain of command. If that approver doesn't action it within one week, it automatically escalates to the next in the chain of command and so on. This takes place all the way up to the Chief executive	Mar-22			Not yet due		No progress							#NUM!	1458	Jul-21	
212281	Overpayments	Director of Finance, Information and IT		R2	The debtors procedure policy states that after 3 months the matter should be referred to a debt collection agency to assist with recovery, however in a number of the cases reviewed, it took longer than 3 months for action to be instigated when the debtor had notified PTHB of an error. For existing employees consideration should be given to revision of the policy to recover overpaid amounts automatically over the same time frame as overpayment initially occurred this is in line with the approach taken in other NHS Wales Health Boards and ensures the swift	Mar-22			Not yet due		No progress							#NUM!	1458	Jul-21	
212281	Overpayments	Director of Finance, Information and IT		R3	The Counter Fraud Team should be referred cases where there is potential for fraud or theft to have occurred. Previously issued guidance by the CFS Wales Team outlines that case of overpayment of salary where that overpayment has occurred for 3 months or more should be referred to their financial investigators for consideration without contact to the individual. This should be used a referral point to the Counter Fraud Team to allow that onward referral and protect the integrity of potential cases.	Mar-22			Not yet due		No progress							#NUM!	1458	Jul-21	

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Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee September 2021

NWSSP Audit and Assurance Services

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4.Proposed Changes to the 2021/22 Internal Audit Plan *4*
5.Engagement *5*
6.Recommendation *5*

Appendix A Assignment Status Schedule
Appendix B Key Performance Indicators
Appendix C Assurance Ratings

1. Introduction

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

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

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

2. Outcomes from Completed Audit Reviews

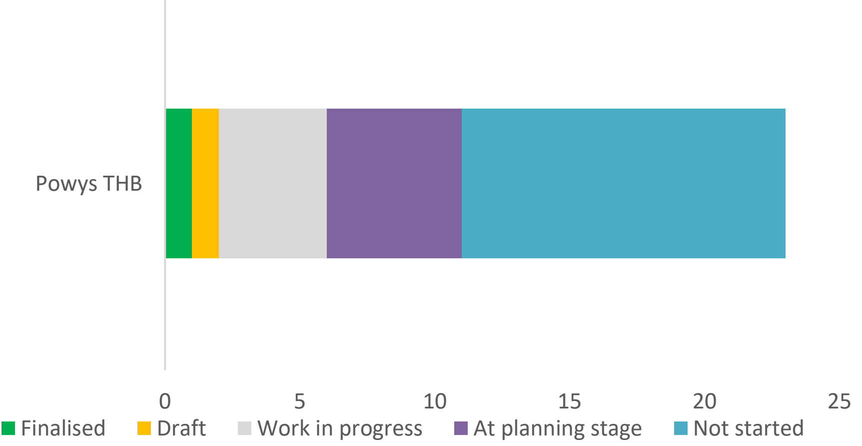
Since the July meeting of the Committee, one review has been finalised. This is included in the table below along with the allocated assurance rating .

The full version of this report is included in the committee's papers as a separate item.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Access to Systems	Reasonable	

3. Delivery of the 2021/22 Internal Audit Plan

There are a total of 23 reviews included within the 2021/22 Internal Audit Plan, and overall progress to date is summarised below.



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From the graph above it can be seen that one audit have been finalised so far this year with another at the draft report stage.

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

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

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

4. Proposed Changes to the 2021/22 Plan

- **Mortality Reviews**

  It has been agreed with the lead Executive that this audit review will be postponed from Q1 to Q4 due to impending changes in the processes around mortality reviews.

- **Post Covid-19 Syndrome**

  It has been agreed with the lead Executive that this audit review will be postponed from Q2 to Q3 due to ongoing developments with the process and the availability of Health Board representatives.

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

- Experience, Quality & Safety Committee – 15 July
- Board – 29 July
- Delivery and Performance Committee – 2 September

Health Board Meetings

- Rani Mallison, Board Secretary – 02 September

Other Assurance Providers

- Audit Wales & Health Inspectorate Wales – 29 July
- Counter Fraud – 10 August

6. Recommendation

The Audit, Risk and Assurance Committee is asked to:

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

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ASSIGNMENT STATUS SCHEDULE

Planned output	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Received	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Access to Systems	Q1	07/06	16/07	21/07	19/08	19/08	Reasonable	September	Final
Midwifery – Safeguarding Supervision	Q2	21/07						November	Work in Progress
Estates Assurance – Control of Contractors	Q2	05/07	05/08	12/08				November	Draft
Medical Equipment & Devices	Q2	15/07						November	Work in Progress
Theatres Utilisation	Q2	13/07						November	Work in progress
Dementia Service	Q2	23/08						November	Work in progress
Machynlleth (Bro Ddyfi Hospital)	Q2							January	
North Powys Well-being Programme	Q3							January	
Breath Well Programme	Q3							January	
Post Covid-19 Syndrome	~~Q2~~ Q3							January	Planning
Looked after children with mental ill health	Q3							January	Planning
Job Matching & Evaluation Process	Q3							January	Planning
Workforce Futures Framework	Q3							January	Planning
Financial Savings & Budgetary Control	Q3/4							March	Planning

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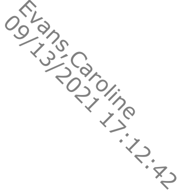
Planned output	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Received	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Network and Information Systems (NIS) Directive	Q3/4							March	
Risk Management & Assurance	Q4							June	
Performance Management & Reporting	Q4							March	
Concerns Tracking/Monitoring Assurance	Q4							March	
Cancer Services	Q4							March	
Mortality Reviews	~~Q2~~ Q4							March	
Site Management (Advisory)	Q4							March	
Estates Assurance - Decarbonisation	Q4							June	
Follow-up Action Tracker	Q4							March	

Key Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100% 1 out of 1	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		0% 0 out of 1	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		100% 1 out of 1	80%	v>20%	10%<v<20%	v<10%

Assurance Ratings

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



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Powys Teaching Health Board

Access to Systems

Final Internal Audit Report

NWSSP Audit and Assurance Services

August 2021

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1. Introduction 4
2. Detailed Audit Findings 4
Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference	Review Reference:
Report status	Final Internal Audit Report
Fieldwork commencement	7 June 2021
Fieldwork completion	16 July 2021
Draft report issued	21 July 2021
Management response received	19 August 2021
Approval and final report issued	19 August 2021
Auditor(s)	Kevin Seward, Martyn Lewis
Executive sign off	Pete Hopgood, Exec. Director of Finance, Information & IT Services
Distribution:	Vicki Cooper, Assistant Director of Digital Transformation & Informatics
Committee:	Audit Committee

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

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

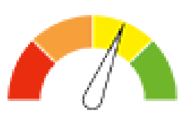
To evaluate and determine the adequacy of the systems and controls in place for Access to Systems at the Health Board.

Overview

Key matters arising concerned:

- The structures to allow cross border access to information between NHS Wales and NHS England have not been put in place. This means that Powys patients are being disadvantaged in a number of ways.
- Testing of leavers identified a number who were still active. From further investigation these resulted from incomplete information provided on the remove access form or on the report received from WOD for bank staff and staff who have moved roles.

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	The Health Board understand its users	Substantial
2	The Health Board understand the needs of each group of staff in relation to data and system access	Reasonable
3	Staff groups are able to access the appropriate data and systems to support the needs of the organisation	Limited
4	There is an appropriate process for granting and revoking access to systems and data	Reasonable

	Matters Arising	Control Design or Operation	Recommendation Priority
1	Access to Systems and Information	Design	High
2	Leavers Process	Operation	Medium
3	User Access Process	Operation	Low

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

1. Introduction

In line with the 2021/22 Internal Audit Plan for Powys Teaching Health Board (the Health Board) a review of the arrangements in place for the management and control of Access to Data and Systems was undertaken.

The review sought to provide the Health Board with assurance that operational procedures are compliant with current best practice guidance and its own key policies and procedures.

Access to systems and data is managed by Powys Information and Communication Technology (ICT) Department to the Service areas and staff of Powys County Council (PCC) and Powys Teaching Health Board under a s.33 agreement. Powys ICT also support the connectivity of client devices to enable access to a range of national and locally hosted systems.

The risks considered in the review are as follows:

- inappropriate or no access to information;
- loss of data;
- applications are not effectively managed or available to those who need them; and
- unauthorised users are able to access IT systems.

2. Detailed Audit Findings

Objective 1: The Health Board understand its users, and these have been appropriately categorised.

We note the following areas of good practice:

- the Health Board is aware of the user types (by role and location).

Our audit did not identify any matters arising under this objective.

Conclusion:

The Health Board understands its users, both in terms of role and of location. (Substantial Assurance)

Objective 2: The Health Board understand the needs of each group of staff in relation to data and system access.

We note the following areas of good practice:

- the needs of different user types (role, location) in relation to access to information and systems are understood;
- the Information Governance issues relating to cross border information flow have been recognised and a way forward agreed with the Information Governance Management Advisory Group (IGMAG) to obviate these; and

Evans,Caroline
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- a business case has been developed in conjunction with DHCW to obtain resource in order to resolve the cross border issues. This covers the provision of information from NHS systems from England to Wales and vice versa and is currently with Welsh Government awaiting approval.

Our audit did not identify any matters arising under this objective.

Conclusion:

The Health Board is clear over what users it has and the information that needs to be provided to different user groups based on role and location. The business case noted above represents a way to address the current issues with provision of information and access to systems. (Reasonable Assurance)

Objective 3: Staff groups are able to access the appropriate data and systems to support the needs of the organisation.

We note the following area of good practice:

- processes have been developed to bypass the lack of cross border information flow and enable access to information.

Our audit identified the following matter arising:

- The structures to allow cross border access to information between NHS Wales and NHS England have not been put in place. This means that Powys patients are being disadvantaged in a number of ways including longer wait times, duplicated appointments and reduced choice. The issue is long standing and is being managed where possible by workarounds such as email and fax. However, this status is inefficient, disadvantages Powys patients and can lead to clinical risk. (Matter Arising 1)

Conclusion:

Due to the nature of Powys Teaching Health Board, services are commissioned from English providers however the processes for providing easy access to information and systems from both sides have not been properly established. The current status is that information is provided using workarounds and manual interventions but this impacts the ability of PTHB to develop its services, patient choice and treatment and patient safety. The Health Board acknowledges the current status and has produced a business case seeking funding for resource to put in place proper information connections. (Limited Assurance)

Objective 4 : There is an appropriate process for granting and revoking access to systems and data.

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We note the following areas of good practice:

- there is a structured process for provision of access to systems and the network;

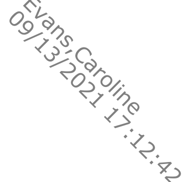
- standard forms are in place for provision of user access;
- there is a process for removing staff access for leavers;
- testing confirmed that the leavers process is operating; and
- work has been done to validate / confirm users as part of Office 365 licencing.

Our audit identified the following matters arising:

- Testing of leavers identified a number who were still active. From further investigation these resulted from incomplete information provided on the remove access form or on the report received from WOD for bank staff and staff who have moved roles. This has led to unnecessary effort and risks duplicated accounts. (Matter Arising 2)
- The setup of users is still being handled by Powys County Council under a project remit and has not transitioned to business as usual. As the service desk systems are different in council and heath this means that there is some duplication of forms and call handling. (Matter Arising 3)

Conclusion:

There are processes for granting staff access to systems when needed, and for removing this access when staff leave. This process is still being run under a project remit however and has not transitioned to business as usual and the leavers process sometimes includes moves and bank staff which results in additional work to re-grant access. (Reasonable Assurance)



Appendix A: Management Action Plan

Matter Arising 1- Access to Information - (Design)	Risk
The structures to allow cross border access to information between NHS Wales and NHS England have not been put in place. This means that Powys patients are being disadvantaged in a number of ways including longer wait times, duplicated appointments and reduced choice. The issue is long standing and is being managed where possible by workarounds such as email and fax. However, this status is inefficient, disadvantages Powys patients and can lead to clinical risk.	Applications are not effectively managed or available to those who need them.

