Audit, Risk & Assurance Committee

Tue 16 November 2021, 10:00 - 13:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_16Nov21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 14 September 2021 for approval

ARA_Item_1.3_Minutes_14 September 2021.pdf (10 pages)

1.4. Matters arising from previous meeting

1.5. Committee Action Log

ARA_Item_1.5_Action Log_16 November 2021.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

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

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Internal Audit Progress Report 2021-22

ARA_Item_3.1_PTHB AC A&A Progress Report November 21.pdf (11 pages)

3.2. Internal Audit Reviews:

3.2.1. Limited Assurance: a. Control of Contractors

ARA_Item_3.2a_PTHB Control of Contractors Final Report.pdf (28 pages)

3.2.2. Reasonable Assurance: b. Medical Equipment and Devices

ARA_Item_3.2b_PTHB 2122.11 - Medical Equipment Final Report.pdf (27 pages)

3.2.3. c. Midwifery Safeguarding Supervision

ARA_Item_3.2c_PTHB_2122_09 Midwifery Safeguarding Supervision Final Report.pdf (13 pages)

3.3. Risk Management Framework

ARA_Item_3.3_Risk Management_Nov21.pdf (4 pages)
ARA_Item_3.3a_Draft_PTHB_Risk_Management_Framework_Nov21.pdf (59 pages)

3.4. Audit Recommendation Tracking

ARA_Item_3.4_Audit Recommendations_November21.pdf (11 pages)
ARA_Item_3.4a_App D - IA Overdue.pdf (10 pages)
ARA_Item_3.4b_App E - IA Complete.pdf (7 pages)
ARA_Item_3.4c_App F - IA NYD.pdf (4 pages)
ARA_Item_3.4d_App G - EA Overdue.pdf (1 pages)
ARA_Item_3.4e_App H - EA Complete.pdf (1 pages)
ARA_Item_3.4f_App I - EA NYD.pdf (1 pages)
ARA_Item_3.4g_App J - LCFS NYD.pdf (1 pages)

3.5. Welsh Health Circular Tracking

ARA_Item_3.5_WHCs October 2021.pdf (3 pages)
ARA_Item_3.5a_WHCs Tracker - Appendix 1 - Outstanding.pdf (2 pages)
ARA_Item_3.5b_WHCs Tracker - Appendix 2 - Complete.pdf (2 pages)

3.6. Annual Governance Programme Reporting

ARA_Item_3.6_Annual Governance Programme_Q2_2021-22_CoverPaper.pdf (3 pages)
ARA_Item_3.6a_Annual Governance Programme_2021-22_Q2_Final.pdf (10 pages)

3.7. Audit Wales: Review of Quality Governance Arrangements

ARA_Item_3.7_2551A2021-22_Powys_Quality_Governance_Report_Eng.pdf (38 pages)

3.8. External Audit Progress Report 2021-22

ARA_Item_3.8_2001A2020-21 Audit Wales ARAC Update.pdf (10 pages)

3.9. Losses and Special Payments Report

ARA_Item_3.9_Losses and Special Payments Interim Report 2021-22 Final.pdf (9 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

4.1. External Audit Report: Picture of Public Services 2021

ARA_Item_4.1_POPS-2021-Eng.pdf (44 pages)

4.2. External Audit Report: Taking Care of the Carers?

ARA_Item_4.2a_Taking-Care-of-the-Carers-October-2021-English.pdf (29 pages)
ARA_Item_4.2b_Checklist_Taking-Care-of-the-Carers_eng.pdf (3 pages)

4.3. Committee Work Programme

ARA_Item_4.3_Committee Work Programme 2021-22.pdf (4 pages)

10:00 - 10:00
0 min

5. OTHER MATTERS

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

5.2. Any other urgent business

5.3. Date of next meeting: 20 January 2022 at 10:00, Microsoft Teams

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 16th NOVEMBER 2021
10.00 – 12.00
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 14 September 2021	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 14 September 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
3	**ITEMS FOR DISCUSSION**		
3.1	Internal Audit Progress Report 2021-22	Attached	Head of Internal Audit
3.2	Internal Audit Reviews: <u>Limited Assurance</u> a. Control of Contractors <u>Reasonable Assurance</u> b. Medical Equipment and Devices c. Midwifery Safeguarding Supervision	Attached	Head of Internal Audit Director of Planning and Performance
3.3	Risk Management Framework	Attached	Board Secretary
3.4	Audit Recommendation Tracking	Attached	Board Secretary
3.5	Welsh Health Circular Tracking	Attached	Board Secretary
3.6	Annual Governance Programme Reporting	Attached	Board Secretary
3.7	Audit Wales: Review of Quality Governance Arrangements	Attached	External Audit and Director of Nursing & Midwifery

3.8	External Audit Progress Report 2021-22	Attached	External Audit
3.9	Losses and Special Payments Report	Attached	Director of Finance and IT
4	**ITEMS FOR INFORMATION**		
4.1	External Audit Report: Picture of Public Services 2021	Attached	External Audit
4.2	External Audit Report: Taking Care of the Carers?	Attached	External Audit
4.3	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: • 20 January 2022 at 10:00, Microsoft Teams		

Key:

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

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

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

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

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 14 SEPTEMBER 2021 VIA MICROSOFT TEAMS MEETING

Present:

Mark Taylor	Independent Member – Capital and Estates (Committee Vice-Chair)
Mel Davies	Independent Member – Vice Chair
Rhobert Lewis	Independent Member
Ronnie Alexander	Independent Member

In Attendance:

Alison Butler	External Audit
Hayley Thomas	Director of Planning and Performance
Ian Virgil	Internal Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	Internal Audit
Pete Hopgood	Director of Finance and IT
Rani Mallison	Board Secretary
Sara Utley	External Audit
Sarah Pritchard	Head of Financial Services
Julie Rowles	Director of Workforce & OD and Support Services (present for item 3.5 only)

Committee Support

Caroline Evans	Head of Risk and Assurance

Apologies

Tony Thomas	Independent Member – Finance
Matthew Dorrance	Independent Member – Local Authority
Carol Shillabeer	Chief Executive

ARA/21/52	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting, and provided a formal welcome to Rhobert Lewis and Ronnie Alexander as new Committee members. It was confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/21/53	**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/21/54	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 12 July 2021 were RECEIVED and AGREED as being a true and accurate record, subject to the following addition: ARA/21/46 Mark Taylor suggested it would be appropriate that delay damages are included within all contracts by default, and that they are excluded if required, subject to expert advice. Carol Shillabeer concurred that there should be flexibility within the process to enable the inclusion or exclusion of delay damages, dependent on the best interests of the particular contract.
ARA/21/55	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/21/56	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/21/46: Action transferred to Delivery and Performance Committee ARA/21/42: Update included on agenda, item 3.5. Action complete. ARA/21/39: Action complete ARA/21/29: Update included on agenda, item 3.4b. Action complete. ARA/21/23: This will be scheduled for Q4, 2021/22 ARA/19/115e: Action transferred to Delivery and Performance Committee

ARA/21/57

APPLICATION FOR SINGLE TENDER WAIVERS (STWs)

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

Sarah Pritchard advised that there were two STW requests made between 1 June 2021 and 31 August 2021is as follows:

Request to waive QUOTE or TENDER threshold	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective
TENDER	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
TENDER	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

A question was raised in respect of future procurement of these services, and whether the default approach would be via the STW process, as well as how frequently STWs are used. Sarah Pritchard confirmed that we would always check the market before using a STW, with the process fully supported by Procurement. Comprehensive evidence is always provided to evidence why the organisation has selected one supplier, or if there is only one supplier available. Furthermore, procurement colleagues are currently developing a more compliant framework, which should remove the requirement for STWs in the future.

Rani Mallison added that procurement training for Board members is being arranged, which will provide a better understanding of the procurement process and the use of STWs.

The Committee RATIFIED the approval of the STWs.

ARA/21/58

UPDATED FINANCIAL CONTROL PROCEDURES (FCPs)

Pete Hopgood presented the previously circulated report, which seeks approval on the updated FCP Covid-19 Decision Making & Financial Governance (update number 7) and the Updated FCP Budgetary Control Procedure (update number 6).

Pete Hopgood advised that changes to the Covid-19 Financial Governance 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

Changes to the Budgetary Control Procedure include:

- 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

The Committee APPROVED the Covid-19 policy (Update#7) and Budgetary Control Procedure (Update#6) presented to Audit Committee.

ARA/21/59

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							
Covid-19 Prioritisation	2017/18 Number	2018/19 Number	2019/20 Number	Internal Audit Priority	2020/21 Number		TOTAL OUTSTANDING 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

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

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

Caroline Evans added that since the report was circulated, a further two audit recommendations have been closed, in respect of the Fire Safety internal audit undertaken in 2020/21, which means that the total outstanding internal audit recommendations is now 50, and that there are no Priority 1 or High priority audit recommendations outstanding.
Ian Virgil stated that it is encouraging that there are no remaining priority 1 recommendations outstanding, but added caution that 28 priority 2 / medium priority recommendations remain outstanding, for future consideration.
Melanie Davies acknowledged the position in respect of the pandemic, but added that focus should be directed towards implementing the outstanding recommendations from 2017/18 reviews, to ensure that work is actioned in a timely manner. Rani Mallison agreed this should be a priority, and also highlighted that Covid-19 and winter pressures may lead to a requirement to re-trigger the prioritisation of recommendations in the future.

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

ARA/21/60

INTERNAL AUDIT PROGRESS REPORT 2021-22

Ian Virgil presented the previously circulated report, which 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.
Ian Virgil advised that one audit has 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.
It has been agreed with the lead Executive that the Mortality audit review will be postponed from Q1 to Q4 due to impending changes in the processes around mortality reviews.

	It has been agreed with the lead Executive that the Post Covid-19 audit review will be postponed from Q2 to Q3 due to ongoing developments with the process and the availability of Health Board representatives. Ian Virgil advised a cognisance of the current pressures on the deliverability of the full internal audit plan, however, any changes to the plan will be discussed with Executives and reported to the Committee. The Committee RECEIVED and NOTED the Internal Audit Progress Report 2021-22.
ARA/21/61	**INTERNAL AUDIT REPORT: ACCESS TO SYSTEMS (REASONABLE ASSURANCE)** Ian Virgil presented the previously circulated report, which outlines the results of the review that was undertaken to assess the arrangements in place for the management and control of Access to Data and Systems. 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. Ian Virgil advised that the review identified three recommendations for improvement: one high priority; one medium priority; and, one low priority. A question arose in respect of monitoring progress of the business case. Pete Hopgood stated that liaison with Welsh Government is ongoing whilst awaiting approval of the funding to support the cross-border access to information. Securement of the funding is a key priority that is being closely monitored, and escalated if any issues arise. Rani Mallison added that progress of the work will be monitored by the Delivery and Performance Committee, and that the audit recommendations identified from this review will be monitored through this Committee as part of the audit recommendation tracking process. The Committee RECEIVED and NOTED the Internal Audit Report.
ARA/21/62	**EXTERNAL AUDIT PROGRESS REPORT 2021-22** Alison Butler provided 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). Alison Butler and Sara Utley advised that the following audit work is currently underway:

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

Area of work	Exec Lead	Focus of the work	Current status
Orthopaedic services – follow up	Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted
Quality Governance	Director of Nursing	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Report in Clearance, to be presented to Committee November 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 Committee in July Phase 2 - Fieldwork Underway, to be presented to Committee November 2021

The Committee RECEIVED and NOTED the External Audit update.

ARA/21/63

WELSH HEALTH SPECIALISED SERVICES COMMITTEE GOVERNANCE ARRANGEMENTS

a. AUDIT WALES REPORT

Sara Utley presented the previously circulated paper, which sets out the findings of the review, which considered 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.

Sara Utley advised that since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there

would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales.

b. MANAGEMENT RESPONSE

Hayley Thomas presented the previously circulated report, which presents the management response to the Audit Wales report WHSSC Committee Governance Arrangements.
Hayley Thomas advised that the report outlined 4 recommendations for WHSSC and 3 recommendations for Welsh Government.