Recommendation	Priority level
Should the business case not be approved and funding not provided the Health Board should seek to escalate this issue outside of the organisation as one that is making it difficult to provide services to patients in an increasingly digital environment.	**High**

Management Response	Target date	Responsible Officer/ Deadline
Noted and agreed, we are informed the decision from WG regarding the business case will be made by the end of Aug 2021	Sept 2021 for a decision relating to the business case	Ass. Dir. of Digital Transformation Deadline – Sep 2021

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Matter Arising 2- Leavers Process - (Operation)	Risk
Testing of leavers identified a number who were still active. From further investigation these resulted from incomplete information provided on the remove access form or on the report received from WOD for bank staff and staff who have moved roles. This has led to unnecessary effort and risks duplicated accounts.	Unauthorised users are able to access to IT systems.

Recommendation	Priority level
Staff should be reminded to provide accurate information for staff who move roles. Consideration should be given to replacing the paper forms with electronic and removing the free text option to ensure that moves are properly reported.	**Medium**

Management Response	Target date	Responsible Officer/ Deadline
Noted and agreed, we are working on using Power Automate and E-Forms. There is a change to be made within DHCW which has been logged for the use of power automate, once the change is made we will look to introduce a process which provides more specific information in more appropriate timeframe.	Dec 2021	Digital Project Manager Deadline – March 2022

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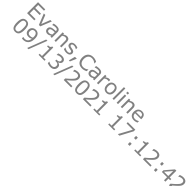
Matter Arising 3- User Access Process - (Operation)	Risk
The setup of users is still being handled by Powys County Council (PCC) under a project remit and has not transitioned to business as usual. As the service desk systems are different in council and heath this means that there is some duplication of forms and call handling.	Applications are not effectively managed or available to those who need them.

Recommendation	Priority level
The setup of users should transition into normal practice and transfer from the PCC project team to the PCC service desk to action requests.	**Low**

Management Response	Target date	Responsible Officer/ Deadline
Noted and agreed, this is a work task within the Digital Project plan to complete the hand over.	Dec 2021	Digital Project Manager Deadline – March 2022



Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Date issued: September 2021

Document reference: 2001A2020-21

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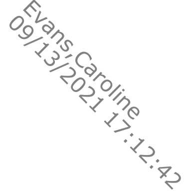

Audit, Risk & Assurance Committee Update

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

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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

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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 in clearance November 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 November 2021

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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

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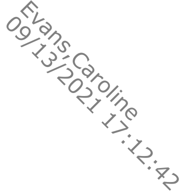
7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh

Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 Since the last Audit Committee meeting, there have been no NHS-related or relevant national studies published.



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

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Welsh Health Specialised Services Committee Governance Arrangements

Report of the Auditor General for Wales

May 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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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**.

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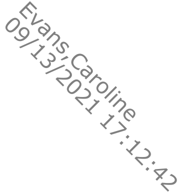

Summary report

Background

1 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.

2 The Joint Committee is hosted by Cwm Taf Morgannwg University Health Board and is responsible for the joint planning and commissioning of specialised services on behalf of local health boards in Wales. WHSSC is made up of, and funded by, the seven local health boards with an overall annual budget of £680 million with the financial contributions determined by population need. Some health boards in Wales provide specialised services. In particular, Cardiff and Vale and Swansea Bay University Health Boards receive significant funding for the services that they provide.

3 On a day-to-day basis, the Joint Committee delegates operational responsibility for commissioning to Welsh Health Specialised Services (WHSS) Officers, through the management team (**Exhibit 1**) and supported by six multidisciplinary commissioning teams. These teams commission specialised services, including:

- Cancer and Blood
- Cardiac
- Mental Health and Vulnerable Groups
- Neurosciences and long-term conditions
- Renal
- Women's and children's

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Exhibit 1: WHSS management structure

Source: Welsh Health Specialised Services Standing Orders

4 In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. The Good Governance Institute highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. In the same year, Healthcare Inspectorate Wales (HIW) conducted a review of clinical governance at WHSSC. That review found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

5 Time has now passed since these reviews. Considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in A Healthier Wales, the Auditor General felt it was timely to review WHSSC's governance arrangements. This report 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. Given the impact of COVID-19 on the capacity and productivity of services, we have also highlighted some specific challenges which relate to recovery.

6 Much of our review was carried out between March and June 2020, but as a result of the pandemic, we paused aspects of the review, restarting in July with a survey to all health boards and concluding the fieldwork in October. The delivery of our work included interviews with WHSS officers and WHSSC independent members, observations of Joint Committee and sub-committee meetings, questionnaires of health board chief executives and chairs and a review of documentation.

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Key findings

7 Overall, we found **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**.

Governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19

8 Our work has found improvements in the overall governance arrangements in WHSSC since 2015. WHSSC is formed of a mix of independent members, health board chief executives, and WHSS officers who work in collaboration to lead specialised services commissioning on behalf of the population of Wales. There are benefits to this system of governance which provides partners with the opportunity to collaborate on service developments. In general, we found that the Joint Committee operates well and there is normally a healthy working relationship between Joint Committee members. There are, however, occasions when this has become more challenging, such as discussions around new service models for major trauma and thoracic surgery. This tends to occur when new services are commissioned from providers who are Joint Committee members. This can present a risk of conflict of interest but the negative impact of this has been reduced through the introduction of a new majority voting system. These conflict-of-interest issues will remain a live risk, particularly when considering post-pandemic service recovery.

9 The agenda of the Joint Committee meetings appears appropriate and proportionate. However, our observations highlighted opportunities to increase the attention given to finance, performance, and quality reporting at Joint Committee. We also identified a need to review the independent member recruitment arrangements and the level of remuneration that they receive to help deal with the challenges of independent member turnover.

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10 The Joint Committee's sub-committees and groups are well-chaired and administered, although there is a need to strengthen the Integrated Governance Committee to ensure it discharges its terms of reference. WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities, and Communications. WHSSC also forms part of the governance and accountability framework of the Health Board via the Audit and Risk Committee and requirement for financial disclosure in annual reports and accounts. Work is ongoing to strengthen the role and function of the Health Board's Audit and Risk Committee in respect of its hosted statutory joint committees.

11 WHSSC has developed good risk management processes using a corporate risk assurance framework. The risks are regularly scrutinised at corporate and Joint Committee levels with a specific arrangement to capture COVID-19 risks since the onset of the pandemic. Likewise, performance management arrangements provide a good foundation, adopting a tiered model for service escalation and appropriate operational monitoring. WHSSC has adapted these arrangements as a result of the pandemic but may need to become more robust in future to ensure specialised services minimise the risk of harm as a result of delays in treatment.

12 After an initially slow response, WHSSC has responded to the recommendations made in 2015 relating to the need to strengthen quality assurance arrangements. In 2019, WHSSC established a Quality Assurance Team, which is embedding well and is now taking steps to update its quality assurance framework.

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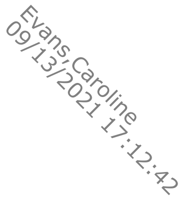
Planning arrangements provide a good foundation but there is a need for a clear strategy to respond to the challenges presented by COVID-19

13 Annual planning arrangements are generally effective. Year on year, development and approval of the Integrated Commissioning Plan has become timelier and there are clear formal arrangements for the identification and prioritisation of emerging specialised care services and treatments. Welsh Government officials told us of the additional capacity and capability they received from WHSSC planning officers to help drive through review of health board and trust quarterly plans during the first wave of the pandemic. This provides a good indication of the expertise within the team. Information to support planning and commissioning is improving and this is supported by a performance information system which continues to develop. Delivery of existing commissioned service plans is well managed, but elapsed time for the introduction of new services such as new service models for major trauma and thoracic surgery in South Wales has been slow. This is not within the sole remit of WHSSC but indicates the need for wider 'end to end' programme management at regional levels.

14 Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan. COVID-19 has significantly reduced access to some specialised services, and recovery will have some significant financial consequences. There is a need to understand the financial consequences resulting from the pandemic in terms of service recovery. Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs to become more ambitious and more strongly linked to patient outcomes, prioritisation, and decommissioning (where there isn't good evidence that services/interventions are leading to improved outcomes).

15 COVID-19 has delayed specialised services strategy development and will no doubt continue to impact on the timeline for the development of the strategy. Specialised service officers can start to shape a strategy that focusses on the impacts of COVID-19 alongside advances in technological, therapeutic and policy developments. Strategy renewal is more crucial than ever and will need to be shaped around the changing risks and opportunities for specialised services taking consideration of the issues and opportunities identified in this report.

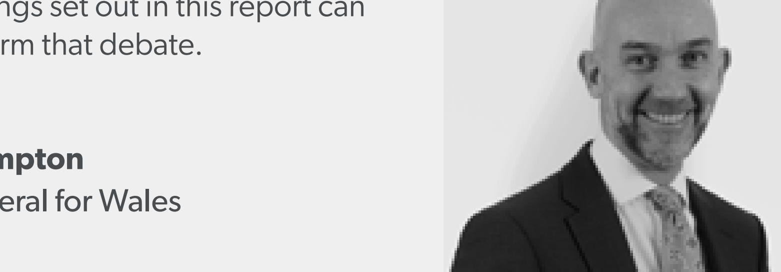


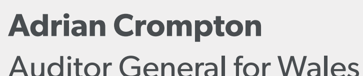
Future arrangements for commissioning specialised services

16 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales, signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability. Whilst the governance arrangements for WHSSC have continued to evolve positively in the main, there would still be benefits in the Welsh Government including WHSSC in the planned review of national hosted functions. In looking at potential future governance and accountability arrangements for specialised services, it should be recognised that the current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that see individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

The Welsh Health Specialised Services Committee (WHSSC) commissions around £680 million of specialised services on behalf of the population of Wales and is a vital component of the Welsh healthcare system. Given this level of responsibility and investment, I'm encouraged by the progress WHSCC has made to improve its governance, management, and planning arrangements over recent years.

An immediate challenge for WHSSC is to develop a clear strategy to address the challenges associated with recovering specialised services following the Covid-19 pandemic. My report also shows that there is still a need to take a more fundamental look at the model for commissioning specialised services, in line with the commitment set out in the Welsh Government's NHS Plan 'A Healthier Wales'. It is important that this commitment is taken forward and I hope that the findings set out in this report can helpfully inform that debate.





Adrian Crompton
Auditor General for Wales

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Recommendations

17 Recommendations arising from this audit are detailed in **Exhibits 2 and 3**.

Exhibit 2: recommendations for the Welsh Health Specialised Services Committee

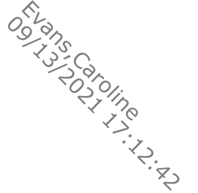
Recommendations

Quality governance and management

R1 **Increase the focus on quality at the Joint Committee.** This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.

Programme management

R2 **Implement clear programme management arrangements for the introduction of new commissioned services.** This should include clear and explicit milestones which are set from concept through to completion (ie early in the development through to post-implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the joint committee.



Recommendations

Recovery planning

R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:

a the backlog of waits for specialised services, how these will be managed whilst reducing patient harm.

b potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening.

c the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.

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Recommendations

Specialised services strategy

R4 The current specialised services strategy was approved in 2012. WHSSC should **develop and approve a new strategy during 2021**. This should:

a embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post-pandemic recovery.

b be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services:

- which do not demonstrate clinical efficacy or patient outcome (stop);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer);
- where alternative interventions provide better outcome for the investment (change);
- currently commissioned, which should continue (continue).

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Exhibit 3: Recommendations for the Welsh Government

Recommendations

Independent member recruitment

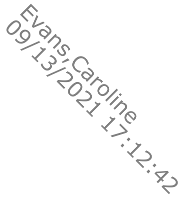
R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role.

Sub-regional and regional programme management

R6 This is linked to **Recommendation 2** made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi-partner programme management arrangements are in place from concept through to completion (ie early in the development through to post-implementation benefits analysis).

Future governance and accountability arrangements for specialised services

R7 **A Healthier Wales** included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.



Main report

Governance and assurance

18 Our review has examined WHSSC's governance and assurance arrangements, such as the way the Joint Committee and its sub-committees conduct business, systems for managing performance and risk, and arrangements to ensure probity and propriety. We found that **governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19**.

Conducting business effectively

19 We looked at the clarity of governance structures, decision-making arrangements and conduct at the Joint Committee and its sub-committees. We found that **committee arrangements have improved, although challenges around conflicts of interest remain and there is a need for stronger focus on quality, finance, and performance at Joint Committee meetings**.

The Joint Committee is well administered with a healthy relationship between members. However, there is scope for greater scrutiny of service quality and routine finance and performance reports, and an opportunity to look afresh at independent member recruitment arrangements

20 The Joint Committee is made up of 15 voting members and three associate members. The voting members include the chief executives of the seven health boards, four independent members (three of whom are drawn from health boards), including the Chair (a Ministerial appointment) and Vice Chair, and four WHSS officers. In October 2020, a new Chair was appointed, taking over from the Interim Chair who had been in post for a little over three years. WHSSC is expecting turnover of independent members in the coming months which will present both capacity and recruitment challenges. It was reported that recruiting independent members is difficult, especially since the pool from which they can be recruited is limited to health boards only. Consideration should be given to widening the recruitment pool to include all NHS Wales organisations, not just health boards. In addition, there is no additional remuneration for independent members of WHSSC, which makes the position less attractive. Thought, therefore, should be given to whether the current remuneration arrangements reflect the commitment expected of independent members of WHSSC.

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21 We observed the Joint Committee both before and during the pandemic. Meetings were well attended and the relationship between members was respectful with a healthy level of challenge. Due to the pandemic, WHSSC moved to holding virtual meetings from March 2020. At this time, the Joint Committee's agenda had a COVID-19 focus with updates on commissioning independent hospitals, which the WHSS team was responsible for, risk management and delivering specialised services during the pandemic. WHSS officers fed back that the revised arrangements improved meeting efficiency and engagement and created better approaches for responding to questions. Moving forward, we would encourage WHSSC to review and consider the advantages of retaining these arrangements.

22 Those we interviewed were positive about the Joint Committee, indicating that it had matured in the past one to two years. Generally, it was felt the Joint Committee works effectively, is open and transparent, that chief executives are supportive of each other, and that roles and responsibilities are clear. Our observations at Joint Committee indicated a tendency to focus on new service modelling which resulted in a south Wales focus in meetings. We also saw limited discussion about the performance of commissioned services. Despite good systems for quality assurance at an operational level within WHSSC, there is a lack of sufficient oversight at Joint Committee. These need to be strengthened as part of a focus on service recovery.

Decision making arrangements have improved, but conflicts of interest remain a risk

23 WHSSC commissions specialised health services for Wales as a whole. Whilst membership of the Joint Committee is drawn from existing health boards, the members are supposed to be independent. However, decision-making for some members poses a potential conflict of interest. This is because the larger Welsh health boards are substantial providers of specialised services, especially in south Wales. Those we spoke to reported that there can be some tensions around negotiations, citing the major trauma centre and thoracic surgery, and potential to draw attention on these specific issues at committee meetings at the expense of wider aspects of the agenda.

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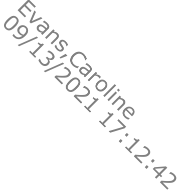
24 As a result of previous challenges in decision making, WHSSC's voting arrangements changed from 100% agreement required to a two-thirds majority vote in accordance with a Ministerial direction dated 12 November 2018. This was subsequently reflected in an amendment to WHSSC's standing orders. The new voting system is more pragmatic and ensures quicker decision-making, but this was introduced relatively recently, so WHSSC should keep this new arrangement under review. The governance arrangements mean that chief executives and independent members take part in votes on commissioning services from their own health board. As a result, the previous interim Chair of WHSSC reinforced the need to act on behalf of the all-Wales position when making decisions. Moving forward, the difficulties presented by the pandemic are likely to be challenging. When acting on behalf of 'all-Wales' and to minimise patient harm as a result of delays in receiving specialised care, shifts in investment may be necessary. This again may increase the risk of conflicts of interest if chief executive members are required to vote on diverting investments from their own health boards.

Flows of assurance between the Joint Committee and individual health boards are variable

25 As the Joint Committee commissions specialised services on behalf of the seven health boards, we would expect to see clear lines of assurance from the Joint Committee to individual Boards. On reviewing health board papers[1] we found that as a minimum all seven health boards had approved their own standing orders, which set out their responsibilities regarding WHSSC, and WHSSC's standing orders. All health boards report WHSSC's assurance reports and minutes of the Joint Committee meetings (or provide a link to the minutes).

26 However, health board minutes show some variability in the extent of discussions of WHSSC services. For example, the programme business case approval for major trauma and thoracic surgery prompted extensive papers and good discussion at health boards. But at other times WHSSC papers were just noted with limited discussion. We found that Board level oversight of quality and escalated specialised services appears limited, but we note that this is something WHSS officers are working to improve through their engagement work with health boards across Wales.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1 For each health board, we reviewed its Board papers and papers for its quality and safety, finance and performance meetings.

WHSSC's hosting arrangements function largely as intended, albeit there are occasional operational challenges and an opportunity to strengthen the governance role of the host health board's Audit and Risk Committee

27 WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities and Communications. WHSSC employees have a contract of employment with Cwm Taf Morgannwg University Health Board and WHSSC's Managing Director has a line of accountability to its Chief Executive. Interviewees indicated that in general these arrangements operated sufficiently, but there were some concerns expressed about Cwm Taf Morgannwg University Health Board's capacity to support WHSSC, particularly in relation to HR and ICT support services. In addition, it was noted that Cwm Taf Morgannwg University Health Board is a provider of specialised services commissioned by WHSSC, which could provide further conflicts of interest over and above the inherent provider/commissioner tension at Joint Committee.

28 A hosting agreement exists between WHSSC and the seven Welsh health boards which includes provision for Cwm Taf Morgannwg University Health Board's Audit and Risk Committee to assist in the discharge of WHSSC's governance and assurance responsibilities. However, the existing hosting agreement has limited detail on how these arrangements should work, and the degree of scrutiny of WHSSC business at the committee can be fairly limited. Hosted organisations are considered at Part 2 of Audit and Risk Committee meetings. Cwm Taf Morgannwg University Health Board is working to clarify the assurance requirements of the hosted bodies[2] through developing an assurance framework. The new framework aims to define the role, function, responsibilities and accountabilities of the Audit and Risk Committee, the host, the all-Wales statutory joint committees and the directors involved. We understand that this work is ongoing and will require further engagement across all bodies affected.

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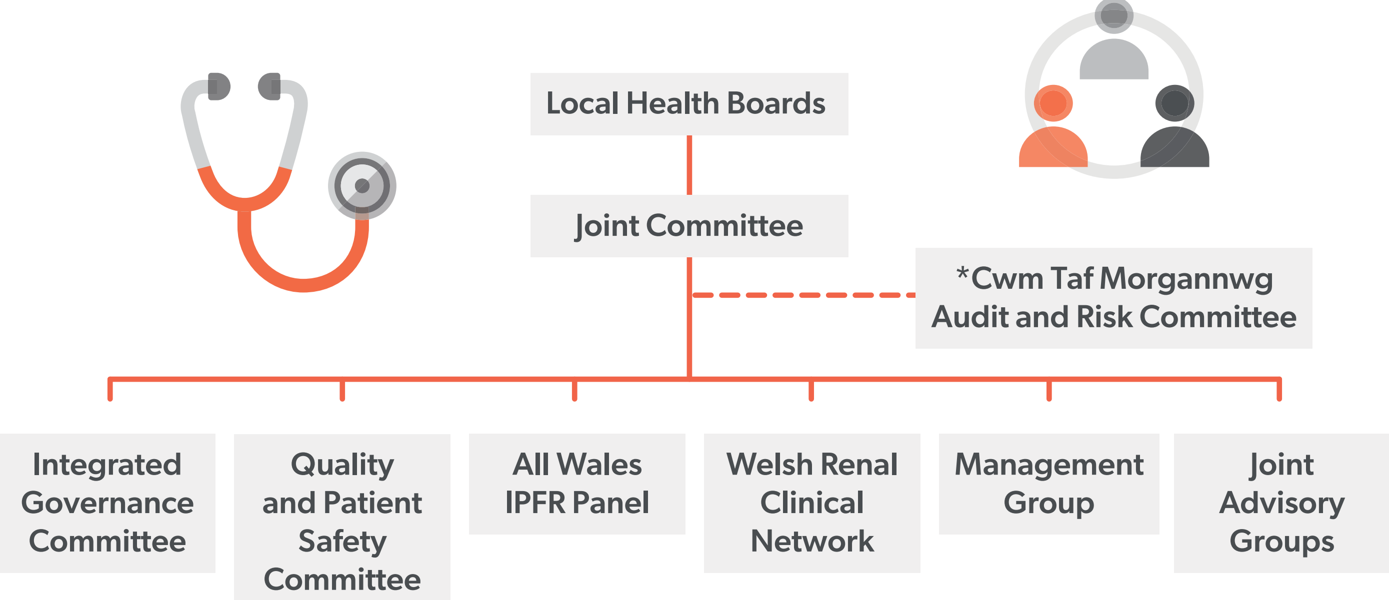
2 Cwm Taf Morgannwg University Health Board is also the host for the Emergency Ambulance Services Committee (EASC) and the NHS National Imaging Academy.

WHSSC's sub-committees and groups generally operate well, although there is a need to ensure that all aspects within terms of reference are appropriately covered

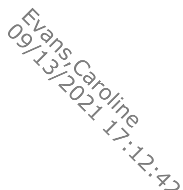
29 WHSSC is required through its standing orders to have committees responsible for quality and safety, and audit. As identified earlier, the Audit and Risk Committee is facilitated through hosting arrangements. However, the Joint Committee is also supported by a range of its own sub-committees and groups (**Exhibit 4**). Some provide scrutiny and receive assurances, while others are more focussed on delivery and decision making. The Quality and Patient Safety Committee, forms part of WHSSC's own committee and group structure. The Joint Committee also has three advisory groups, which at the time of our fieldwork were under review.

Exhibit 4: WHSSC Governance Structure[3]



* Functions as both the Health Board's Audit and Risk Committee and WHSSC's Audit Committee.

Source: WHSSC



3 See section 2.3 of the 2019/20 WHSSC Annual Governance Statement for more information on the arrangements for Cwm Taf Morgannwg's Audit and Risk Committee and Quality and Patient Safety Committee in relation to WHSCC governance.