A concern was raised in respect of the management response to recommendation 7, which relates to future governance and accountability arrangements for specialised services. The response states that a more national model may be appropriate, in response to a risk highlighted in respect of conflicts of interest. It was stated that knowledge and experience of this area is highly beneficial, and that experience may be lost if the decision-making body does not include health board members. In additional, what is meant by national focus? We need to ensure that our own representatives are not excluded in the future due to the small scale and size of Powys, and therefore would like to keep an eye on this.

Hayley Thomas stated that the governance and decision-making process was changed to address the conflict of interest identified, which recognised that the seven health boards across Wales, which form membership of WHSSC, might benefit from the decision-making process in relation to the delivery of tertiary and specialised services.
Powys has equal membership and voting rights comparted to the other members of WHSSC, however, it needs to be looked and closely and progress tracked against the matters raised within the report.

Melanie Davies added that the minutes from WHSSC Committee are reported through the Patient Experience, Quality and Safety Committee, so we are sighted on the decisions made.

Sara Utley stated that the recommendations made within the report are included within the hosting organisation's audit recommendation tracker, which enables their audit committee to monitor progress against those recommendations.

Hayley Thomas added that any developments to the NHS Executive function, as referred to in Andrew Goodall's letter attached to the report, will be shared with the Board as soon as they are available.

The Committee RECEIVED and NOTED the Welsh Health Specialised Services Committee Governance Arrangements update.

ARA/21/64	**POSITION STATEMENT ON THE PROGRESSION OF THE FIRE SAFETY IMPROVEMENTS** Julie Rowles presented the previously circulated report, which 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 constituted of eight Fire Safety Audit recommendations and two Follow Up audit recommendations. Julie Rowles advised that there are two medium-priority fire safety audit recommendations and one medium-priority follow up audit recommendation remaining in progress, with work on track to implement these outstanding recommendations by 30th September 2021. A question was raised as to whether more work could be undertaken in respect of fire drills, given the scattered nature of the estate. Julie Rowles responded that the paper specifically refers to Bronllys, where the annual fire drill has not yet been completed. However, during 2020 there were eight unwanted fire signals where a response was provided to each of those signals. Discussions are ongoing as to how we deploy the fire drills, and this will be monitored through the Fire Safety Group. Hayley Thomas added that there has been a whole organisational response to the fire safety arrangements, and that we have been working to develop the right model to deploy those arrangements, with staff appropriately trained. Ian Virgil stated that he is confident with the progress made. Independent assurance on the progress will be provided through a follow-up review of the audit towards the end of the year. Hayley Thomas stated that the Fire Safety Policy is going through Board for approval at the end of the month. The Committee RECEIVED and NOTED the Fire Safety Update.
ARA/21/65	**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/21/66	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Fire Safety Policy will be presented to Board for approval.
ARA/21/67	**ANY OTHER URGENT BUSINESS**

	There was no other urgent business for discussion. The Chair declared the meeting closed at 11.10 pm.
ARA/21/68	**DATE OF NEXT MEETING** 16 November 2021, 10:00 am, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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

Minute	Date	Action	Responsible	Progress	Status
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.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 16 November 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 September 2021 and 31 October 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 September 2021 and 31 October 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 September 2021 meeting which covered the period from 1 June 2021 to 31 August 2021.

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

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2122008	TENDER	Not included due to commercial sensitivities	Trade Waste Collection	Maintain service whilst formal tender process undertaken	01/09/2021	£88,528	12 Months	Prospective	A1
POW2122007	TENDER	Not included due to commercial sensitivities	Upgrade of Electrical Utilities Infrastructure to Llandrindod Wells Hospital	Sole Supplier of Utilities and owner of Transformer unit where Infrastructure requirement is being upgraded to enable additional power to the hospital	20/10/2021	£32,490	6 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.

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee November 2021

NWSSP Audit and Assurance Services

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

1. Introduction

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

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

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

2. Outcomes from Completed Audit Reviews

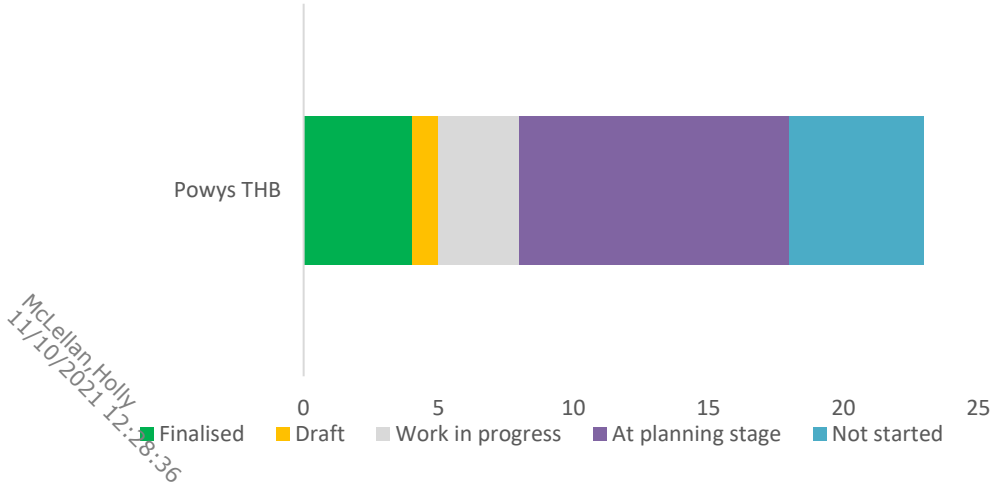
Since the September meeting of the Committee, three reviews have been finalised. Details of these are included in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Medical Equipment & Devices	Reasonable	
Midwifery – Safeguarding Supervision		
Control of Contractors	Limited	

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.



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

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

Progress with the delivery of the annual Internal Audit plan is currently behind the point expected at this stage of the year. This reflects the difficulties that have been experienced in agreeing the scopes for a number of audits and also progressing with fieldwork in some cases. It is acknowledged that these delays are primarily due to the pressures currently being faced by the Health Board. There have also been some delays as a result of the availability of Internal Audit resources.

At the current time it is anticipated that we will still be able to deliver the remainder of the annual plan. However, given the potential for further pressures and delays over the winter period, we have begun an exercise to identify those audits that are of a lower priority / risk or are less critical to the delivery of the annual opinion.

The table below identifies those audits that have been highlighted through this process so far. It is proposed that these audits will be initially rescheduled to the end of the 21/22 plan, but with the possibility that they could be deferred into 22/23 if required.

These have been identified following our review of the plan and discussion with Executives at an informal Executive Team meeting in October.

Audits Identified	Rational for rescheduling
Cancer Services	The Medical Director confirmed that the Mortality Reviews audit is the current priority. Cancer Services is viewed as a lower priority given the ongoing service changes and the fact that key issues are already known by the Health Board.
Looked After Children with Mental Ill Health	The Director of Nursing & Midwifery confirmed that the Concerns Tracking / Monitoring audit is the current priority. The Looked After Children audit would still be beneficial but would be appropriate to postpone.
Performance Management & Reporting	Ongoing update and implementation of the Health Board's performance reporting framework and the recent appointment of the new Assistant Director of Performance. Rescheduling would allow further time for the Framework to bed in before being audited.
North Powys Well-being Programme	The programme has already been subject to a number of recent reviews which will provide assurance to the Health Board. These include a Programme Assessment review by Welsh Government and a Finance audit by the Council.

The ongoing delivery of the plan will continue to be monitored and the updated position and / or any subsequent adjustments will be further discussed with the Executive Team

as required and reported to the Audit, Risk & Assurance Committee meeting in February 22.

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

- **Workforce Futures Framework**

  The Chief Executive and Executive Director of Workforce and OD have proposed that the focus of this audit be changed to a review of the Health Board's Occupational Health Service.

- **Estates Assurance Decarbonisation**

  This audit has been proposed for deferral to 22/23, reflecting the fact that the Health Board is not required to publish its Decarbonisation Action Plans until March 2022, and the timing of expenditure of the initial capital allocations provided by Welsh Government. As such, there will be more value in the audit if it is progressed from Q1 of 22/23 onwards.

  In order to ensure that appropriate coverage is maintained within the Internal Audit plan for 2021/22, it has been proposed that the Estates Assurance review for the current year will instead focus on Waste Management. This would also be in line with Estates Assurance coverage being provided at other UHBs/Trusts during 2021/22.

5. Engagement

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

Board / Sub Committees

- Board – 29 September
- Informal Executive Team – 13 October

Health Board Meetings

- Rani Mallison, Board Secretary – 08 November

Other Assurance Providers

- Audit Wales & Health Inspectorate Wales – 20 October

6. Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Note the outcome from the finalised 21/22 audits;
- Note the progress with delivery of the 21/22 plan and agree the proposals for the potential rescheduling / deferment of audits; and
- Agree the proposed changes to the 21/22 plan.

ASSIGNMENT STATUS SCHEDULE

Planned output	Outline Timing	Start of Field work	End of Field work	Draft Report Issued	Management Response Received	Final Report Issued	Assurance Rating	Planned Audit Committee	Status
Access to Systems	Q1	07/06	16/07	21/07	19/08	19/08	Reasonable	September	Final
Estates Assurance – Control of Contractors	Q2	05/07	05/08	12/08	20/10	21/10	Limited	November	Final
Midwifery – Safeguarding Supervision	Q2	21/07	18/10	27/10	04/11	05/11	Reasonable	November	Final
Medical Equipment & Devices	Q2	15/07	12/10	19/10	28/10	29/10	Reasonable	November	Final
Theatres Utilisation	Q2	13/07	03/11					November	Drafting Report
Dementia Service	Q2	23/08						November	Work in progress
Machynlleth (Bro Ddyfi Hospital)	Q2	13/09						January	Work in Progress
North Powys Well-being Programme	Q3							January	Planning
Breath Well Programme	Q3							January	Planning
Post Covid-19 Syndrome	~~Q2~~ Q3	04/10						January	Work in Progress
Looked after children with mental ill health	Q3							January	Planning
Job Matching & Evaluation Process	Q3							January	Brief agreed
Workforce Futures Framework	Q3							January	Planning
Financial Savings & Budgetary Control	Q3/4							March	Planning

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	Brief agreed
Risk Management & Assurance	Q4							June	Planning
Performance Management & Reporting	Q4							March	
Concerns Tracking/Monitoring Assurance	Q4							March	Draft brief produced
Cancer Services	Q4							March	
Mortality Reviews	~~Q2~~ Q4							March	Planning
Site Management (Advisory)	Q4							March	
Estates Assurance – Waste Management	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% 4 out of 4	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		50% 2 out of 4	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		100% 4 out of 4	80%	v>20%	10%<v<20%	v<10%

Assurance Ratings

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

Office details:

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

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

Control of Contractors
Final Internal Audit Report

October 2021

Powys Teaching Health Board

NWSSP Audit and Assurance

Contents

Review reference:	PTHB-2122-03
Report status:	Final
Fieldwork commencement:	5 July 2021
Fieldwork completion:	5 August 2021
Draft report issued:	12 August 2021
Draft report meeting:	17 August 2021
Management response received:	20 October 2021
Final report issued:	21 October 2021
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Hayley Thomas, Director of Planning & Performance
Distribution:	Wayne Tannahill, Associate Director of Estates & Property Geraint Davies, Head of Estates Louise Morris, Head of Capital Anthony Holt, Senior Health & Safety Officer Rani Mallison, Board Secretary
Committee:	Audit, Risk & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the terms of reference / audit brief, and the Audit Charter approved by the Audit Committee.

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

Executive Summary

Purpose

The audit was undertaken to evaluate the processes and procedures that support the management and control of contractors working for the THB, within Capital and Estates, and compliance with Health and Safety Executive (HSE) and other associated guidance and legislation.

Overview

We have issued limited assurance on this review and the significant matters which require management attention are:

- Limited evidence that contactor health and safety practices, competencies and accreditations had been verified by the THB.
- Robust practices developed by Estates were not replicated at the jobs managed by the Capital team.
- Absence of signing in / out systems operating, suspended as part of the Covid restrictions.
- Insufficient performance and compliance monitoring and reporting processes.

The absence of the above places the THB at risk of HSE action in the event of adverse incidents occurring on site.

Other recommendations have also been raised, relating to minor enhancements to existing processes (refer to **Appendix A**).

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary

Assurance objectives		Assurance
1	Governance	Reasonable
2	Appointment of Contractors	Limited
3	Management of work on site	Limited
4	Monitoring & Reporting	Limited

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

Key Matters Arising

		Assurance objective	Control Design or Operation	Recommendation Priority
2.1	Appointment – communication of rules	2	Operation	Medium
2.2	Appointment – health and safety checks	2	Operation	High
4.1	Management of work on site – Capital Team	3	Operation	High

5.1	Management of work on site - Signing in	3	Operation	High
5.2	Management of work on site – Visitor passes	3	Operation	Medium
6	Monitoring & reporting of contractor performance	3,4	Operation	High
7	Incident Recording	4	Operation	Medium

1. Introduction

1.1 The Control of Contractors audit was commissioned in order to evaluate the processes and procedures that support the management and control of contractors working for Powys Teaching Health Board (the THB). The audit forms part of the approved 2021/22 internal audit plan.

1.2 Both the THB and its appointed contractors have responsibilities under health and safety law, to ensure appropriate precautions are taken to reduce the risks of danger to patients, employees, visitors and contractors themselves. Applicable legislation includes Health and Safety at Work Act 1974, Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002 and the Control of Asbestos Regulations 2012, amongst others.

1.3 The Health and Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including "Managing Contractors" (HSG 159) and "Using Contractors- a Brief Guide". The audit will assess compliance with the requirements of this guidance.

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

- Patient, staff, contractor and public safety;
- Damage to THB property;
- Adverse publicity / reputational damage;
- Breach of HSE regulations and potential financial penalties; and
- Prosecution / criminal negligence.

1.5 This audit focused on the management of contractors within the responsibility of the Capital & Estates function only. The review did not therefore consider the management of other contractors such as IT or Medical Equipment, which may be considered at future audit plans.

1.6 Assessment of compliance with the Construction (Design and Management) (CDM) Regulations 2015 was also outside the scope of this current review.

1.7 Noting the impact of Covid 19, the delivery of this audit has included an increased element of remote working.

2. Detailed Audit Findings

Governance: To ensure the THB had adequate arrangements in place to support the control of contractors and compliance with regulations and guidance, including appropriate policy and procedural documents.

2.1 The THB had an approved Control of Contractors Policy in place, focused on the management of contractors within Capital and Estates. Recognising Covid priorities during 2020, the policy's review date expired in September 2020.

2.2 A new Management of Contractors Policy was in draft at the time of this review, prepared by the THB's Health and Safety team and with a THB-wide focus. The new policy was more comprehensive, however some minor enhancements to the detailed content have been recommended, with the policy also requiring further THB consultation and approval at the time of reporting (see **MA1**).

2.3 The THB has additionally developed comprehensive guidance for contractors, via the Health & Safety Contract Rules and Guidance document.

2.4 Whilst noting the new policy required further review before it can be finalised and approved, the THB's existing policy and procedural documents provided reasonable guidance to Capital and Estates staff and contractors. Accordingly, **reasonable assurance** has therefore been determined.

Appointment of Contractors: To ensure potential contractors had been appropriately checked to establish compliance with Health & Safety Executive (HSE) requirements and the THB's standards for health and safety.

2.5 The HSE 'Managing Contractors' guide states that "health and safety is a key criterion in the selection of contractors." The guidance sets out the key considerations to be made (including obtaining documentary evidence), when selecting a contractor. The THB's policy and procedures support the HSE requirements.

2.6 The audit assessed these requirements against a sample of twenty contractors appointed for minor 'estates' maintenance and repair jobs (i.e., those under £5,000), during 2020/2021. See **Appendix B** for a summary of audit findings.

2.7 The contractors included in the sample had long-standing relationships with the THB, were used on an ad-hoc basis and had not been subject to recent formal tender / re-contracting exercises. The procurement and contractual arrangements operated by the Estates function were previously assessed at the 2019/20 Financial Safeguarding audit, at which Management agreed that the absence of formal contracts would be addressed, with a target date of October 2020. Whilst progress has understandably been delayed noting Covid pressures, management confirmed that some key maintenance contracts had recently been formally tendered (post the date of the jobs reviewed at this audit). The contractual / letting arrangements applied were not in the scope of this current review but will be considered as part of future audit planning updates.

2.8 The audit identified the following issues

a. There was no evidence that the Health & Safety Contract Rules and Guidance had been issued to any of the contractors sampled (**MA2**);

b. Evidence was only available at 8 of the 20 (40%) jobs examined that contractor competency, accreditations or health and safety practices had been checked by the THB (**MA2**); and

c. A system was in place for the annual monitoring of contractor insurance cover, with evidence provided of current insurance at 17 of 20 (85%) jobs reviewed at this audit. However, three of the contractors used by the Capital team had not been included in this process (**MA4**).

2.9 Noting the limited evidence available that contractors had been assessed against the key HSE requirements (i.e. health and safety policy and practice, competency and industry accreditation etc.), **limited assurance** has been determined in this area.

Management of work on site: To ensure appropriate arrangements were in place to manage contractors working on THB premises.

2.10 The HSE has established clear guidance for managing contractors on site, including the requirement for all contractors to sign in/out, a clear site contact to be established, information and rules to be reinforced and job checks to be undertaken, before a job can commence. The THB had documented its requirements (aligned with the HSE requirements) for on-site contractor management within its Health & Safety Contract Rules and Guidance document.

2.11 The twenty minor estates maintenance and repair jobs examined were managed by a mix of the THB's Estates and Capital teams. From our review, the following issues were noted:

a. Induction: Induction training had been delivered at 15 of the 20 (75%) jobs, whilst recognising that the process had been adapted to address the restrictions imposed by Covid (**MA2&3**);

b. Contractor Job Form: The Contractor Job Form had been completed at 14 of the 20 (70%) jobs examined, demonstrating that key checks had been undertaken in these cases (including receipt of RAMs, competencies, induction, asbestos register & Permits to Work) (**MA2&3**);

c. There was inconsistency in the application of the THB's defined processes (particularly at the sampled jobs where members of the Capital team were assigned responsibility to manage jobs) i.e. the absence of a formal induction process, use of the Contractor Job Forms, evidence of checking of worker competencies and use of the Working at Height Permit to Work (**MA4**). This significantly reduced the audit trail available to confirm these four jobs had been managed in accordance with HSE / THB requirements;

d. In response to the Covid pandemic, management advised that visitor reception facilities (e.g. waiting areas/ signing in registers/ visitor badge logs) throughout the THB were suspended during the period under review. Contractors were therefore unable to sign in when arriving on site.

   In response, contractor activities were limited to essential work only, reducing the number of contractors required to be on site. The Contractor Job Form (as above) was also introduced as a compensatory control by the Estates team, ensuring contact was recorded between the Estates Officer and contractor when the job commenced. However, the requirements for track and trace etc. may have warranted increased contractor site visit controls.

   Whilst the introduction of the Contractor Job Form is acknowledged, it does not replicate the site-access controls provided by a signing in system (including site security, fire safety etc.). It is also noted that other NHS Wales organisations examined during this period have maintained visitor signing in processes (including for contractors) (**MA5**); and

e. Whilst management advise that Estates Officers routinely attended site to monitor contractor performance, there was minimal evidence (only seen at three of the 20 jobs (15%)) of the formal monitoring of contractor health and safety practices whilst on site (**MA6**).

2.12 Whilst recognising the robust controls developed, and consistency of application of the same, by the Estates team, the required controls had not been applied at those jobs managed by the Capital team. The maintenance of robust site access arrangements is also

essential. Noting the absence and inconsistency in applying the THB's key controls in this area, therefore, **limited assurance** has been determined.

Monitoring & Reporting: To ensure the ongoing monitoring and review of contractors and related incidents, to maintain the required standards of health and safety, and improve existing processes.

2.13 The THB's existing Control of Contractors policy sets out the requirement for the auditing of contractor health and safety performance, but does not define how this should be achieved. No THB audit process was in operation at the time of review, to provide assurance on compliance with policy and procedural requirements.

2.14 Noting the absence of formal contractor performance and compliance data, there was also no associated reporting in place of assurances in respect of the management of contractors, to senior management, executives, or the relevant Committee (**MA6**).

2.15 Management advised that minimal contractor-related incidents had occurred on THB premises in recent years, with those identified by management relating to capital projects. However, it is noted that some of these incidents had not been recorded on Datix (**MA7**).

2.16 Noting the absence of formal performance / compliance review mechanisms, to provide assurance on the management of contractors and compliance with procedures, **limited assurance** is determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy (Design)	**Impact**
The Health & Safety Executive (HSE) 'Managing Contractors' guide (HSG 159) defines having a policy as the number one step in successful health and safety management, with a policy being a clear statement of management's commitment to health and safety in the area of contractor management. The THB's current, published, Control of Contractors policy was last reviewed in 2015, and had been scheduled for next review in February 2020 - subsequently extended to September 2020. Recognising the prioritisation of the Covid response, this review was further delayed. At the time of the audit (July 2021), a new Management of Contractors policy had been drafted, and was undergoing consultation with key departments, including the Capital and Estates function. Whereas the current policy focused on the management of contractors only within the Estates department, the new draft policy has been prepared by the THB's Health & Safety team and provides more comprehensive guidance to all departments within the THB. Whilst recognising the generally comprehensive nature of the new policy (reflecting HSE guidance), and that the document was still being reviewed by the Capital & Estates function, it was noted it does not currently address the THB's contractor insurance requirements.	Potential risk that: • Changes to legislation and guidance may not be addressed by the THB's approved policy and approach. • Potentially inconsistent/ inappropriate processes applied due to dated guidance.
Recommendations	**Priority**
1.1a The new Management of Contractors policy should be finalised, approved and published as soon as possible. 1.1b The new Management of Contractors policy should specify the THB's minimum insurance requirements for contractors.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1a Agreed. The Policy was approved by the Executive Team on 22 September 2021. 1.1b Agreed. The Policy was updated as recommended prior to agreement by the Executive Team.	N/A	Closed - actioned since fieldwork.

<table>
<tr><th>Matter Arising 2: Appointment of Contractors (Operation)</th><th>Impact</th></tr>
<tr><td>
The HSE 'Managing Contractors' guide states that "health and safety is a key criterion in the selection of contractors." The guidance sets out the key considerations to be made (including obtaining documentary evidence) when selecting a contractor as including:

Experience in the specific area of work;
Health and safety policy and practice, including health and safety track record, use of sub-contractors; and
Training and competence (including industry memberships and accreditations).

The above criteria were reviewed for a sample of twenty Estates repair and service / maintenance jobs undertaken by the Capital and Estates function during 2020/2021. See Appendix B for a summary of audit findings.
The contractors included in the review had long-standing relationships with the THB, were used on an ad-hoc ongoing basis, and had not therefore been subject to recent formal tender exercises. The procurement and contractual arrangements operated by Estates were previously assessed at the 2019/20 Financial Safeguarding audit, with a recommendation made that formal contractual arrangements should be implemented for pre-planned maintenance areas. A target date of October 2020 was agreed, and whilst not formally reviewed at this audit, management advised that some of the larger maintenance arrangements, e.g. water safety, had recently been formally tendered (post the date of the jobs sampled for this audit).
The THB has developed a comprehensive procedural guide for contractors ('Health & Safety Contract Rules & Guidance'), setting out its requirements for contractors' health and safety practices. However, whilst an abbreviated pamphlet version was available at key locality offices for contractors to view in person, there was no evidence provided that the full version had been issued to the contractors sampled.
Noting the historical relationships in place, management advised they were assured of previous contractor experience (notwithstanding the issues noted at MA6 regarding formal monitoring of contractor performance). Evidence was only provided for 8/20 (40%) jobs reviewed to demonstrate that health and safety policy and practices, and industry competence / accreditations, had been recently checked.
</td><td>
Potential risk that:

Contractors may not be aware of the THB's required standards for health and safety practices.
Contractors may not have appropriate competencies and insurance cover to adequately protect the THB and patients/visitors.
Potential non-compliance with HSE requirements.