30 Most of our observations took place prior to the pandemic. Generally, we found that the meetings had a clear agenda, were well administered with formal procedures observed as expected, such as declarations of interest and review of previous minutes. Meeting papers were clearly written with a templated cover report detailing the purpose of the paper such as for approval, noting and assurance. The sub-committees have an up-to-date work programme and terms of reference.

31 WHSSC's Quality and Patient Safety Committee effectively scrutinises assurance reports from all of its commissioning teams on escalated services, service risks, quality visits, inspections and any incidents or concerns. The committee also receives reports on concerns, serious incidents, ombudsman reports, clinical policy review and COVID-19. WHSS officers are also aiming to improve the flow of information between WHSSC and the quality and safety committees of health boards.

32 During 2019-20, the Integrated Governance Committee met infrequently, leaving a six-month gap between the October 2019 and April 2020 meetings. However, the number of meetings was still in line with the committee's terms of reference and, since April 2020, the frequency of meetings has increased. Our work indicates that there needs to be greater clarity on the role and function of this committee. At present, part of the Integrated Governance Committee's remit is to maintain oversight of the work of the Quality and Patient Safety Committee, Audit and Risk Committee, and the Welsh Renal Network. The Integrated Governance Committee is also responsible for scrutinising delivery and performance of the Integrated Commissioning Plan. Whilst there was good oversight of the plan's development by the committee, we found that with the exception of a routine report on escalated services, there was no evidence of wider scrutiny of delivery against the plan.

33 Our observations found that Management Group, an officer-level group which makes recommendations to the Joint Committee, is well chaired, and in general papers are well discussed. But, as with Joint Committee, we saw a need for better discussion of performance, finance, and service quality and patient safety.

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Systems of assurance

34 We examined whether the Joint Committee has an effective system of internal controls to support assurance systems. We found that **in recent years there has been notable strengthening of systems of assurance, but there is scope to strengthen them further**.

Arrangements to promote probity and propriety are in place

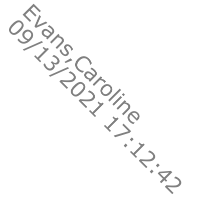
35 WHSSC's governance and accountability framework was last fully reviewed in September 2019. This version reflects the amended voting arrangements and includes:

- Standing Orders
- Memorandum of Agreement
- Hosting Agreement
- Joint Committee Business Framework

36 To help ensure probity and propriety, WHSSC maintains registers for declarations of interest and gifts, hospitality, and sponsorship. The registers are appropriately updated, with records available on the WHSSC website and declared within the Annual Governance Statement.

37 WHSSC keeps an internal audit recommendation tracker, which is clearly formatted and reviewed at each Audit and Risk Committee meeting. There were no external audit recommendations on the tracker when we conducted our review, but we are told that historically recommendations have been listed on the tracker and they were scrutinised in the same way as they were for the host. We would particularly expect the recommendations made in this review to appear on the tracker and be subjected to scrutiny.

38 WHSSC also monitored progress against the 2015 Good Governance Institute and HIW reviews. WHSSC developed a governance action plan and most actions are closed. The Integrated Governance Committee received six-monthly updates on the outstanding actions, the last of which was in March 2019.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Good risk management processes are in place, with risks regularly scrutinised at corporate and Joint Committee level, and systems in place to capture risks arising from COVID-19

39 WHSSC has a Corporate Risk Assurance Framework (CRAF) which identifies high-level risks to commissioned services. Each of the commissioning teams has a risk register. Risks rated 15 or above after controls are put in place are escalated to the CRAF. The Joint Committee has sight of the CRAF twice a year and it is reviewed regularly by the sub-committees and the Corporate Directors Group Board. The CRAF is clearly presented and includes the information we would expect to see on a corporate risk register including a lead director and assuring committee for each risk.

40 WHSSC has recently updated its integrated risk management framework including reviewing existing risk registers, developing a new risk register template, and training staff. The framework sets out accountabilities, responsibilities, and the organisation's risk appetite. WHSSC is seeking further improvements to tighten escalation and de-escalation processes and by introducing an electronic risk management system. It hopes to roll out new risk processes in spring 2021.

41 During the pandemic, a separate risk assessment and register was completed to assess how essential specialised services were impacted by COVID-19. The assessment is a live document which is updated as providers supplied more information. The Joint Committee continues to review both the COVID-19 risk register and the CRAF.

WHSSC is taking necessary action to strengthen its performance management arrangements but will need to consider how these are adapted to monitor and manage the post-pandemic recovery of services

42 WHSSC predominantly monitors a service's performance through national key performance indicators. The measures are set out in contracts and service specifications. Underperformance is managed through WHSSC's escalation framework, which has four levels of escalation, with level four being the highest. The WHSS team holds regular Service Level Agreement (SLA) meetings with Welsh providers, and at least an annual contract meeting with English providers. Escalated services are subject to enhanced performance management arrangements until significant improvement can be demonstrated to allow de-escalation.

43 During the height of the pandemic, WHSSC stood down SLA monitoring in line with the Welsh Government's practice. At this point only essential specialised services were being delivered. During this time, the WHSS team found it difficult to engage with both Welsh and English providers who were heavily focussed on the pandemic. Pragmatically, to overcome this they adopted a direct monitoring system, reviewing available performance data and challenging providers on the findings. WHSSC is still 'direct monitoring' services and is sharing information with the Welsh Government. Where the WHSS team has been able to proactively engage with providers they have been able to negotiate the continuation of some services. WHSSC reported that despite the pandemic, escalation arrangements continued to work well, and it has helped to highlight differences in activity and productivity between different providers.

44 The pandemic has also highlighted the need to review performance management arrangements and metrics. For example, performance against referral to treatment (RTT) waiting times was often used to determine escalation levels[4]. But in the current climate where RTT waiting times have risen across the NHS, it is difficult to differentiate risk of harm or patient outcome when so many patients are delayed and waiting. As a result, WHSSC is currently in the process of reviewing each service in escalation to see if it is still relevant. WHSSC does not currently have an overarching Performance Management Framework, although it has developed a performance analysis system called 'MAIR' (My Analytics and Information Reports). However, the team is developing a Commissioning Assurance Framework. The framework will set out a new performance assurance process alongside more outcome focussed performance measures. It also proposes an annual meeting between WHSSC executives and health board executives to understand commissioner priorities to feed into the Integrated Commissioning Plan development process. It is hoped the new framework will be launched alongside the refreshed Integrated Commissioning Plan. This is a positive development as monitoring services as they recover from the pandemic will need a different approach. Reviewing data on patient outcomes and harm will need to be an important part of these developing arrangements.

45 WHSSC's integrated performance dashboard is presented to the Corporate Directors Group Board and Management Group monthly, and to the Joint Committee bi-monthly. While there is discussion and challenge at commissioning team meetings, as stated earlier, we observed little scrutiny of this report at Joint Committee. The existing reports do not have a breadth of measures, reporting mainly on waiting times and RTT performance and there is opportunity to refresh these as part of post-pandemic recovery and the new Commissioner Performance Assurance Framework.

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4 The escalation framework works on a four-tier basis with level four being the highest level of escalation. Services can be escalated for performance and/or quality issues.

WHSSC is driving quality improvement through its Quality Assurance Team and quality assurance framework

46 In 2015, the Good Governance Institute and HIW made several recommendations related to quality governance. Since these reviews, WHSSC has made good progress in improving quality governance. The Joint Committee has senior clinical representation, the Director of Nursing and Quality Assurance is a member of the Joint Committee and the Medical Director attends the meeting. At an operational level, each of the six multidisciplinary commissioning teams has an associate medical director for clinical advice and guidance.

47 A Quality Assurance team, led by the Director of Nursing and Quality Assurance, was established in 2019. The team is responsible for monitoring and learning from quality and patient experience to help improve commissioned services. Specifically, this includes managing and responding to complaints, near misses, serious incidents and never events. The team is also part of the multidisciplinary commissioning teams and is involved in planning and quality assuring commissioned services. In addition, WHSSC has updated its Quality Assurance Framework which was agreed in 2014 and will form part of the new Commissioning Assurance Framework.

48 To share intelligence and reduce duplication, the Quality Assurance team maintains good relationships with providers and regulators. For example, the team holds quarterly meetings with the quality leads at provider health boards to review a range of quality measures and information. They also use intelligence from regulators, clinical audit, and the National Collaborative Commissioning Unit (mental health services) to feed into planning and monitoring of services. There is a different system for English providers. NHS England has a quality assurance portal, which WHSSC accesses. Information on the portal is detailed and benchmarked against similar NHS England providers. WHSSC plans to replicate this approach for Swansea and Cardiff and Vale University Health Boards.

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Strategic planning

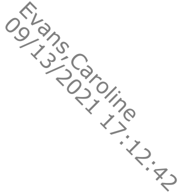
49 Our work examined whether WHSSC has a clear and robust approach to strategic and financial planning. As a result of the pandemic, the specialised services environment has changed, with some services, particularly surgical, stopping or significantly curtailed. Our review found that **planning arrangements provide a good foundation but there is need for a clear strategy to respond to the challenges presented by COVID-19**.

Annual planning arrangements are generally effective, but recovery of services will be challenging

50 WHSSC currently undertakes planning each year culminating in a rolling three-year Integrated Commissioning Plan. This plan is agreed annually and has become increasingly timely and mature in recent years. There are clear stages of development and engagement with health boards as part of the approval process, prior to formal ratification/approval at the WHSSC Joint Committee. There is also a clear process and accountability for different stages of preparation and approval and, if necessary, consultation with relevant stakeholders.

51 WHSSC consults key stakeholders and the public on new commissioning policies, service specifications and revised commissioning policies where there are material changes to the service. There are good examples of this in relation to major trauma and thoracic surgery with the relevant community health councils actively engaging in stakeholder feedback and analysis. Community health council feedback informs both WHSSC planning and the relevant health boards whose population may be affected by proposed service changes.

52 The extent that health boards incorporate specialised services within their own integrated medium-term plans is variable across Wales. For example, Powys Teaching Health Board and Hywel Dda University Health Board rely more significantly on externally commissioned specialised services and we see these featuring in their plans more so than in the plans of the health boards that are specialised service providers.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53 Our work indicates that WHSSC has sufficient capacity and capability to support planning. That capacity and capability was drawn upon in 2020 to help support the Welsh Government's NHS Planning Team's review of health boards' quarterly plans, using their knowledge and experience of complex service planning. WHSSC's planning arrangements include significant contribution from each of the specialised services commissioning teams, clinical impact advisory group and WHSSC Management Group. Clinical advice helps to shape specialised services and WHSSC intends to increase the level of internal 'consultant-level' expertise further.

54 WHSSC has adopted a continuous approach for identifying and evaluating new research, treatments and using NICE[5] guidance to shape commissioned services. This 'horizon scanning' is supported by a consistent and transparent prioritisation process (**Exhibit 5**) to help ensure that investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. The robustness of the approach helps to secure agreement of new proposals at the Joint Committee.

Exhibit 5 – key principles of the prioritisation process adopted by WHSSC

- Scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out using formal and agreed methodology
- The prioritisation process is intended not to duplicate work already completed (for example by NICE)
- There must be appropriate and timely engagement with NHS Wales as part of the process
- There are clear and agreed scoring criteria and voting technology is utilised during assessment. The criteria include:
  - Strength of clinical evidence
  - Patient benefit
  - Economic assessment
  - Burden of disease (severity of condition and also impact on the population)
  - Reducing inequalities of access

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Source: Audit Wales fieldwork

5 National Institute for Health and Care Excellence https://www.nice.org.uk/

55 COVID-19 has significantly affected the delivery of specialised services across Wales and England. After the first wave of the pandemic, we understand that variation in service productivity between providers was increasing, with some providers able to restart specialised services earlier and with greater degrees of success than others. This creates a commissioning challenge as WHSSC looks to develop post-pandemic recovery plans on behalf of the population of Wales.