</td></tr>
</table>

The control of contractors was reviewed across six Health Boards during 2019/20, and it is recognised that Constructionline or Safety Schemes in Procurement (SSIP) had been utilised as a minimum requirement for appointment in some cases. It may be beneficial for the THB to widen the use of such services, where appropriate, to reduce the administrative burden to the THB of undertaking checks themselves.	
Recommendations	**Priority**
2.1 Contractors should be periodically reminded of the THB's H&S requirements, via issue of the H&S Contract Rules & Guidance.	**Medium**
2.2 Contractor competencies and H&S practices should be periodically rechecked, with formal records maintained to confirm when checks were last made and are next due for review, ensuring compliance with HSE requirements.	**High**
2.3 The benefits of using a standard contractor accreditation service should be considered (where appropriate, noting the size of the contractor appointed by the THB).	**Low**

Agreed Management Action	Target Date	Responsible Officer
2.1 The PTHB Contractor Health and Safety Guidance Booklet will be circulated to all current Estates Maintenance Contractors and a database will be created to record issue dates and frequency of issue.	December 2021	Associate Director of Estates & Property
2.2 There is an ongoing emphasis, as noted in the audit comments, for a formal series of 3 to 5 year maintenance contract appointments to be rolled out. This involves circa 30 separate contracts with progress delayed by the Estates team focus on the pandemic response. The appointment processes are more rigorous by virtue of the tender assessments, with health and safety performance and KPIs included as part of a formal annual review arrangement.	December 2021	Associate Director of Estates & Property

2.3 Formal contractor health and safety accreditation will be considered for inclusion in the maintenance contracts: the merits of each accreditation process will need to be assessed.	December 2021	Associate Director of Estates & Property

Matter Arising 3: Management of work on site – Pre-Commencement checks (Estates) (Operation)	**Impact**
The HSE 'Managing Contractors' guide advises: *"Contractors need to be told about the hazards they face when they come on site. Often an induction talk is the best way of passing this information on."* The THB's Control of Contractors Policy states (3.1): *"Contractors and their operatives will not be permitted to enter site unless they have received a detailed induction,"* and *"The Compliance & Maintenance Manager will check the competency skills levels."* The Estates department have implemented a central control process, via the Contractor Job Form, for ensuring the above are checked before a job can commence. The Contractor Job Form additionally confirms that other key pre-commencement checks have been made, including the Risk Assessment & Method Statement (RAMs), asbestos register, and use of a Permit to Work. Noting Covid restrictions during the period under review, the induction process was adapted to provide an electronic presentation, with written confirmation of understanding obtained from each of the contractors' employees. Audit findings in respect of pre-commencement checks undertaken at the sample of jobs managed by the Estates team (16 of the 20 reviewed) are detailed at **Appendix B**. In summary: • Inductions had been undertaken at 15/16 jobs (94%); • Worker competency checks were evidenced at 15/16 jobs (88%) *; and • The Contractor Job Form had been completed at 14/16 jobs (88%)*. ** Omissions did not all occur at the same jobs.* Whilst recognising the low-risk nature of the jobs where the omission in process was noted, management have acknowledged the benefit of incorporating such contractors into the wider control processes. Application of these controls at the sample of jobs managed by the Capital team are considered at **MA4.**	Potential risk that: • Contractors may not be fully aware of UHB's Health & Safety requirements. • Key checks may not be undertaken, exposing the contractor / THB to H&S risks if contractors do not perform safely.

Recommendations	Priority
3.1 The approach to monitoring "low risk" contractors should be reviewed to ensure periodic checks are still undertaken in the following areas: • Evidencing of worker competencies (as appropriate to the nature of work being undertaken); • Application of the induction process; and • Use of the Contractor Job Form to record checks undertaken (should a specific check not be considered necessary (e.g. at low risk jobs), the form should be annotated accordingly).	**Low**

Agreed Management Action	Target Date	Responsible Officer
3.1 Worker Competencies: these are checked in relation to high-risk activities and as directed by WHTMs for gas, electrical, medical gas, asbestos, etc. and in these instances, the competencies are assessed and recorded on an individual operative basis. There is no acknowledged formal competency for basic trades / low risk activity involving flooring, roofing, etc. Inductions were undertaken on 15 of the 16 jobs checked.	October 2021	Associate Director of Estates & Property

Matter Arising 4: Management of work on site – Pre-Commencement checks (Capital) (Operation)	**Impact**
A number of the controls / processes observed during the audit were developed by the Head of Estates, and had been applied consistently to the sample of jobs managed by the Estates team (16 of the 20); providing a clear audit trail of key checks undertaken in line with HSE and THB policy requirements. However, the same controls had not been applied to the four sampled jobs which were passed to the Capital team to manage (refs 17-20, **Appendix B**). This included: • Use of the central Administrative Team Contractor Database to ensure contractor insurance details were up to date; • Application of the induction process (which includes sharing of a presentation, and receipt of responses to confirm understanding of key points); • Use of the Contractor Job Form, to record that key checks had been undertaken prior to the job commencing (including receipt of the RAMs, worker competency checks, asbestos checks, etc); and • Use of the appropriate Permit to Work for 'high risk' work, i.e. working at height. Whilst recognising that the THB's 'H&S Contract Rules & Guidance' is not prescriptive as to which types of high-risk work require use of a permit, a permit for working at height had been developed by the Estates team, and applied at Estates-managed jobs. The requirement had also been factored into the new Management of Contractors policy, and is also detailed on the Contractor Job Forms. A central filing system was also not observed for these four jobs, meaning some key job-related documentation, such as RAMs, could only be located through review of the responsible officer's email system. At the time of reporting, some requested evidence had not been received. In the event of an adverse incident, the absence of appropriate documentation, would place the THB at a greater risk of actions / penalties by the HSE.	Potential risk of: • Insufficient audit trail of controls applied to demonstrate compliance with HSE requirements. • Potential inability to respond to future investigations if an incident occurs.

Recommendations	Priority
4.1a Management should review the controls applied to the 'estates' jobs managed by the Capital Team, and ensure best practice applied in the Estates team, including use of standard processes and proformas, is applied consistently across both teams for comparable / applicable works, to ensure compliance with HSE requirements. 4.1b Job-related documentation such as RAMs, communication with contractors etc. should be filed centrally in accessible folders.	**High**

Agreed Management Action	Target Date	Responsible Officer
4.1a Agreed. This audit was focussed on Estates activity and we acknowledge that a member of our Capital team did support some emergency/urgent works in relation to roof repairs and fire doors (team member's area of expertise) but did not follow the 'Estates' processes. Further training has been given for these occasional cross-over activities and it is the case that an incident could have arisen which would not have had the full and appropriate paper trail, albeit the contractors were familiar to the Capital team member and their health and safety competency was historically good. The acknowledgement of the robust nature of the core Estates team application of the appropriate checks, in all instances, is noted. Regarding Permits to Work; these are necessary and are enacted for designated high risk activities such as work on electrical switchgear, accessing medical gas pipelines, etc. There is no formal requirement for Working at Height permits, for instance, and these have been implemented, where possible, as a good practice measure. The risks are formally addressed in the RAMS in all cases and in a geographical footprint covering 25% of Wales and with a limited workforce, this good practice measure is not possible to apply in all instances. In light of the audit finding, we will review the approach to the viability of good practice measures if these are not implemented consistently.	September 2021	Associate Director of Estates & Property

4.1b Job related information is retained in the maintenance file – this finding relates to the small number of jobs undertaken by the Capital team member and further training has been provided.		

Matter Arising 5: Management of work on site – Site Access Controls (Operation)	**Impact**
The HSE 'Managing Contractors' guide specifies that "All contractors sign in and out," to ensure the THB knows who is working on its sites at any given time. THB procedures ('Health & Safety Contract Rules & Guidance' and the induction presentation) also require signing in, and the issue of visitor passes. Recognising the Covid restrictions in place during the period under review, Capital and Estates management advised that adjustments to wider THB procedures meant visitor signing in facilities were removed, including waiting areas and signing in registers. Contractors were therefore not able, or asked, to sign in and out at the local sites at which they were working. Further, the issuing of ID badges was not formally recorded during this time. Whilst specific Covid guidance for contractors was produced by the Head of Estates, it is noted this does not reference signing in/out arrangements. It is also noted that absence of formal on-site records may not have addressed Covid Track and Trace requirements - which may in fact have necessitated enhanced visitor controls. Management have not been able to evidence any formal advice / instruction received from senior management outside Estates on this matter. Audit testing (detailed at **Appendix B**) found evidence of signing in at only 1/20 (5%) jobs. There was also minimal evidence of the issue of visitor passes, seen at 5/20 (25%) jobs. As a compensating measure, to ensure appropriate contact remained in place between the contractors and Estates officers, the Contractor Job Form was introduced by the Head of Estates (see discussion at **MA3**) – completed at the central Estates offices (Bronllys or Newtown), prior to the contractor attending site. Management additionally advised that contact was increased with the local staff on site, e.g. senior nurse, to make arrangements for the work to take place, and agree e.g. start/finish times and any additional Covid measures which would apply, however evidence was not available to support these comments. Whilst recognising the strength of controls provided by use of the Contractor Job Form, it does not act as a signing in record, noting it does not record dates/ times in/out, all worker names or the issue of ID badges, and would only be completed once (so would not reflect if the contractor was on site for a number of days).	Potential risk that: • Fire Safety / Security / Track and Trace may not be adequately controlled if persons on site are not known to the local site managers.

Recommendations		Priority
5.1 Recognising the THB's current review of local site management responsibilities (in response to the 2020/21 Fire Safety audit), site access controls should be considered in tandem: to ensure all contractors sign in and out, in compliance with HSE requirements.		**High**
5.2 A written record should be maintained of the issue / return of visitor passes to contractors.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 Agreed. The testing period was largely during COVID-19 when alternative measures were put in place which were considered pragmatic and appropriate in the circumstances. In a business as usual situation, with a significantly geographically spread estate and with Estates presence on only limited sites, the signing in and out process will need local involvement and buy-in. Signing-in protocols at all Reception areas has been reinstated.	Immediate	Associate Director of Estates & Property
5.2 As above, with local management of passes.	Immediate	Associate Director of Estates & Property

Matter Arising 6: Monitoring & reporting of contractor performance (Operation)	**Impact**

HSE guidance (HSG 159, section 4) references the importance of keeping a check on how work is going, including keeping a record, against:
• *"The plan;*
• *Your agreement, including the job specification; and*
• *Agreed working methods, including any PTW or safety method statement,"*
and recognises that high risk work, including that using Permits to Work, will require increased monitoring.
HSG 159 (Section 5) also addresses the need for further review of performance on completion of the job:
• *"Review the job and contractor;*
  ○ *How effective was your planning?*
  ○ *How did the contractor perform?*
  ○ *How did the job go?*
• *Record the lessons."*
In support of these requirements, the THB's Control of Contractors Policy states (5.1):
"PTHB will monitor, by way of checks, inspections and audits, all contractors and their operatives' health and safety performance. This will be carried out by the Compliance & Maintenance Manager, Health & Safety Officers and members of the dedicated auditing team. Checklists will be provided to assist anyone in the monitoring process."
Audit findings in respect of monitoring of work being undertaken are included at **Appendix B**. Evidence of contractor monitoring was available at only three jobs (15%) (all managed by members of the Estates team). It was noted however that the proformas used to record observations varied, including a 'Work in Progress' form, "Retrospective Work Check" and 'Contract Monitoring Form.'
Management have acknowledged that, whilst they are confident that Estates Officers regularly monitor contractors working on site, the formal documentation of these checks should be improved.
	Potential risk of:
	• Failure to identify non-compliance with H&S / THB requirements.
	• Continued utilisation of under-performing contractors.
	• Inability to provide assurance to management / executives that appropriate contractor management controls are operating.

The THB's Health & Safety Officers also undertake ad hoc reviews of contractors working on site. Again, these are not typically documented, unless health and safety issues are identified - with evidence provided that emails have been issued to the relevant Estates Officer to report matters for resolution. It was also noted that there was no internal compliance audit process in operation. The control of contractors was reviewed across six Health Boards during 2019/20, and best practice observed included routine retrospective reviews of a sample of contractors / jobs, to ensure compliance with key requirements such as competency checks, inductions, signing in/out, RAMS, Permits to Work etc. Implementation of a more formal performance review process would enable management and executives to receive formal assurance as to the adequacy of controls operating in the management of contractors, improving scrutiny and accountability.	
Recommendations	**Priority**
6.1 The THB should apply their existing procedures to demonstrate compliance with HSE guidance in the following areas: a) Apply a consistent methodology for the monitoring of contractor working practices on site as defined in the Control of Contractors policy, and through retrospective compliance auditing, i.e. a percentage of jobs to be checked, the process for documentation of checks undertaken / observations made and recording of any follow up actions completed; b) Introduction of a formal contractor performance review, i.e. Key Performance Indicators to assess overall performance and assist future decision making; and c) Periodic reporting of the above to the relevant Executive / Committee.	**High**

Agreed Management Action	Target Date	Responsible Officer
6.1a Real time monitoring of Contractor performance in Powys is a logistical challenge. Audit and monitoring by definition, would not occur in 100% of cases. Audit identified checks being undertaken on 15% of jobs which exceeds what would be considered as industry good practice at circa 5%. We will apply the 5% rule going forward. 6.1b The new contracts being let on 3-5 year basis have KPI monitoring and annual reviews as a core requirement in relation to performance assessment. 6.1c Reporting of Contractor performance for Estates is reported via the Estates Compliance Group by exception with the group chaired by an Executive Director. Any matters of note or concern are escalated to the Innovative Environments Group which is chaired by CEO – any further escalations would be dictated by the group as required.	September 2021	Associate Director of Estates & Property

Matter Arising 7: Monitoring & Reporting – Incident Recording (Operation)		**Impact**
Management confirmed that only a small number of minor incidents involving contractors, had occurred in the last three years. The incidents referenced related primarily to capital projects (and therefore fell within the CDM Regulations to manage), and not Estates maintenance or repair work, as reviewed at this audit. It was noted however that only one contractor incident could be located on Datix for the period reviewed. Two other incidents (both of which were related to capital projects) were brought to the attention of Audit with the recognition they had not been logged onto Datix. It should be ensured that all incidents are captured on Datix in line with procedure, to facilitate comprehensive management monitoring.		Potential risk of: • Insufficient records to enable management review / reporting / lessons learnt.
Recommendations		**Priority**
7.1 All contractor-related incidents / accidents should be recorded on Datix, and appropriately coded to facilitate management review / reporting.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 Very little data on Datix systems reflects the status of incidents related to Estates contractor activity, with the incident we were aware of recorded appropriately on the system. We recognise the importance of formal incident recording on Datix / Once for Wales.	Immediate	Associate Director of Estates & Property

Appendix B: Audit Testing Results

		Appointment				Management of work on site							
Ref	**Job type**	**THB H&S standards conveyed**	**Competency & Experience assessment[1]**	**H&S Assessment**	**Insurance**	**RAMS**	**Induction**	**Worker competencies checked**	**Contractor Job Form**	**Signed in / out**	**Asbestos checked**	**Permit to work**	**Performance monitoring**
Managed by members of the Estates team													
1	Fire systems	N	N	N	Y	Y	Y	Y	Y	N	Y	-	N
2	Medical gas quality control	N	Y	Y	Y	N[2]	N	Y	N	N	Y	-	N
3	Construction work	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	N
4	Boiler maintenance	N	Y	Y	Y	Y	Y	Y	Y	N	Y	-	Y
5	Boiler maintenance – annual servicing	N	Y	Y	Y	Y	Y	Y	Y	N	Y	-	N
6	Electrical work	N	Y	Y	Y	Y	Y	Y	Y	N	Y	-	N
7	Nurse call system	N	N	N	Y	Y	Y	Y	Y	N	Y	-	N
8	Door repairs	N	N	N	Y	Y	Y	Y	Y	Y	Y	-	N
9	Water safety	N	N	N	Y	Y	Y[3]	Y	N	N	Y	-	N
10	Medical gas	N	Y	Y	Y	Y	Y	Y	Y	N	Y	-	N
11	Lifts	N	Y	Y	Y	Y	Y	N	Y	N	Y	-	N
12	Chimneys	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y
13	Refrigeration	N	N	N	Y	Y	Y	Y	Y	N	Y	-	N
14	Roofing	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y
15	Flooring	N	N	N	Y	Y	Y	N/A [4]	Y	N	Y	-	N
16	Roofing	N	N	N	Y	Y	Y	Y	Y	N	Y	-	N
Managed by members of the Capital team													
17	Construction work	N	Y	N	N	Y	N	N	N	N	Y	-	N
18	Roofing	N	N	N	N	Y	N	N	N	N	Not evidenced	N	N
19	Roofing	N	Y	Y	Y	Y	N	N	N	N	n/a post-2008 building	N	N
20	Fire doors	N	N	N	N	Y	N	Y	N	N	Not evidenced	-	N
Summary findings		**0/20**	**8/20**	**6/20**	**17/20**	**19/20**	**14/20**	**15/20**	**14/20**	**1/20**	**18/20**	**3/5**	**3/20**

Notes

[1] Whilst contractors had been used historically, and therefore the THB had experience of prior work undertaken, there was limited evidence that the contractor's competencies had been formally assessed.

[2] A RAMS was not deemed necessary by Management for this work, noting it did not involve any invasive work to the estate – only visual and other quality checks to gas quality.

[3] Evidence has been provided that the water safety contractor's workers have completed the induction process. However, the date of these inductions post-dates the job reviewed. Management advised that inductions were previously delivered, pre-Covid, but evidence was not available to support this.

[4] Management advised that worker competencies for low-risk jobs such as flooring would not be checked.

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

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

Medical Equipment and Devices

Final Internal Audit Report

October 2021

Powys Teaching Health Board

NWSSP Audit and Assurance Services

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

Review reference:	Review Reference: PTHB-2122-11
Report status:	Final Internal Audit Report
Fieldwork commencement:	15 July 2021
Fieldwork completion:	21 September 2021
Debrief meeting:	21 September 2021
Draft report issued:	28 September 2021 and 14 & 19 October 2021
Management response received:	28 October 2021
Final report issued:	29 October 2021
Auditors:	Ken Hughes, Audit Manager Jayne Gibbon, Audit Manager
Executive sign off:	Claire Madsen, Director of Therapies & Health Science
Distribution:	Lucie Cornish, Ass. Director of Therapies & Health Science Helen Kendrick, Medical Device & POCT Manager
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed terms of reference / audit brief, and the Audit Charter as approved by the Audit, Risk & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit & 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.

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place for the management of medical equipment & devices and point of care testing.

Overview

Our overall rating of Reasonable Assurance reflects the fact that a policy and procedures are in place, but improvements are required in a number of areas to ensure that controls are being consistently complied with.

The Key matters requiring management attention include:

- The inventory of medical devices and equipment which was incomplete.
- The preferred equipment list which was not being maintained and the lack of assurance that the procurement team were involved in the purchase of new equipment.
- Indemnity forms which were not always being completed for items of equipment loaned out to patients.
- Staff training which was not always being recorded on the ESR system.
- The lack of contract monitoring.
- The lack of documentation of Internal Quality Checks and compliance self-audits relating to POCT.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2017/18

Assurance summary[1]

Assurance objectives		Assurance
1	Policies and Procedures	Substantial
2	Preferred list of devices & equipment	Limited
3	Inventory Listing	Limited
4	Loaned devices and equipment	Limited
5	Cleaning & maintenance of equipment	Substantial
6	Decontamination of equipment	Reasonable
7	Storage of devices and equipment	Reasonable
8	Risk assessments	Reasonable
9	Incidents, defects & faults	Substantial
10	Staff training	Limited
11	Contract monitoring	Limited
12	Quality Assurance of POCT devices	Limited
13	Introduction of new POCT	Reasonable

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

Key Matters Arising		Assurance objective	Control Design or Operation	Recommendation Priority
1	Purchase of new equipment	2	Operation	High
2	Inventory record	3	Operation	High
3	Indemnity forms for loaned equipment	4	Operation	Medium
5	Recording of staff training	10	Operation	Medium
6	Contract monitoring	11	Design	Medium
7	Point of Care Testing	12	Operation	High

1. Introduction

1.1 The Medical Equipment & Devices and Point of Care Testing audit was completed in line with the 2021/22 Internal Audit Plan. The review sought to provide Powys Teaching Health Board ('the health board') with assurance that medical equipment & devices and point of care testing is managed appropriately.

1.2 The term medical device includes all products, excluding medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is wide and includes dressings, tubing, syringes, infusion pumps, heart valves, surgical instruments, resuscitators, radiotherapy machines, wheelchairs, walking frames or other assistive technology products.

1.3 POCT is defined as any diagnostic test undertaken by staff other than a laboratory healthcare scientist, usually carried out in the home, a clinic, in general practice, care home, high street pharmacy, screening venue, hospital or in transit. Examples of POCT devices include blood glucose and ketone devices, urinalysis test strips and devices, pregnancy test kits and devices, CRP devices, creatinine devices, lactate devices, haematology devices, blood gas analysers and cardiac test kits and analysers.

1.4 A systematic approach to the acquisition, deployment, maintenance (preventative maintenance and performance assurance), repair and disposal of medical devices and medical device training ensures that medical devices are used safely, competently, and effectively for the best care of patients and to comply with all relevant legislation and guidance.

1.5 The previous audit of this area was undertaken in May 2017. However, the audit was not completed as the initial findings were of significant concern. An audit debrief meeting was held with the Executive Lead to provide a detailed overview of the initial findings so that they could be appropriately escalated within the Health Board. It was subsequently agreed to defer the audit whilst the Health Board put in place corrective measures to mitigate the relevant risks. The interim report, which was advisory in nature, did not include an opinion rating but was presented to the Audit Committee.

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

- Responsibilities and processes described in the policies and procedures are not adhered to resulting in harm and possible death.
- Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

2. Detailed Audit Findings

Objective 1: The Health Board has appropriate policies and procedures in place for the management of Medical Equipment & Devices and staff are aware of their responsibilities.

2.1 The Health Board has a policy covering the management of medical devices and equipment. The policy, which had been approved by the Medical Devices Group in July 2021, had been recently updated to reflect role changes and process improvements.

2.2 The policy document was found to be comprehensive and up to date and included detailed roles and responsibilities for all relevant Health Board management and staff.

2.3 The policy had been made available to all staff on the Medical Devices pages of the PTHB intranet.

Conclusion:

2.4 There is an appropriate policy in place for the management of medical devices and equipment. We have provided substantial assurance against this objective.

Objective 2: The Health Board has a recommended list of medical equipment and devices in place that staff are able to order from. Orders placed should be in accordance with existing procurement guidance.

2.5 There was a 'Preferred Equipment' list in place that has been split into 23 categories, for example Audio & Ophthalmology, Beds and Mattresses, Syringes & Needles etc. The list is available on the 'Medical Devices' section of the PTHB intranet site, together with a list of NWSSP Procurement Department contacts.

2.6 The preferred equipment list includes a description of each item, model number, manufacturer and the cost code to use when placing an order. There is a standard Equipment and Devices Ordering Form (EDOF) that must be completed and approved prior to ordering new medical devices and equipment.

2.7 Testing was carried out on a sample of ten purchases made this year to ensure that new equipment purchased was on the preferred equipment list and had been purchased in accordance with the prescribed procedure. There was no evidence of a quotation being received for 2/10 purchases, and no evidence that items had been purchased through the procurement team for 6/10 purchases **(Matter Arising 1).**

2.8 In addition, 6/10 items were not on the preferred equipment list and there was no process in place to enable items to be added to or removed from the list **(Matter Arising 1).**

Conclusion:

2.9 Although there was a 'Preferred Equipment' list in place, it was not being kept relevant and up to date, and purchases were not always being made in accordance with procedures. We have provided limited assurance against this objective.

Objective 3: There is an inventory listing in place that accurately records the purchase and disposal of medical equipment and devices, with all equipment being disposed of appropriately.