Information to support planning and commissioning is improving and will need to adapt to the challenges brought about by the pandemic

56 WHSSC's development of My Analytics and Information Reports (MAIR) in 2018-19 was a notable improvement on previous arrangements. WHSSC has worked closely with health board teams to ensure that health boards now have access to the comprehensive information sets now available. Reports can be tailored by health board or provider, by specialty and point of delivery. Results can also be made available using a variety of visualisation tools including maps, charts, tables, and pathways. This has enabled health boards to gain a deeper understanding of their demand patterns for specialised services and compare their own access rates to other health boards and inform areas for targeted review.

57 Plans for further development of MAIR include:

- Producing performance management dashboards and heat mapping
- Improving the timeliness of performance reporting
- Exploring how quality and outcomes data can be incorporated
- Improving the familiarisation of health boards with the variety of WHSSC's contracts by the production of deep dive reports.

58 Commissioning and contracting services can only be effective if there is robust information to inform operational and strategic decisions. Our work has identified that prior to the COVID-19 pandemic, there was a good track record of analysis of demand and capacity of services both in Wales and England. This will become even more important post-pandemic, to help provide options for recovering service performance and reducing risk of harm as a result of delays in access to care.

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Delivery of Integrated Commissioning Plans is effective, but development and implementation of new services can be slow

59 For services that are already commissioned and being delivered, the necessary arrangements are in place to ensure they are resourced and being delivered as intended, with arrangements to escalate matters should there be any concerns.

60 Commissioning of new services from first consideration through to the launch of new services can, however, be a lengthy process, particularly for services provided in Wales. For example, the major trauma network in south Wales was launched in September 2020, after having been originally identified as necessary back in 2013, although WHSSC's involvement only commenced in 2018-19. Similarly, the improvements to thoracic surgery services, identified as necessary by the Royal College of Surgeon's report in 2016, are not expected to go live until 2024, and this is subject to a capital business case requiring Welsh Government funding.

61 Whilst introduction of new services is by no means simple, there has been protracted debate on where the new developments mentioned above should be housed, although the statutory engagement and consultation process, which is integral to this, can consume considerable time. The roll out of such schemes is not the sole domain of WHSSC and depends upon the wider architecture that supports regional service development within the NHS in Wales. There is scope, however, to strengthen end-to-end programme management of such schemes to improve timeliness of service development. The pandemic has created a common sense of urgency amongst providers. This momentum needs to be maintained to identify and rapidly develop or reshape services to accelerate recovery.

Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan but will need to ensure value for money as services restart and aim to recover

62 Financial planning is an integral element of the Integrated Commissioning Plan. Health boards are fully engaged in discussions on costs and projected cost growth for the coming financial year during planning and agreement stages, prior to ratification of the plan. Cost growth is explicitly defined in the plan and justified through the agreed process for horizon scanning and prioritisation. Financial planning has two distinct elements:

- determining overall specialised services costs and the apportionment of these costs to health boards; and
- contracting and commissioning health boards and trusts in relation to provision of specialised services.

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63 These are managed through financial risk-sharing agreements. These agreements set out who pays for what in relation to the provision and receipt of services. The risk sharing agreements are based on a financial formula and this is used both as part of planning and at the year-end to look at variance in activity against plan and determine distribution of under and overspends. There are different models for risk sharing designed to suit different types of commissioned services. For most services, planning is based on actual utilisation and a two-year average of activity. This is designed to smooth some peaks and troughs but also create incentive for efficiency. Highly specialised services which are not utilised often are funded using a population-based formula which is designed to provide continuity of income. This is to ensure services are sustainable, but also to protect against peaks of extreme costs when services are required.

64 Our review of health board expenditure on specialised services for the period 2014-15 to 2020-21[6] indicates the overall costs have increased above inflation. We understand that this is typical when new specialised therapies and treatments are developed and adopted into commissioning agreements.

65 In the short to medium term, however, the impact of COVID-19 on finances presents a number of challenges, including:

- payments to providers have continued in Wales and England albeit recent negotiations have resulted in rebates/reductions where there is under-delivery by providers;
- lack of service delivery during the pandemic has created a backlog of waits for some specialised services; and
- lack of patients presenting to primary and secondary care with symptoms during the pandemic may mean that there is greater hidden demand, and that conditions may have exacerbated, requiring more costly intervention downstream.

66 The Joint Committee should seek to understand the short and medium term financial impacts of COVID-19 to determine what this means for service recovery plans.

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6 2019-20 data is taken from the Month 12 Health Board expenditure on Welsh Health Specialised Services. 2020-21 costs are based on forecast expenditure budgeted within the 2020-21 integrated commissioning plan. We acknowledge that 2019-20 data is currently unaudited, and 2020-21 data is subject to significant variation as a result of the COVID-19 outbreak.

Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs more strongly to link to patient outcomes, prioritisation, and de-commissioning

67 Prudent and value-based care is a core aspect of the 2020-2023 Integrated Commissioning Plan. This focussed on increasing the value achieved through improvement, innovation, use of best practice and eliminating waste. The value-based commissioning approach adopted by WHSSC is logical and methodical. This includes identifying commissioning opportunities, refining these, and engaging the WHSSC Management Group members and wider teams. WHSSC has developed thematic areas for value-based commissioning. Some of these will be easier to achieve than others and some may need to be pursued over a multi-year period. The areas include procurement, efficiency, service rationalisation, disinvestment, and assessing access criteria.

68 While COVID-19 has changed the position significantly, the extent of the original value-based commissioning savings for 2020-21 was around £2.75 million. Overall, our review has identified that WHSSC's value-based approach is developing and there is opportunity to exploit this further. In doing so, we expect there will need to be a clear and strong focus on collecting patient outcome information to inform the development of opportunities to reduce waste and maximise the benefit of investment in specialised care. For example, there remains greater opportunity to assess services:

- which do not demonstrate clinical efficacy or patient outcome (**stop**);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (**transfer**);
- where alternative interventions provide better outcome for the investment (**change**);
- currently commissioned, which should continue (**continue**).

COVID-19 has delayed the development of a new specialised services strategy, but this now provides the opportunity to shape the direction to focus on recovery, value and to exploit new technology and ways of working

69 A key function of commissioning relates to planning of services to meet population need. The specialised services strategy provides a framework for commissioning services, but the current version is dated 2012. Senior specialised services officers had intended to refresh the strategy in 2020, but this has been delayed by the pandemic. However, this gives specialised service officers the opportunity to shape the strategy to focus on COVID-19 recovery arrangements alongside routine technological, therapeutic and policy developments.

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Future arrangements for commissioning specialised services

70 Our review, in examining both WHSSC's governance and planning arrangements indicates that **there would still be merit in reviewing the future arrangements for commissioning specialised services in line with the commitments of A Healthier Wales.**

71 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales signalled an intention to create a national executive to strengthen national leadership and strategic direction across a range of areas. Linked to this, **A Healthier Wales** signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability.

72 Whilst the findings in this report show that the governance arrangements for WHSSC have continued to evolve positively in the main, they do also point to a need still to undertake the wider review signalled within **A Healthier Wales**. The current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that sees individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

73 The Good Governance Institute's report in 2015 questioned the hosting arrangements for WHSSC, suggesting that a more national model might be appropriate. WHSSC's hosting arrangements have remained unchanged since that report and our work has shown that in respect of WHSSC's governance, the use of the hosting health board's Audit and Risk Committee needs to be reviewed to ensure there is sufficient depth of debate and scrutiny (see **paragraphs 27** and **28 above**).

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		Agenda Item	4.5
Meeting Title	**Joint Committee**	Meeting Date	13/07/2021
Report Title	WHSSC Committee Governance Arrangements – Management Response		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services	Public	Public

Purpose	The purpose of this report is to present the management response to the Audit Wales report WHSSC Committee Governance Arrangements.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☐

Sub Group /Committee	Audit Committee	Meeting Date	09/06/2021
Recommendation(s)	Members are asked to: • **Note** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, • **Note** the Welsh Government response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan			Health and Care Standards		
Principles of Prudent Healthcare			IHI Triple Aim			Quality, Safety & Patient Experience		
Resources Implications			Risk and Assurance			Evidence Base		
Equality and Diversity			Population Health			Legal Implications		

Commissioner Health Board affected

Aneurin Bevan	✓	Betsi Cadwaladr	✓	Cardiff and Vale	✓	Cwm Taf Morgannwg	✓	Hywel Dda	✓	Powys	✓	Swansea Bay	✓

Provider Health Board affected (please state below)

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WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS – MANAGEMENT RESPONSE

1.0 SITUATION

The purpose of this report is to present the management response to the Audit Wales report WHSSC Committee Governance Arrangements.

2.0 BACKGROUND

In 2015, the Good Governance Institute (GGI) and Healthcare Inspectorate Wales (HIW) undertook two separate governance reviews for WHSSC which highlighted issues with WHSSC's governance arrangements. The GGI highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. HIW) conducted a review of clinical governance and found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

Since then, considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in Welsh Government's "A Healthier Wales", the Auditor General for Wales felt it was timely to undertake a review WHSSC's governance arrangements.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to Health Board Chief Executive and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report.

The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government.

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3.0 MANAGEMENT RESPONSE

3.1 WHSSC Management Response

The report outlined 4 recommendations for WHSSC and the draft management response has been circulated to Health Board CEO's, Welsh Government and Audit Wales for comment and feedback.

The feedback received has been reviewed and the updated WHSSC management response is presented at ***Appendix 1*** for information and assurance.

Progress against the actions outlined within the management response will be monitored through the Integrated Governance Committee (IGC) on a quarterly basis, and a full progress report will be presented to the Joint Committee 18 January 2022, once the actions related to the Integrated Commissioning Plan (ICP) process and engagement events have been completed.

3.2 Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and the management response is outlined in the letter from Dr Andrew Goodall, Director General Health & Social Services/ NHS Wales Chief Executive to Mr Adrian Crompton, Auditor General for Wales which is presented at ***Appendix 2*** for information and assurance.

Progress against the WG management response will be monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief executive.

4.0 GOVERNANCE & RISK

Audit Wales undertake an annual programme of independent external audits on NHS services, and NHS bodies are required to present a formal management response to recommendations through a public report.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the Welsh Government response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the proposed arrangements for monitoring progress against the actions outlined in the management responses.

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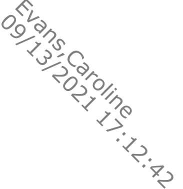
6.0 APPENDICES / ANNEXES

Appendix 1 - WHSSC Management Response to the Audit Wales Report Committee Governance Arrangements at WHSSC
Appendix 2 – Letter from Welsh Government to Audit Wales – Welsh Government's Management Response



Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Implementation of the agreed ICP
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety and patient experience.
Resources Implications	Some improvement actions may require the application of additional resources.
Risk and Assurance	Risk management is a key element of developing WHSSC's services and risk assessments will be undertaken as required.
Evidence Base	-
Equality and Diversity	There are no equality and diversity implications.
Population Health	There are no immediate population health implications.
Legal Implications	There are no direct legal implications.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

Response to the Recommendations from the Audit Wales Report
Welsh Health Specialised Services Committee Governance Arrangements

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response to the WHSSC recommendations are outlined below:

Recommendation	Response/ Action	By when	By whom
Quality governance and management			
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.	We accept the recommendation and intend to take the following actions. We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion. We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	 Sept 2021 Mar 2022	 WHSSC Executive leads WHSSC Executive leads

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[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Recommendation	Response/ Action	By when	By whom
	We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted. We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sept 2021 Sept 2021	Chair of WHSSC Chair of WHSSC
Programme Management			
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.	We accept the recommendation and intend to take the following actions. **a) Building Programme Management competency/capacity** A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already	To commence Sept 2021	WHSSC Director of Planning

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Recommendation	Response/ Action	By when	By whom
	applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones. **b) Programme management on WHSSC commissioned services.** Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to joint committee. **c) HB Commissioned Services** – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and		

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Recommendation	Response/ Action	By when	By whom
	the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.		
Recovery Planning			
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.	We accept the recommendation and recognise the post COVID-19 recovery challenges. We intend to take the following actions. **a) Managing backlog of waits whilst reducing harm** i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	i. Sep 2021 ii. Jul 2021 iii. From Apr 2021 iv. In place v. In place Completed May 2021	WHSSC Executive leads v. WHSSC Executive leads

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Recommendation	Response/ Action	By when	By whom
	b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non-WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact. **c) Financial consequences of services that were commissioned and under-delivered as a result of COVID-19** i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories	In Place Q3/Q4 2021/22 In Place	WHSSC Executive leads

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Recommendation	Response/ Action	By when	By whom
	and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels. **d) Reporting Analysis** We will review and analyse the business intelligence gathered from the actions outlined in points a,b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	
Specialised Services Strategy			
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by	We accept the recommendation and work had begun on developing a new Commissioning strategy, however the COVID-19 pandemic delayed progress. To move forward the new specialised services strategy will be informed by the WG policy for reset and recovery. We intend to take the following actions. **a. Embrace New Innovations** i. We will continue to utilise our well-established horizon scanning	Q4 2021/22 In place Jul 2021	WHSSC Managing Director

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Recommendation	Response/ Action	By when	By whom
developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); • currently commissioned, which should continue (continue).	process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery ii. We will continue to develop our relationship with NICE, AWMSG and HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long term ambitions and to inform how	Q3 2021/22 In place Dec 2021 Dec 2021	

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Recommendation	Response/ Action	By when	By whom
	we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan. **b. Approach to Review of Services will be considered in strategy engagement** i. The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB’s to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the development of an outcome	Sept 2021	

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Recommendation	Response/ Action	By when	By whom
	manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.		

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Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Mr Adrian Crompton
Auditor General for Wales
Audit Wales Head Office
24 Cathedral Road
Cardiff
CF11 9LG

c/o Dave.Thomas@audit.wales

2 June 2021

Dear Adrian

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements: Report of the Auditor General for Wales, May 2021

Thank you for the above Audit Wales report, published on 12 May.

I welcome your conclusion that governance arrangements and decision making at WHSSC have improved since previous reviews. The WHSSC team has worked hard to make these changes and I will expect them to make further progress by addressing your recommendations in relation to an increased focus on quality, programme management, COVID-19 recovery and the specialised services strategy. My officials will be following up on these areas at their regular meetings with WHSSC.

In terms of your recommendations to the Welsh Government, I set out my initial response below, although these may well be subject to any views from the new Minister in light of her priorities.

Recommendation 5: Independent Member recruitment – accepted and action in train

I am aware there have been challenges in securing nominations from health boards to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.

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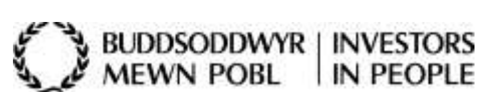

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Recommendation 6: Sub-regional and regional programme management (linked to recommendation 2 directed to WHSSC) – accepted

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

Recommendation 7: Future governance and accountability arrangements for specialised services – accepted in principle

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

Yours sincerely

Dr Andrew Goodall CBE

cc: Chair of the Senedd Public Accounts Committee.

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Agenda item: 3.5

AUDIT, RISK AND ASSURANCE COMMITTEE	Date of Meeting: 14 September 2021
Subject:	**FIRE SAFETY AUDIT: STATUS UPDATE**
Approved and Presented by:	Julie Rowles, Director of Workforce, Organisation Development and Support Services
Prepared by:	Wayne Tannahill, Assistant Director Estates and Property
Other Committees and meetings considered at:	Executive Committee (Policy): Fire Safety Group

PURPOSE:

The paper provides an update on progress against Findings in the 23 October 2020 NHS Wales Audit and Assurance Services, internal audit on Fire Safety, which resulted in a Limited Assurance outcome.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is requested to receive INFORMATION and DISCUSSION on progress made in relation to the 8 Fire Safety Audit recommendations and 2 Follow Up audit recommendations.

Approval/Ratification/Decision[1]	Discussion	Information
x	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	x
	2. Provide Early Help and Support	x
	3. Tackle the Big Four	x

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[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

	4. Enable Joined up Care	x
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	x
	8. Transforming in Partnership	x
Health and Care Standards:	1. Staying Healthy	x
	2. Safe Care	x
	3. Effective Care	x
	4. Dignified Care	x
	5. Timely Care	x
	6. Individual Care	x
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Fire Safety audit undertaken by NHS Wales Audit and Assurance Services in 2020, resulted in a Limited Assurance outcome. A summary of recommendations and status is as follows:-

Recommendation	Priority	Status
1.Fire Safety policy - update	Medium	Approved with minor amendments at Exec Committee – to be submitted for Board on 29th September 2021
2.Fire safety management structure - clarify	High	Complete
3.Fire safety roles documented, allocated, agreed.	Medium	Complete
4.Fire plans Llandrindod - update	Medium	Complete
5.Local fire management folders – staff training	Medium	Training ongoing. Progress against the training plan to be reviewed by 30th September.
6.Local fire management folders – Fire Safety Advisor checks	Medium	Complete
7.Fire Warden and Incident Coordinators – confirm coverage	High	Complete. Fire Wardens and Fire Incident Coordinators nominated.

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8.Fire drills; undertake, schedule and report	High	Complete. All sites other than Bronllys complete in December 2020. Bronllys fire drill to take place before 30th September.
Follow-up – fire training needs assessment	Medium	Fire training ongoing to support new fire safety management structure. Progress against the training plan to be reviewed by 30th September.
Follow up – fire drills	Medium	Superseded by recommendation 8

DETAILED BACKGROUND AND ASSESSMENT:

The Fire Safety audit undertaken by NHS Wales Audit and Assurance Services in 2020, resulted in a Limited Assurance outcome, with the details included in the 23 October 2020 Final Internal Audit Report.

The 8 recommendations and associated progress against each are set out as follows:-

1.MEDIUM PRIORITY: 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 (O).***

Management response status, recommendation 1: the policy has been updated to reflect changes in the Welsh Healthcare Technical Memorandum 05-01, to address recent changes in no smoking legislation and to add a section on the Dangerous Substances and Explosive Atmospheres Regulations 2002. The policy has also been updated to reflect the current operational fire safety management structure with the policy approved at Executive Committee on 25 August with minor amendments to name specific role designations undertaking named roles in the fire structure. Policy to be taken to Board in September. Policy has been endorsed by NWSSP-SES Authorising Engineer.

2.HIGH PRIORITY: 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 (D).

Management response status, recommendation 2: updated operational fire safety management structure has been agreed at Executive Committee. The new structure includes the Director of Primary Care, Community and

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Mental Health Services as Fire Safety Manager (Operational) who has nominated Site Coordinators for all sites. The Site Coordinators have nominated Fire Incident Coordinators and Fire Wardens for all sites with training ongoing.

3.MEDIUM PRIORITY: 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 (O).

Management response status, recommendation 3: fire safety management structure, operational, has been agreed as item 2 above.

4.MEDIUM PRIORITY: The fire plans displayed at Llandrindod Wells War Memorial Hospital will be updated to reflect the recent site changes (O).

Management response status, recommendation 4: Complete.

5.MEDIUM PRIORITY: Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed (O).

Management response status, recommendation 5: the ongoing training for Fire Wardens and Fire Incident Coordinators includes specific training on the local fire management folders. Progress against the training plan will be reviewed by 30th September 2021, with an action plan developed as a matter of urgency for any further training required.

6.MEDIUM PRIORITY: Sample checks should be made during Fire Safety Adviser site visits to ensure folders are being completed as required (O).

Management response status, recommendation 6: Complete. The findings are varied across the sites in terms of the completion of the Fire Safety Folder status and this is being addressed as part of the current training regime for Fire Wardens, etc. Estates department have records of key statutory elements such as fire alarm testing, emergency light tests, etc. which addresses statutory compliance.

7.HIGH PRIORITY: 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 (D).

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Management response status, recommendation 7: The Fire Safety Advisors have developed a specific training package which is being delivered on site. Nominations for the roles of Fire Incident Coordinators and Fire Wardens have been made by the Site Coordinators for all sites. Training is being actively rolled out across the sites with limiting factors being the numbers of individuals who can be trained in a session due to COVID-19 social distancing rules. Further training resource has been identified to support the 2 Fire Safety Advisors to assist in the training programme, which will be assessed at the end of September for progress.

8.HIGH PRIORITY: a) Site fire drills should be performed on an annual basis (as a minimum).

b) Non-compliance with planned drills will be reported to the Fire Safety Group.

c) The fire drill schedule will be enhanced to provide distinction between planned and actual fire drills. (D).

Management response status, recommendation 8: The Fire Safety Advisors, as directed by the Fire Safety Group, supported a series of fire evacuation drills in 2020, with the cooperation of site based operational staff resulting in nearly all drills being performed by December 2020. Only Bronllys remains outstanding, which will take place before 30th September. Schedules have been prepared for 2021 with ownership to be picked up by the appropriate staff identified in the fire safety management structure, in order to maintain compliance.

MEDIUM PRIORITY: Follow Up – review fire training needs analysis

Management response status, follow up 1: training packages have been developed and will be rolled out to appropriate staff identified under the fire safety management structure.

MEDIUM PRIORITY: Follow Up – perform fire drills at least annually.

Management response status, follow up 2: superseded by recommendation 8.

SUMMARY: Six of the eight recommendations are complete and one of the two follow up recommendations is superseded. The remaining items are:

- **Policy Update**: has been approved at Executive Committee on 25 August, subject to minor amendment, and to be taken to Board in September.

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- **Fire Safety Management Structure – training**: nominations to the roles of Site Coordinators, Fire Incident Coordinators and Fire Wardens complete. Training package developed and delivered on a site level to ensure practical and bespoke training is appropriate. Training programme ongoing with further resource identified to accelerate activity to support the two Fire Safety Advisors.

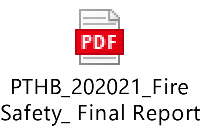
RECOMMENDATIONS:

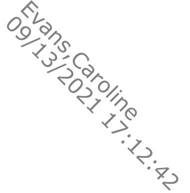
- The Audit, Risk & Assurance Committee to note the progress made to date in implementing actions from the Fire Safety Audit;
- To note that progress against outstanding actions (training) will be reviewed by 30th September 2021, with an action plan developed as a matter of urgency for any further training identified as a result of the review.