2.10 All medical devices and equipment should be recorded on the e-Quip system which was purchased following our previous audit in 2017/18 to replace the inventory module of the Datix system.

2.11 The e-Quip system should record details such as the item description, location, the date each item was purchased, when it was last serviced or maintained, and whether the item is in use, on loan, decommissioned or has been disposed of. However, despite ongoing efforts the system has not yet been fully populated with all the Health Board's medical devices and equipment **(Matter Arising 2).**

Conclusion:

2.12 Having an accurate, up to date inventory listing is key to the effective management of the Health Board's medical devices and equipment. Until the system is fully populated the Health Board is exposed to a number of risks including harm to staff or patients

due to the use of unsuitable medical devices and equipment and the loss of items due to theft and misappropriation. We have provided limited assurance against this objective.

Objective 4: Appropriate records are maintained for medical equipment and devices that are loaned out by the Health Board.

2.13 The Policy for the Management of Medical Devices and Equipment requires all loaned out equipment to be fully documented. This includes to whom the item has been loaned and by whom, the date of loan and the make, model and serial number of the item. An indemnity form must also be completed. Items loaned out should be marked as such on the inventory listing, however this was incomplete at the time of our audit, so reliance was placed on local records.

2.14 Testing was undertaken at a sample of eight sites to ascertain whether medical devices and equipment was being loaned out and if so whether suitable local records were being maintained. For most sites visited no medical devices or equipment was being loaned out.

2.15 We were informed that where patients require the loan of equipment, for example walking sticks or zimmer frames, loans are arranged via NRS who have a contract with the Health Board for loan items. The only site to loan out medical devices to patients was the birthing centre at Llanidloes where a record was kept of all items loaned out. Items loaned out included Breast Pumps, Tens Machines and BP monitors. Whilst indemnity forms were completed for loaned out Breast Pumps, they were not being completed for Tens Machines or BP monitors **(Matter Arising 3)**.

Conclusion:

2.16 The failure to complete indemnity forms for medical devices and equipment loaned to patients could result in legal action being taken against the Health Board in the event that a patient suffers harm from a medical device or equipment on loan. We have provided limited assurance against this objective.

Objective 5: Medical equipment and devices are cleaned and maintained and kept in an appropriate state of repair.

2.17 Much of the medical equipment used is single use and disposed of after use. In line with the Management of Medical Devices & Equipment Policy, all re-usable medical devices must be effectively decontaminated prior to use in accordance with Health Board decontamination policies and procedures. We were informed that re-usable equipment and devices that did not require de-contamination were cleaned before and after use with Clinell anti-bacterial wipes in accordance with Health Board policy. There is a contract in place with Cwm Taf Morgannwg University Health Board (CTMUHB) for the decontamination of theatre and endoscopy equipment, and where this is required items are sent to Prince Charles Hospital, Merthyr.

2.18 The Management of Medical Devices & Equipment Policy requires all planned, preventative maintenance (PPM) to be carried out by technical staff and must follow the manufacturers' guidance. This may be through service contracts with the manufacturer or suitable third-party contractors. There are contracts in place with a

number of external providers for the planned preventative maintenance (PPM) of medical devices and equipment across the health board.

2.19 Although PPM was suspended during lockdowns, review of maintenance contracts for a sample of sites confirmed that this has recommenced and is getting back on track. The Medical Devices Risk Register includes a risk in relation to delays to annual planned preventative maintenance due to COVID. However, the June 2021 update states that PPM has recommenced across the Health Board by EBME (the main PPM contractor), and the company is currently ahead of the November completion target, and all other PPM providers are up to date with service inspections.

Conclusion:

2.20 There are suitable arrangements in place to ensure that medical equipment and devices are cleaned and maintained and kept in an appropriate state of repair. We have provided substantial assurance against this objective.

Objective 6: Medical equipment and devices are suitably decontaminated after each patient use.

2.21 The decontamination of devices and equipment is carried out at Prince Charles Hospital, Merthyr under an agreement (or contract) with CTMUHB. Enquiries were made at a sample of sites to ensure that staff were aware of the decontamination arrangements, and there were appropriate records being maintained of all decontaminated equipment.

2.22 We were informed that there is a defined decontamination process in place, and all decontaminated items are returned with a decontamination certificate. Discussions with staff at all sites visited confirmed that they were aware of the process to be followed if items required decontamination, but all sites stated that they did not have items that required decontamination. No detailed testing has therefore been undertaken of the decontamination process.

Conclusion:

2.23 There are suitable arrangements in place for the decontamination of medical devices and equipment. We have provided reasonable assurance against this objective.

Objective 7: Medical equipment and devices are stored in a safe and secure location when not in use.

2.24 The Management of Medical Devices and Equipment policy requires 'appropriate, safe and clean storage' for all medical devices and equipment which must be decontaminated prior to return to the central or shared storage area. The storage areas were reviewed at a sample of eight sites and checked for compliance with the policy.

2.25 Storage areas visited were dry, clean and secure and generally adequate at all sites visited with the exception of the Graham Davies ward at Llanidloes Hospital which did not have a secure storage area for medical equipment and devices. The storage area

was also shared with a number of other departments within the hospital **(Matter Arising 4).**

Conclusion:

2.26 It is acknowledged that the provision of suitable storage is the responsibility of individual wards and departments. However, if storage arrangements are not adequate, there is a risk that medical devices and equipment may be lost, stolen or may deteriorate. We have provided reasonable assurance against this objective.

Objective 8: Risk Assessments are completed on devices and equipment which may pose a significant risk to patients or staff.

2.27 The Medical Devices Group maintains a Medical Devices Risk Register which had four live risks at the end of June 2021, none of which related to risk assessments.

2.28 The requirement for risk assessments to be completed for any new medical devices or equipment had been suspended at the time of our review pending the introduction of an adapted risk assessment tool specifically for medical devices and equipment. However, this was delayed due to covid.

2.29 In June 2021 it was agreed that staff would use the standard Health & Safety Risk Assessment Tool when implementing new medical devices and equipment. We were therefore unable to undertake detailed testing of risk assessments.

Conclusion:

2.30 The completion of risk assessments for new medical devices and equipment had lapsed at the time of our audit so we were unable to undertake any detailed testing, although we were informed that risk assessments have now recommenced. We have provided reasonable assurance against this objective.

Objective 9: All adverse incidents, defects and faults relating to medical equipment and devices are recorded on Datix.

2.31 All incidents in respect of medical equipment and devices and point of care testing that result in harm to patients or staff must be recorded on the Datix system in accordance with Health Board policy. Where equipment breaks down or becomes faulty, the user must contact the maintenance service contractor as soon as possible to arrange a repair or for a substitute device to be provided. The faulty device must be labelled as 'Do Not Use' and stored separately and securely until it is repaired or disposed of.

2.32 We were provided with a list of all reported incidents for the current financial year to date which was obtained from the Datix system. There were just 2 POCT incidents recorded for the period 01.04.21 to the 15.06.21, and 15 medical device incidents reported for the period 01.04.21 to the 15.07.21.

2.33 These were a mixture of adverse incidents and defects / faulty equipment. Although we were able to confirm that adverse incidents, defects and faults are being recorded on Datix, we are unable to confirm that all incidents, defects and faults are being recorded. However there clearly is a process that enables staff to record and report adverse incidents relating to medical devices and equipment and POCT.

Conclusion:

2.34 Staff were able to record adverse incidents, defects and faults relating to medical devices and equipment on the Datix system, and there was evidence that this was being done. We have provided substantial assurance against this objective.

Objective 10: Staff receive appropriate training before using medical equipment and devices.

2.35 The Management of Medical Devices policy requires Directorate Leads, Community Service Managers, Lead Therapists and Professional Heads to ensure that staff are suitably trained and competent to use all medical devices and equipment they use, and to document evidence of training taking place which must be recorded on ESR.

2.36 The policy also requires manufacturer's instructions to accompany any new devices or equipment, and these must be scanned and made available to all staff electronically.

2.37 It was identified during testing that some training is recorded on ESR, for example mandatory training such as manual handling and training provided by external providers. Some training is also recorded on staff personal files but not on ESR, for example cascade training and training provided by equipment manufacturers or suppliers. Where this happens, although training was recorded on staff personal files there was no central departmental training record kept **(Matter Arising 5).**

2.38 All wards and departments visited kept manufacturer's instructions, either together in a box or file, or with the equipment. The updated Management of Medical Devices & Equipment Policy requires the Local Responsible Officer to create a digital copy of the manufacturer's instructions that must be stored electronically, but we saw no evidence of this **(Matter Arising 5).**

Conclusion:

2.39 There was no single record of all training received by staff in respect of medical devices and equipment, either on ESR or staff personal files, and no assurance that all training received by staff is actually being recorded. There was also no evidence that manufacturer's instructions were being scanned and made available to staff electronically. We have provided limited assurance against this objective.

Objective 11: For medical devices provided by a third party there is a clear process for contract monitoring.

2.40 The main contract for medical devices provided by a third party is the contract with NRS Healthcare for the provision of equipment such as disability aids and other equipment that is used in patients' homes on a loan basis. It is a joint contract with the Local Authority (Powys County Council). A contract performance report was prepared by NRS for 2020/21 and submitted to the Medical Devices Group in July 2021.

2.41 The NRS performance report covers both Powys County Council and PTHB and does not differentiate between the two organisations. Although the report included a large amount of data, no analysis of this data is undertaken and the report does not include any key performance indicators or comparative data, for example with previous years or similar organisations **(Matter Arising 6).**

2.42 No other contract monitoring information was provided to the Medical Devices Group (MDG) in the minutes reviewed. We were informed that no contract monitoring is undertaken for any of the contracts associated with medical devices and equipment,

some of which are significant, for example the PPM contract with EBME and the bed maintenance contract **(Matter Arising 6)**.

Conclusion:

2.43 The development of key performance indicators and robust contract monitoring arrangements is vital to ensure that poor performance is identified and corrected, and the Health Board receives value for money through its contracts. We have provided limited assurance against this objective.

Objective 12: There is a clear process in place for quality assurance of POCT devices in line with manufacturer's guidelines and National / Local policy.

2.44 Quality Assurance is a systematic process for verifying that a product or service is meeting specific requirements and includes:

- Internal Quality Control (ICQ)
- External Quality Assessment (EQA)
- Clinical audit
- Risk Management

2.45 The Welsh Government's policy on the management of POCT, What, When and How, requires that as a minimum, a Health Board's Quality Assurance processes should include undertaking Internal Quality Control (ICQ) and External Quality Assessment (EQA).

2.46 The Health Board's POCT Policy also requires POCT users to ensure Internal Quality Control checks are carried out and recorded, and independent contractors carry out EQA's and ensure that all users carry out and record ICQ checks.

2.47 Where devices and equipment used for POCT are owned by the Health Board, the POCT policy requires Internal Quality Control (ICQ) processes to be in place. This means that the results of POCT should fall within a pre-determined, acceptable range, and this should be checked and documented by the tester each time the device or equipment is used. Results that fall outside of the pre-determined range my suggest that there is a problem with the test process.

2.48 Testing was undertaken at a sample of eight wards and departments across three sites to determine whether ICQ processes were in place. At all sites visited, we were informed that POCT was only undertaken by suitably qualified and trained staff using only approved medical devices and equipment. The consensus was that staff undertaking POCT were aware of the range of tolerances for each device or piece of equipment, and results were assessed in relation to the tolerances but also the condition of the patient. The policy also requires each POCT device to have a Standard Operating Procedure (SOP). However, there were no SOP's in place at any of the sites visited **(Matter Arising 7).**

2.49 Should a test provide unusual results, we were informed that testing would be re-done using a different machine, or the results would be corroborated using different tests. The results of all tests are documented within each patient's notes. However the Health Board's Management of POCT Policy requires users of POCT devices to ensure that all ICQ checks are recorded and made available for review, but no such records were available at any of the sites visited **(Matter Arising 7).**

2.50 We note that the range of acceptable results for each medical device or piece of equipment had not been documented, although it is unclear from the policy if there is an expectation that this would be done. We were unable to carry out any detailed EQA testing.