NEXT STEPS:

- Policy approval to be sought from Board in September
- Maintain progress on training for new operational fire safety management structure and review and report

Appendix: NHS Wales Audit and Assurance Services, Fire Safety Audit, October 2020

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The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** ***The fire safety audit outcome is a Limited Assurance. Prioritisation required to define, agree and allocate roles and responsibilities, with suitable training, as soon as practicable.***
Clinical		x			
Financial		x			
Corporate		x			
Operational			x		
Reputational		x			

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Estates Assurance – Fire Safety

Final Internal Audit Report

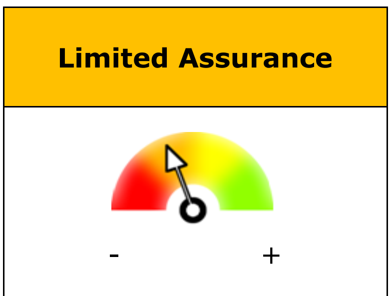
2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Limited Assurance



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2. Scope and Objectives 4
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Opinion and key findings

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7. Summary of Recommendations 12

Appendix A Management Action Plan
Appendix B Follow up of previously agreed actions
Appendix C Assurance opinion and action plan risk rating

Review reference:	SSU_PTHB_2021_02
Report status:	Final
Fieldwork commencement:	13 August 2020
Fieldwork completion:	2 October 2020
Draft report issued:	6 October 2020
Draft report meeting:	8 October 2020
Management response received:	21 October 2020
Final report issued:	23 October 2020
Auditor/s:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign off	Julie Rowles, Director of Workforce & Organisational Development (Board level director – Fire)
Distribution	Wayne Tannahill, Assistant Director of Estates & Property (Fire Safety Manager) Hayley Thomas, Director of Planning & Performance Jamie Marchant, Executive Director of Primary, Community & Mental Health Services Jason Crowl, Assistant Director: Community Services Group Craig Turner, Fire Safety Advisor Gwyn Lewis, Fire Safety Advisor Rani Mallison, Board Secretary
Committee	Audit, Risk & Assurance Committee

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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.

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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 assignment originates from the internal audit plan for 2020/21.

It is noted that a change in Executive responsibility for Fire Safety was scheduled, for October 2020, from the Director of Planning & Performance to the Director of Workforce & Organisational Development. However, due to staff secondments, this has been delayed for a further six months.

The Regulatory Reform (Fire Safety) Order 2005 requires a managed risk approach to fire safety. The process of fire risk assessment, mitigation and review requires a robust system of management, capable of identifying hazards, qualifying their impact, devising appropriate mitigation and continual monitoring.

The Firecode (WHTM 05-01: 'Managing Healthcare Fire Safely') provides guidance in respect of the management of fire safety in healthcare organisations. Therefore, an assessment was undertaken of the controls and practices in place within Powys Teaching Health Board (the THB) to ensure that the key fire safety regulatory requirements were adequately addressed and appropriate management arrangements are embedded within the organisation.

The review was cognisant of the outputs from other assurance providers such as NWSSP: Specialist Estates Services (SES).

This was the third audit undertaken of this area [2013/14: No assurance; and 2016/17: Reasonable assurance]. Compliance testing at two THB sites was undertaken to determine compliance with the THB's and national legislative requirements:

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

2. Scope and Objectives

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

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

Accordingly, the scope and remit of the audit included:

- **Follow up:** review of the status of previously agreed management actions.

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- **Governance:**
  - Assurance that the THB had an appropriate policy in place to address fire safety issues and compliance with legislative requirements.
  - There were defined allocation of responsibilities, clear lines of communication, reporting and approval processes.
- **Management:**
  - Assurance that relevant staff had received appropriate training, and appropriate resources were allocated to fire safety;
  - Assurance that an appropriate inspection regime was operated e.g. fire alarm systems in accordance with BS 5839-1.
- **Monitoring & Reporting:**
  - Assurance that the THB estate was appropriately monitored.
  - Assurance that there was appropriate record retention and dissemination of information through to the Executive Team and Board.
- **Risk Management:** Assurance that the THB had performed and maintained a suitable and sufficient assessment of risks across its estate.

3. Associated Risks

The potential risks considered at the review were as follows:

- Inadequate arrangements are in place to manage fire precaution requirements at THB sites;
- Inadequate monitoring and reporting arrangements result in a loss of key control objectives;
- Non-compliance with the Firecode and Health & Safety legislation which may lead to legal action and adverse publicity;
- Inadequate response procedures and responsibilities; exposing staff and patients to unacceptable levels of risk.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

We evidenced reasonable control arrangements to have operated at the THB in a number of key areas:

- an appropriate governance structure for the discussion of fire-related issues;
- reasonable progress made with the delivery of training following the return of responsibility to Estates (July 2020);
- robust local site procedures;
- significant risks such as compartmentation and fire doors being managed via medium-term programmes of work across the THB estate to bring buildings up to the required standard;
- robust management of unwanted fire signals; and
- all site risk assessments completed at the time of the audit.

Positive observations were also noted at the two sites visited. All areas reviewed were in good order, with no obstructions/fire hazards noted and inspections and testing of key equipment being in date.

However, the audit identified the following key control weaknesses:

- there was lack of clarity over the assignment and operation of key fire safety roles and responsibilities; and
- the Fire Warden and Incident Coordinator listings were out of date, meaning assurance could not be provided that the THB would have sufficient, trained support in the event of a fire incident; and
- fire drills were not being undertaken in accordance with THB procedures and general best practice.

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

- the review of the Fire Safety policy to be cognisant of current governance arrangements and the current Firecode;
- the display of current fire zone plans at Llandrindod Wells Hospital; and
- training across sites in respect of local fire management record keeping;

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

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

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

5. Assurance Summary

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

	Assurance Summary				
1	Follow Up			✓	
2	Governance		✓		
3	Management		✓		
4	Monitoring & Reporting			✓	
5	Risk 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 **3** issues that are classified as weaknesses in the system control/design for fire safety management.

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Operation of System/Controls

The findings from the audit have highlighted **5** issues that are classified as weaknesses in the operation of the designed system/control for fire safety management.

6. Summary of Audit Findings

Follow Up

Assurance that previously agreed management actions had been implemented.

The status of these actions arising from prior audits was as follows:

Closed	Outstanding	Partially Implemented	Superseded	Total
-	-	1	1	**2**

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

Accordingly, **reasonable assurance** has been determined in respect of the action taken to address previously agreed audit recommendations.

Governance

That an appropriate policy was in place to address fire safety issues and compliance with legislative requirements. That there were defined allocation of responsibilities, clear lines of communication; reporting and approval processes.

The Fire Safety Policy was last updated and approved in 2018, and remained 'in date' at the time of the current review. The policy pre-dates the publication of the latest Firecode guidance (Welsh Health Technical Memorandum 05-01) 2019. The policy therefore requires review and updating (**recommendation 1**).

The current management structure evidenced during the review included:

- Board-level lead for Fire (Director of Workforce & Organisational Development),
- Fire Safety Manager (Assistant Director of Estates & Property); and
- Two Fire Safety Advisers (reporting to the Fire Safety Manager).

The THB has implemented a number of changes in respect of the fire management structure, roles and responsibilities in the last year, with further changes forthcoming in October 2020.

However, the current assignment and delivery of key roles and responsibilities lacked clarity, particularly in respect of the division of responsibilities between Estates and local management. Board-level

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direction needs to be secured to ensure the fulfilment of responsibilities by all parties going forward, and be appropriately reflected within the Fire Safety policy (**recommendations 2 & 3**).

An appropriate governance structure for the management and scrutiny of THB fire related issues was in place i.e.:

- Fire Safety Group – the forum to manage and monitor fire safety issues to comply with regulatory requirements; and to provide strategic direction for the development of fire safety within the THB; minutes of which were evidenced as reported to the Executive Committee.
- Fire Sub-Group – an operational forum for matters related to the fire safety under the Fire Safety Manager [Estates]; minutes of which were evidenced as reported to the Fire Safety Group.

Reporting of key fire management issues was also evidenced to the Innovative Environment Group via highlight reports; and to Executive Committee via exception reports.

Noting the issues to be resolved in terms of overall structure and responsibilities for fire, and the need for the Fire Safety Policy to be updated, **limited assurance** has been determined in this area.

Management

That relevant staff have received appropriate training, appropriate resources are allocated and that an appropriate inspection regime is operated.

Local fire management practices were assessed via the two site visits undertaken in September 2020; and from the review of key documents.

Good practice was noted in a number of areas:

- Recognising that responsibility for training had only recently returned to Estates (July 2020), the Fire Safety Advisers had developed both a training needs analysis and a robust training package for delivery of face-to-face training to site-based staff/fire wardens. Management advised that training had been delivered, via Teams (noting the current COVID restrictions), to a significant number of staff in the last few months, permitting fire safety training compliance rate to be reported as 92% for the year to date. However, see outstanding actions at the follow up (ref **Appendix B**);
- Local fire management folders have been issued by the Fire Safety Advisers to all departments/wards, incorporating robust evacuation procedures and proformas for the recording of local fire management activities;

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- Inspections and testing of key equipment (e.g. fire extinguishers, fire alarms) was in date at the time of the visit, with appropriate record keeping of routine checks observed;
- Significant risks such as compartmentation and fire doors are being managed via medium-term programmes of work across the THB:
  - compartmentation programme spanning five years, with an estimated total cost of £700k; and
  - fire doors programme, across six years, with circa £25k per year to be invested.
- The sites were in good order, with no obstructions or fire hazards noted.

However, the following issues were identified at the sampled sites:

- The fire plans displayed in the main entrance at Llandrindod Wells War Memorial Hospital were out of date (**recommendation 4**); and
- Fire management folders were not being completed by local staff (**recommendations 5 & 6**);

In addition, the following THB-wide issues were noted:

- The current fire warden listing was out of date, having been prepared in 2015 (**recommendation 7**); and
- Fire drills have not been undertaken as scheduled during 2020 (**recommendation 8**, and also **Appendix B**).

Whilst recognising that no significant issues were found during the site visits, and good progress has been made with training delivery, the issues surrounding fire drills and wardens are significant. **Limited assurance** has therefore been determined in this area.

Monitoring & Reporting

That the THB estate is appropriately monitored; and that there is appropriate record retention and dissemination of information through to the Executive team and Board.

It was confirmed that the THB was not subject to any Fire Service enforcement or advisory notices.

Unwanted Fire Signals were robustly monitored, with causation identified and actions taken to reduce repeat signals linked to the same problem.

Highlight reports prepared by the Fire Safety Manager have identified the common risks / themes from various sources of assurance across the THB, with reporting to the Fire Safety Group and Innovative Environment Group.

There are two annual fire safety submissions:

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- an annual fire safety report to the Executive Committee; and
- an annual audit submitted to NWSSP: SES. Whilst it is noted that the 2019 return was submitted substantially late, the 2020 return was submitted on time.

Appropriate arrangements for the monitoring of leased premises were observed, including the undertaking of fire risk assessments by the THB in some cases; and in others, the receipt of assessment information from the third party occupier.

The THB receives assurance and recommendations from key external sources such as the Fire & Rescue Service and NWSSP:SES. Whilst it does not currently operate a centralised means of monitoring the progress towards implementation of the recommendations made (as evidenced at other Health Boards), management consider and prioritise the recommendations made with high priority issues receiving sufficient profile and attention e.g. reporting to Fire Safety Group and a summary of themes arising in the monthly Estates Compliance Highlight Reports etc.

Noting the monitoring arrangements currently being applied at the THB, **reasonable assurance** has been determined in this area.

Risk Management

That the THB has performed a suitable and sufficient assessment of risks across its estate.

Fire risk assessments are required by the Regulatory Reform (Fire Safety) Order, which stipulates that they should be 'a *suitable and sufficient assessment of the risks'* and also '*assessments should be reviewed regularly so as to keep it up to date'*. The THB undertakes all site fire risk assessments on an annual basis. It was confirmed that all were up to date at the time of the audit.

The THB's fire risk has recently been escalated for inclusion in the Corporate Risk Register. Fire has a risk score of 15 - recognising the recent activity in areas of surveys and preventative maintenance, but noting the age of the estate and maintenance backlog, and work to be done in areas such as fire drills.

High priority risks were also seen to be escalated via the above mentioned Highlight Reports to the Innovative Environment Group.

Noting that risk assessments have been undertaken as required, and high priority issues receive sufficient focus through the governance structure, **reasonable assurance** has been determined in this area (refer also to Monitoring & Reporting above).

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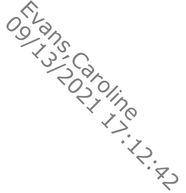
7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations raised	3	5	-	**8**
Actioned since fieldwork	-	1	-	**1**
Recommendations to address	3	4	-	**7**

Note: *Management agreement has been provided to all of the recommendations arising at this report. Noting the unprecedented times the THB is facing, reasonable timeframes have been set for the management actions.*



Finding 1: Governance arrangements	Risk
The assignment and operation of key fire safety roles and responsibilities within the THB lacked clarity at the time of the audit. A number of changes have taken place in the last two years, including: • Changes in the assignment of key fire safety roles (including Fire Safety Managers, site/locality responsible persons); and • Changes in responsibility for training delivery between the Workforce and Estates directorates. Further overarching changes in fire safety responsibility are now anticipated by the end of the financial year, with directorate responsibility moving from Planning & Performance to Workforce & Organisational Development. Lack of clarity / ownership of responsibility to date has impacted the delivery of key fire safety activities, such as the management of fire wardens and operation of fire drills (refer to **findings 4 & 5**). Whilst all THB staff have responsibility for Health & Safety embedded within their job descriptions, there was no evidence of a system for the individual formal assignment and acceptance of key fire roles to date. However, management has provide assurances that, following the forthcoming structural changes, new roles will be supported by documented terms of reference confirming individual's responsibilities. It was noted that concern over the lack of clarity of responsibilities was raised by the Mid & West Wales Fire & Rescue Service in their recent site inspection reports.	Lack of clarity and ownership of key roles and responsibilities risks the effective delivery of key fire safety activities. Potential risk of loss of life in the event of a fire. Non-compliance with regulations.

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Further, the THB's 'live' Fire Safety Policy was approved in August 2018, and does not reflect the current fire safety structures and responsibilities. There was no evidence of formal documentation/ approval of the current structure, roles and responsibilities. Further, the policy pre-dates the publication of the current Firecode guidance (Welsh Health Technical Memorandum 05-01) in February 2019. It is noted that these issues have been previously reported by NWSSP: Specialist Estates Services (SES), in their December 2019 report '*Independent Review of Fire Precautions at Newtown Hospital*.' To date, the recommendations raised remain to be actioned (refer to **finding 6**).	
Recommendations 1, 2 & 3	**Priority level**
1. 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 **(O)**.	**Medium**
2. 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 **(D)**.	**High**

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3. 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 **(O)**.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. Agreed. 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.	Assistant Director of Estates & Property January 2021
2. Agreed. 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.	Executive Director of Primary Care, Community & Mental Health Services January 2021
3. Agreed. Once the operational site structures have been finalised, a document will be issued to the relevant officers providing clarification on the role.	Executive Director of Primary Care, Community & Mental Health Services Fire Safety Advisers January 2021

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Finding 2: Fire Plans	Risk
Local fire management practices were assessed via site visits to Llandrindod Wells War Memorial Hospital and Llanidloes & District War Memorial Hospital (September 2020) The fire plans displayed in the main entrance at Llandrindod Wells Hospital were out of date (2015), and were not reflective of the recent changes made as part of the Phase 1 refurbishment project (which was handed over in February 2020). The Fire Safety Advisors provided assurance that the updated plans had been submitted to the local Fire & Rescue Service, and that the changes made during the refurbishment project did not significantly impact the zoning displayed on the plans. Management acknowledged the need for a clear project hand-over process between the Capital and Estates teams, to ensure site documentation is appropriately updated at the completion of a project.	Local fire plan information may not direct the Fire & Rescue Service to the correct areas in the event of a fire incident. Delayed responses risk increased damage to property and risk to life.
Recommendation 4	**Priority level**
The fire plans displayed at Llandrindod Wells War Memorial Hospital will be updated to reflect the recent site changes **(O)**.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The plans have now been finalised and are displayed next to the fire panel in the main entrance of the site.	Actioned since fieldwork

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Finding 3: Local Fire Management Folders	Risk
Local fire management folders, containing site and department-specific procedural information, have been provided to departments across the THB estate. The folders, prepared by the Fire Safety Advisers, were found to contain a comprehensive set of fire safety information, coupled with proformas for the recording of key information by local staff, including: • Key roles and responsibilities (including local fire wardens); • Weekly departmental check sheets (e.g. whether the fire alarm tests were heard in the department, whether escape routes have been kept clear); • Monthly departmental check sheets (e.g. observations on fire doors, evacuation aids, firefighting equipment); • Training status; and • Fire drill activity. The above procedures are designed to supplement the legislative testing and inspection of key fire safety systems by appointed contractors and/or internal Estates maintenance officers. Recognising that formal inspections are undertaken annually, and Fire Safety Adviser visits can only take place every few months, local staff are key to the effective monitoring and reporting of day-to-day fire safety matters. During the site visits, it was observed that some folders were not being completed by staff in the departments reviewed.	Non-compliance with local procedures risks the non-detection and escalation of issues impacting on fire safety.

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This may be a training issue, and it has been acknowledged that training responsibility has been passed back to the Fire Safety Advisers, future training will incorporate the use of these folders to improve compliance with required procedures. This issue also reflects the wider matter of clarity and commitment to responsibilities across the THB (refer to **finding 2**).	
Recommendations 5 & 6	**Priority level**
5. Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed **(O)**.	**Medium**
6. Sample checks should be made during Fire Safety Adviser site visits to ensure folders are being completed as required **(O)**.	**Medium**
Management Response	**Responsible Officer/ Deadline**
5. Agreed. The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	Fire Safety Advisers July 2021
6. Agreed. A checklist will be added to the folders for officers [either Fire Safety Advisers / Estates Officers / Responsible Persons] to provide a signature to confirm appropriate completion.	Fire Safety Advisers July 2021

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Finding 4: Fire Wardens	**Risk**
The central fire warden list maintained by the THB was dated 2015; therefore is significantly out of date in terms of staff turnover and departmental restructure. The Fire Safety Advisers confirmed that they are currently reviewing the list as part of their re-assigned responsibility for training delivery (noting that training can't be effectively delivered without up to date records of assigned roles). Whilst recognising the role of the Fire Safety Advisers, the responsibility for the allocation of a sufficient number of fire wardens rests with locality management.	Insufficient fire wardens risks a reduced response in the event of an evacuation, potentially risking loss of patient/staff lives.
Recommendation 7	**Priority level**
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 **(D).**	**High**
Management Response	**Responsible Officer/ Deadline**
Agreed. These roles will be allocated upon finalisation of the roles and responsibilities of the Senior Operational Managers (see recommendation 2)	Executive Director of Primary Care, Community & Mental Health (in consultation with the Senior Operational Managers – once defined) April 2021

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Finding 5: Fire Drills	Risk
We evidenced robust desk-top evacuation procedures, prepared as part of the site-specific fire safety manuals and distributed to each department via the local fire management folders. THB procedures require that: *"Fire drills should be organised by the hospital/department manager (responsible person) and should be undertaken to ensure all staff take part in at least one fire drill a year. Depending on the size and complexity of the building, the drills can include the whole building, part of the building or individual wards. This will ensure staff can become competent about evacuating their area."* Drill report forms should then be completed by the local responsible person, and sent to the Fire Safety Adviser for review. Fire drills have received focus at the Fire Safety Group in the last year, with concerns expressed regarding lack of clarity of responsibilities; and insufficient commitment from site management to ensure drills are undertaken as required. This has also been reported as an outstanding recommendation from prior audit reports (refer to **Appendix B**). The Mid & West Wales Fire & Rescue Service site inspection reports stated: *"Staff are unaware of who is responsible in taking the lead during an evacuation. This could cause a delay in ensuring the safety of persons."* It is acknowledged that a consolidated schedule of planned fire drills (2020 to 2022) has now been prepared by Estates. This plan was reported to the Fire Safety Group meeting in September 2020.	Uncertainty over what to do in the event of an evacuation risks loss of staff and patient life.

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Review of the schedule has noted it could provide greater clarity on the distinction between planned and actual fire drills, to enable accurate interpretation and reporting. Of the eight drills that had been scheduled during 2020 to the date of audit fieldwork (end of August), only two (25%) had been undertaken Whilst recognising the appropriate focus this issue has received to date, it is clear more work needs to be done to ensure the agreed procedures are embedded and drills are operated as required.	
Recommendation 8	**Priority level**
a) Site fire drills should be performed on an annual basis (as a minimum). b) Non-compliance with planned drills will be reported to the Fire Safety Group. c) The fire drill schedule will be enhanced to provide distinction between planned and actual fire drills. **(D)**.	**High**
Management Response	**Responsible Officer/ Deadline**
Agreed. The Assistant Director: Community Services Group has made a commitment that a fire drill will be performed at every site before the end of December.	Assistant Director: Community Services Group December 2020

Follow Up of previously agreed recommendations

Prior Ref	Recommendation	Status reported May 2020	Previous Responsibility & Timescale	Priority Rating	Current status as at September 2020
2	The proposed fire training needs assessment (TNA) should be reviewed by the Fire Safety Group and implemented accordingly.	**Partially implemented** Whilst there was evidence of training having been discussed at the Fire Safety Group, and training needs assessment developed, there was no evidence that it had been implemented accordingly. Management confirmed that the TNA will be reviewed and taken to the next Fire Safety Group meeting for approval on 10 September 2020. This review will incorporate learning from COVID-19 in respect of delivery of training.	Associate Director: Estates & Property September 2020	**Medium**	**Partially Implemented** The training needs assessment was reported to the September 2020 Fire Safety Group (24 September). Noting this meeting took place towards the close of audit fieldwork, there has not been sufficient time to evidence any subsequent implementation/ embedding of the contents of the TNA in the training programme currently being delivered. It is recognised that responsibility for training only passed back to Estates in July 2020, so this area is very much a work in progress. However, we have received assurance that Estates have already delivered Teams training to over 400 staff, with current face-to-face training compliance standing at over 90%. The TNA now needs to be fully embedded in the training programme, so robust assurance can be given that staff are receiving training as required.

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Prior Ref	Recommendation	Status reported May 2020	Previous Responsibility & Timescale	Priority Rating	Current status as at September 2020
3	Site fire drills should be performed on an, at least, annual basis.	**Outstanding** There was no evidence to confirm that site fire drills were being performed in an appropriate timely manner. Management advised this weakness was also raised through Fire Safety Inspections that had recently been undertaken [noting that the frequency of such had increased post Grenfell]. Management confirmed that the Fire Safety Advisors will work closely with the Operational managers on sites to support a programme of fire drills across the THB estate. The fire drill status will be documented and reported to the Fire Safety Group meeting on 10 September 2020.	Associate Director: Estates & Property September 2020	**Medium**	**Superseded** **Refer to recommendation 8** As discussed in more detail in the main body of the audit, fire drills are still not being undertaken as scheduled. However, the FSAs have worked with the operational managers to produce a schedule of planned fire drills across the next three years. It is recognised that the fire drill status was included on the agenda for the September 2020 FSG meeting. New recommendations have been made at this report to enhance the fire drill monitoring schedule and ensure compliance is accurately reported to the FSG.

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Appendix C: Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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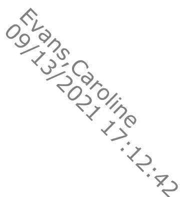
AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2021-22

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.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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					✓		
Welsh Health Circulars	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					✓			✓

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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