2.51 Compliance audits previously undertaken by the Medical Devices Team were stopped towards the end of 2019/20 due to Covid. The updated Management of POCT Policy and Management of Medical Devices & Equipment Policy now require staff responsible for the management of medical devices and equipment and those carrying out POCT to monitor compliance with the policies by undertaking self-audits and submitting the results electronically to the Medical Devices Team. However, to date no self-audits have been undertaken by users. We note that the Management of POCT policy does not specify when or how often self-audits should be undertaken, and there is no link to the self-audit tool in the Management of Medical Devices & Equipment Policy **(Matter Arising 7).**

Conclusion:

2.52 There was a lack of documented evidence of compliance with ICQ / EQA processes as defined in the Management of POCT Policy at the sites visited. There were also no SOP's in place for any medical devices or equipment at any of the sites visited. In addition no POCT compliance audits have been undertaken anywhere within the HB since the end of 2019/20. We have provided limited assurance against this objective.

Objective 13: There is a clear governance process in place for the introduction of new POCT to the organisation.

2.53 The Health Board has a Point of Care Testing (POCT) Policy that was reviewed and updated in June 2021 by the Point of Care Testing Group. The POCT Group reports directly to the Health Board's Quality Governance Group.

2.54 The POCT Policy provides detailed guidance for the introduction of new POCT to the organisation. This includes a checklist for the implementation of a new POCT service and a Business Case template. The introduction of any new POCT service must also comply with the Welsh Government's policy on the management of POCT, 'What, When and How' that was issued in July 2017.

2.55 We were informed by the Medical Devices & POCT Manager that the department had not been approached for advice regarding the implementation of new POCT services within the current financial year. Therefore, there were no specific departments, wards or services that we could identify to test for compliance with the POCT policy for implementing new POCT services.

2.56 Enquiries were made during site visits to try and identify areas where new POCT services have recently been implemented, and to test accordingly for compliance with the policy. However, all sites visited confirmed that no new POCT had been introduced within the last few years.

Conclusion:

2.57 There is a clear governance process for the introduction of new POCT to the organisation, although we were unable to test for compliance with the process. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1 - Purchase of New Equipment (Operating effectiveness)	Impact
A list of purchases during the current year was obtained from the Equipment & Devices Order Form (EDOF) record. The corresponding EDOF forms and supporting documentation for a sample of 10 purchases were reviewed for completeness, authorisation and the involvement of NWSSP Procurement. The items were also cross referenced to the Preferred equipment list. Our testing identified the following issues: • Only 4/10 items were on the preferred equipment list. There is no defined process for adding items to or removing items from the preferred equipment list to ensure it remains relevant and up to date. • There was no evidence of NWSSP procurement team involvement for 6/10 items ordered, and no quotation was provided for 2/10 items ordered, so the Health Board may not be able to ensure / evidence value for money. • 2/10 forms had not been fully completed.	Inefficient use of financial resources due to purchase of unsuitable medical equipment or devices, or inappropriate procurement practices.
Recommendation	**Priority**
1.1) A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. 1.2) The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. 1.3) The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	**High**

Agreed Management Action	Target date	Responsible Officer
1.1) Management will ensure a review of the purpose of the Preferred Equipment List is undertaken. How it is maintained and kept current will be part of this review. Both Procurement and Finance support will be required for this review.	March 2022	Medical Device & POCT Manager
1.2) There is currently a section within the EDOF stating NWSSP Procurement must be involved. However, management will ensure this is strengthened by adding a specific field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not.	November 2021	Medical Device & POCT Manager
1.3) Management will ensure all EDOF's not fully completed will be returned to the requesting service for completion.	November 2022	Medical Device & POCT Manager

Matter Arising 2 - Inventory Records (Operating effectiveness)	**Impact**
Inventory reports for a random sample of 14 sites were obtained from the e-Quip system and reviewed to ascertain how many items had been recorded on the system for each location and how many of these items were still in use. Where recorded, the 'status' dates were also reviewed, together with the oldest and most recent last Planned Preventative Maintenance (PPM) dates, and the next PPM dates. Overall, the number of items recorded for each location ranged from none to 124 which clearly indicates that some sites inventory records are incomplete. The 'Status' and PPM dates would also suggest that the inventories are not currently up to date. Site visits were also undertaken to 8 of the 14 wards / departments for which e-Quip reports had been obtained. This confirmed that local inventory records are not being kept so there is a reliance on the E-Quip system to record all medical devices and equipment. However, staff were generally unsure whether their e-quip reports were complete or up to date. Maintenance schedules were also cross referenced to the corresponding e-Quip inventory records for a small sample of sites, and this identified some significant discrepancies between the records. For example, the maintenance schedule for district Nursing at Glan Irfon had a total of 143 items, but the corresponding e-Quip inventory only had 17 items, all of which were showing as having been de-commissioned. Whilst it is acknowledged that efforts have been ongoing for some time to get all medical devices and equipment recorded on the e-Quip system, progress to date has been slow with reliance placed on site-based staff to submit details of their inventories to the Medical Devices Manager for input to the e-Quip system.	Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.
Recommendation	**Priority**
Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include:	

• Using item data from maintenance schedules to populate the e-Quip system, then forwarding e-Quip Inventory records to each site for verification. • Nominated e-Quip 'champions' at each site with access to input data directly to the e-Quip system; • Undertaking site visits; • Sending out e-Quip inventory reports to each site on a half yearly basis for updating; and • Identify additional staff resources on a temporary basis to help populate the e-Quip system.	**High**

Agreed Management Action	**Target date**	**Responsible Officer**
e-Quip implementation timeframes have been extended to December 2021, from September 2021. Action has been taken in the form of escalation to ensure services engage in the implementation, which is essential to meet the desired outcome. Challenges in terms of capacity are being met but additional resource options are being explored in the form of temporary bank support, student roles and any areas with spare capacity. Should any of these options become available the implementation will gather pace.	December 2021	Medical Device & POCT Manager

Matter Arising 3 - Loaned Equipment (Operating effectiveness)	Impact
The Policy for the Management of Medical Devices and Equipment requires all loaned out equipment to be fully documented. This includes to whom the item has been loaned and by whom, the date of loan and the make, model and serial number of the item. An indemnity form must also be completed. The loaning out of equipment and devices should also be recorded on the inventory listing. However, the inventory listing is incomplete so reliance is placed on local records. Testing was undertaken at a sample of eight sites to ascertain whether medical devices and equipment was being loaned out and if so whether suitable records were being maintained. For most sites visited no medical devices or equipment was being loaned out directly to patients. The only site to loan out medical devices to patients was the birthing centre at Llanidloes where a local record was kept of all items loaned out. Items loaned out included Breast Pumps, Tens Machines and BP monitors. We were informed that indemnity forms were completed for the loan of Breast Pumps, but they were not being completed for the loan of Tens Machines or BP monitors.	Without an indemnity form signed by the patient, the Health Board may be held liable for any harm that may be caused to the patient by loaned out equipment.

Recommendation	Priority
All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	**Medium**

Agreed Management Action	Target date	Responsible Officer
All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service governance leads in the form of self-audits. Governance leads will provide assurance to the Medical Devices Group through "At a Glance Reports."	November 2021	Governance Leads

Matter Arising 4 - Storage of Medical Equipment Devices & Equipment (Operating effectiveness)	Impact	
The Management of Medical Devices and Equipment policy requires 'appropriate, safe and clean storage' for all medical devices and equipment which must be decontaminated prior to return to the central or shared storage area. The storage areas were reviewed at a sample of eight sites and checked for compliance with the policy. Storage areas visited were dry, clean and secure and generally adequate at all sites visited except the Graham Davies ward at Llanidloes Hospital which did not have a secure and dedicated storage area for medical equipment and devices.	Losses due to theft or misappropriation, or deterioration of equipment due to unsuitable storage conditions.	
Recommendation	**Priority**	
4.1) Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. 4.2) A general reminder should be issued to all sites within the Health Board of the requirement to ensure that all medical devices and equipment are stored in a safe, secure location when not in use.	**Low**	
Agreed Management Action	**Target date**	**Responsible Officer**
4.1) Storage will be reviewed at Graham Davies Ward and all options explored. Feedback back on this review will be provided through Medical Device Group "At A Glance Report." McLellan,Holly 11/10/2021 12:28:36	December 2021	Ward Manager – Graham Davies Ward/ Governance Lead Department Leads / Medical Device & POCT

4.2) A Storage Audit Tool has been in use and was developed with input from Internal Audit following the previous audit. The tool was previously used by Medical Devices Team to audit several sites and services across the health board, this highlighted some areas of good practice but also some areas in need of improvement. Service Leads were notified immediately of any areas of concern in the form of photographs and audit reports. This learning was also shared wider across the health board through various forums, for example, the Medical Devices Group and Capital Control Group. The tool has now been transferred into the format of Microsoft Forms and is embedded within the recently reviewed Policy. The Policy states service leads should be undertaking 6 monthly self-audits. Governance arrangements for this process will be the responsibility of the service group governance leads.	March 2022 March 2022	Manager/ Governance Leads Governance Leads

Matter Arising 5 - Staff Training (Operating effectiveness)	Impact
Health Board staff were asked about training during site visits to a sample of eight wards / departments within Llanidloes Hospital, Glan Irfon Community Health Centre (Builth Wells) and Bronllys Hospital. We were informed by staff at all locations that some training, for example manual handling that is part of some staff's mandatory training, is recorded on ESR. Generally, training provided by external contractors is also usually recorded on ESR. However, some training is provided by staff that have received the initial training (cascade training), or by manufacturers or suppliers of equipment, and where this happens the training is usually recorded on staff personal files, together with copies of certificates where provided, although some areas did not keep any local records. There is therefore no single record of all training received by individuals, either on ESR or staff personal files, and no assurance that all training received by staff is actually being recorded. All wards / departments visited kept manufacturer's instructions, either together in a box or file, or with the equipment. The updated Management of Medical Devices & Equipment Policy requires the Local Responsible Officer to create a digital copy of the manufacturer's instructions that must be stored electronically, but we saw no evidence of this.	Harm to staff or patients due to inappropriate use of medical equipment and devices. The Health Board may be unable to provide evidence that staff had been suitably trained in the use of medical devices or equipment in the event that a patient is harmed and a legal case is brought against the Health Board.
Recommendation	**Priority**
5.1) The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 5.2) The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	**Medium**

Agreed Management Action	Target date	Responsible Officer
5.1) Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group is scheduled for 8th November, this was delayed at the request of Clinical Education as waiting for new members of the team to commence into post. The aim of the group will be to pilot a process for a small number of devices. Once this is in the place, the same process will be rolled out for all devices and all staff groups.	March 2022 (for initial pilot)	Head of Clinical Education / Medical Device & POCT Manager
5.2) Management will ensure manufacturer's instructions are stored digitally via the Medical Devices Intranet page where applicable. Capacity to undertake this task is limited. Responsibility for this role and timeframe for completion to be identified.	To be confirmed	Medical Device & POCT Manager

Matter Arising 6 - Contract Monitoring (Control design)	Impact
The main contract for medical devices provided by a third party is the contract with NRS Healthcare for the provision of equipment such as disability aids and other equipment that is used in patient's homes on a loan basis. It is a joint contract with the Local Authority (Powys County Council). A contract performance report was received by the Health Board for 2020/21, and this was submitted to the Medical Devices Group in July 2021. The annual performance report, which is prepared by NRS, provides contract data for both Powys CC and Powys THB, but does not provide performance data solely for the Health Board. The report makes reference to performance indicators (PI's) but does not actually include any PI's. Discussions with the Medical Devices and POCT Manager confirmed that there are no PI's in place for this contract, and no contract monitoring is undertaken by the Health Board for this or any other contracts such as the Planned Maintenance Contract with EBME, or the Beds Maintenance Contract. At the time of our audit the annual value of maintenance contracts as recorded on the e-Quip system was in excess of £300k.	The Health Board and patients do not receive value for money or the services being paid for through contracts.
Recommendation	**Priority**
The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (kpi's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (PPM Contracts)	**Medium**

• Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	

Agreed Management Action	Target date	Responsible Officer
Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The renewal of the main maintenance contract (due 1st April 2022) provides an opportunity to significantly strengthen this area.	April 2022	Medical Device & POCT Manager
Standing agenda item will be added to the Medical Devices Group to review contract monitoring and KPI's.	January 2022	Medical Device & POCT Manager

Matter Arising 7 - Point of Care Testing (Operating effectiveness)	Impact
Both Welsh Government and Health Board POCT Policy requires staff undertaking POCT to ensure that Internal Quality Control (IQC) checks are carried out and recorded. Policy also requires independent contractors undertaking POCT to carry out and record External Quality Assessments (EQA's). It was identified during testing carried out at eight wards / departments across three sites that although POCT was being undertaken, no records were available for review. The updated Management of POCT Policy and Management of Medical Devices and Equipment Policy were approved in June 2021. These require staff responsible for the management of medical devices and equipment and those undertaking POCT to monitor compliance with the policies by undertaking self-audits and submitting the results electronically to the Medical Devices Team. However, to date no self-audits have been undertaken by users. We note that the Management of POCT policy does not specify when or how often self-audits should be undertaken, and there is no link to the self-audit tool within the Management of Medical Devices and Equipment Policy. In addition, there were no Standard Operating Procedures (SOP's) in place for any medical devices or equipment at any of the sites visited.	Harm to staff or patients due to inappropriate or incorrect use of medical equipment and devices.
Recommendation	**Priority**
7.1) Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy. 7.2) Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking	**High**

self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 7.3) A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.		
Agreed Management Action	**Target date**	**Responsible Officer**
7.1) Actions and improvements will be made through the POCT Group. Processes will be implemented for monitoring compliance and will be developed through the POCT Group in collaboration with service group Governance Leads.	March 2022	Governance Leads
7.2) The Management of POCT policy will be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form is already included in the Management of Medical Devices and Equipment Policy. Will be raised through POCT Group in relation compliance with policy.	November 2022	Medical Device & POCT Manager
7.3) All new POCT devices will have SOP's in place prior to implementation. The management, in conjunction with Governance Leads, will ensure all current Point of Care Testing Devices have SOP's in place and that they are regularly reviewed and updated accordingly. This work will be implemented through the POCT group.	December 2022	Governance Leads/Medical Device & POCT Manager (via POCT Group)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Midwifery – Safeguarding Supervision

Final Internal Audit Report

November 2021

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB-2122-09
Report status:	Final Internal Audit Report
Fieldwork commencement:	2nd August 2021
Fieldwork completion:	18th October 2021
Draft report issued:	27th October 2021
Management response received:	4th November 2021
Final report issued:	5th November 2021
Auditors:	Jayne Gibbon, Audit Manager Ian Virgil, Head of Internal Audit
Executive sign-off:	Alison Davies, Director of Nursing & Midwifery
Distribution:	Jayne Wheeler-Sexton, Assistant Director of Nursing Safeguarding Julie Richards, Head of Midwifery & Sexual Health
Committee:	Audit, Risk & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the Health Board for Midwifery – Safeguarding Supervision.

Overview

Our overall rating of Reasonable Assurance reflects the protocol and guidance that is in place and available to all staff. A number of areas requiring improvement were identified.

We identified two key matters requiring management attention:

- Compliance rates for safeguarding supervision are low, management need to ensure that the action plan is implemented.
- Enhancements are required to the safeguarding supervision data reported in the Safeguarding performance Report.

Other recommendations / advisory points are within the detail of the report.

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	Appropriate Safeguarding Supervision guidance	Substantial
2	Robust processes in place within the Midwifery service	Reasonable
3	Supervision sessions appropriately documented	Substantial
4	Monitoring and reporting arrangements	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Attendance at Safeguarding Supervision Sessions	2	Operation	Medium
2	Reporting of Compliance	4	Design	Medium

1. Introduction

1.1 The review of Midwifery – Safeguarding Supervision was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Health Board ('The Health Board').

1.2 The relevant Executive Director for the review is the Director of Nursing and Midwifery.

1.3 Healthcare professionals are required to assure their professional regulator, employer, service users and themselves that they are fit to practice safely and effectively by having up-to-date knowledge and clinical skills. Safeguarding supervision is one of the most important vehicles through which practitioners can gather evidence that they have achieved this.

1.4 Supervision is a term used to describe a formally agreed process of professional support and learning which enables practitioners to develop knowledge and competence.

1.5 The purpose of safeguarding supervision is to ensure that all staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults at risk.

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

- Non-compliance with applicable legislation, guidance and policy;
- A lack of training and development of staff to ensure effective working; and
- A duty of care to children and adults at risk not being implemented.

2. Detailed Audit Findings

Objective 1: There is appropriate Safeguarding Supervision guidance / policy in place and all relevant staff are aware of their responsibilities.

2.1 The Health Board has a Safeguarding Supervision Protocol in place which is available to all staff on the Safeguarding page on the Health Board's intranet.

2.2 The protocol document was found to be comprehensive and up to date and included responsibilities for all staff, information on different types of supervision and how to access.

2.3 There is a dedicated page for Safeguarding on the Health Board's intranet where advice on safeguarding issues can be accessed.

2.4 As a result of the Covid-19 pandemic in September 2020 a Safeguarding newsletter was introduced to provide staff with updates on safeguarding issues. The newsletter was well received and has now become a regular issue.

2.5 Feedback from a sample of midwifery staff contacted noted that staff are aware of requirements regarding attending safeguarding supervision sessions and the advice that is available on the Safeguarding page of the Intranet.

Conclusion:

2.6 There is appropriate guidance in place for Safeguarding Supervision. We have provided substantial assurance against this objective.

Objective 2: Robust processes are in place within Midwifery services to ensure that staff comply with safeguarding supervision requirements and appropriate supervision sessions are provided

2.7 Safeguarding Supervision sessions for midwifery staff are run jointly with health visiting staff, with the central Safeguarding Department scheduling the sessions. Once the sessions have been scheduled the information will be shared with all staff.

2.8 Responsibility for booking onto a session lies with the individual member of staff, if a session is not fully booked then reminder emails will be issued to request staff book a place.

2.9 Since the 1st April 2021 a 'Safeguarding Tracker' has been in place for Safeguarding Sessions attended. Whilst the tracker is maintained by the Corporate Safeguarding Team the Lead Midwife for Safeguarding is able to access and review the compliance of midwifery staff.

2.10 When midwifery staff fail to attend a safeguarding supervision session an email will be sent to their line manager to advise of the non attendance.

2.11 The service was aware that compliance for safeguarding supervision sessions had fallen during the Covid-19 pandemic. As a result of this a Safeguarding Women and Children Work Plan covering midwifery staff was drawn up to address the situation. **(Matter Arising 1)**

2.12 We undertook testing on a sample of midwifery staff to ascertain their safeguarding session compliance. Of the 20 staff selected we noted that 1 member of staff had not attended a safeguarding session at the time of the fieldwork. **(Matter Arising 1)**

Conclusion:

2.13 Whilst safeguarding supervision compliance rates fell during the pandemic, a work plan has been developed which, once implemented, should help to ensure that the rates improve. We have provided reasonable assurance against this objective.

Objective 3: Supervision sessions are appropriately documented and actions are taken to address any identified issues, concerns or staff training and development needs.

2.14 For each supervision session that takes place a document titled 'safeguarding group supervision agreement and record of supervision session' is completed by the Safeguarding Lead for the Session. The document records:

2.14.1 Attendee name and designation

2.14.2 Theme discussed at the session and main discussion points

2.14.3 Agreed actions, completion date and name of action lead.

2.15 A copy of the completed form will then be forwarded to the Corporate Safeguarding Team, all session participants and their line managers.

2.16 When required one to one sessions will take place for staff. They usually arise out of a concern for a specific case and will result in a safeguarding plan of care being drawn up and placed in the patient's case notes.

2.17 The 'supervision records' are reviewed by the Safeguarding Team to highlight any themes/trends. If any are identified then the Safeguarding Lead Midwife will meet with the relevant team to discuss the issue and agree appropriate actions. The theme would also be a discussion point for a future safeguarding session.

Conclusion:

2.18 We found that supervision sessions are appropriately documented. We have provided substantial assurance against this objective.

Objective 4: Appropriate arrangements are in place within the midwifery service for the monitoring and reporting of safeguarding supervision.

2.19 Safeguarding compliance will be reviewed and discussed at the Weekly Midwifery Management Team meeting when the agenda theme is governance.

2.20 At the above meeting the Midwifery aspect of the Women and Children Action plan will be reviewed.

2.21 An update on Midwifery Compliance for the specific month is also presented by the Lead Midwife for Safeguarding.

2.22 The service is represented at the Health Board's Safeguarding Strategic group by the Head of Midwifery and the Health Board's Operational Safeguarding group by Lead Midwife for Safeguarding.

2.23 The Head of Midwifery will provide updates to the Safeguarding Strategic Group on any safeguarding issues.

2.24 Midwifery Safeguarding Supervision Sessions Compliance is reported with the Safeguarding Performance Report that is produced by the Corporate Safeguarding

Team. The report is submitted to both the Safeguarding Strategic and Operational Safeguarding Groups quarterly.

2.25 We were provided with a copy of the 2020/21 Quarter 4 Performance Report. From our review of the report we confirmed that data concerning safeguarding sessions is reported. We also noted that midwifery compliance is reported jointly with health visiting staff resulting in us being unable to ascertain the actual level of compliance for midwifery services. **(Matter Arising 2)**

Conclusion:

2.26 There are processes within both Midwifery Services and Corporately for monitoring and reporting safeguarding supervision compliance however enhancements regarding the information reported Corporately are recommended. We have provided Reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Attendance at Safeguarding Supervision Sessions (Operating Effectiveness)	Impact
In accordance with the Safeguarding Supervision Protocol midwifery staff are expected to attend a Safeguarding Supervision session every 3 months. A random sample of midwifery staff was selected to ascertain compliance for the period 1st April 2021 to 30th September 2021. The following was noted from the testing: • Of the 20 staff selected 1 member of staff had not attended a supervision session during that period. As a result of the Covid pandemic, compliance levels for safeguarding supervision had reduced and this has been acknowledged and reported by the department as part of the compliance figures detailed in Matter Arising 2 below. As a result of this, a Safeguarding Women and Children Work Plan covering midwifery staff supervision was drawn up in December 20 to address the situation. At the time of review, the work plan had not been updated to confirm the status of the actions.	Failure of staff to attend sessions could lead to ineffective working and a failure of duty of care to patients.
Recommendations	**Priority**
1.1 Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 1.2 Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	Medium

Agreed Management Action		Target Date	Responsible Officer
1.1	a) Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months	11th Nov 2021	Julie Richards, Head of Midwifery and Sexual Health
	b) Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives	Nov 2021	Julie Richards Head of Midwifery and Sexual Health
	c) Requirements to attend Safeguarding supervision and available dates for Q3 are highlighted through the Midwifery Weekly brief that is shared to all Powys Midwives	Completed	Debbie Howells, Named Midwife for Safeguarding supervision
1.2	a) Safeguarding supervision compliance will be monitored through monthly Midwifery Management and Leadership Governance meeting and has been included into the Women and Children's Senior Leadership Performance Dashboard	December 2021	Julie Richards, Head of Midwifery and Sexual Health
	b) Women and Children's Safeguarding Work plan to be reviewed and updated to ensure improvements with compliance is effectively implemented	December 2021	Louise Turner, Assistant Director for Women and Children's services

Matter Arising 2: Reporting of Compliance (Control Design)	Impact
We note that Safeguarding Supervision Sessions compliance is reported as part of the Performance report that is considered at the Health Board's Safeguarding Strategic and Operation Safeguarding Group meetings. As part of our audit fieldwork we were provided with a copy of the 2020/21 Quarter 4 Performance Report. From our review of the report we made the following observations: • There is no separate compliance figure report for Midwifery Safeguarding compliance, it is reported as a joint figure with Health Visiting. • For the period 1st July 2020 to 28th February 2021 (which was reported in the Quarter 4 Safeguarding Performance Report that went to the July 21 Safeguarding Group) there were 78 midwifery and health visiting staff in post meaning there should have been 156 attendances. The actual number of attendances reported was 70 which is a compliance rate of 45%. • Due to the fact that midwifery and health visiting staff compliance is reported as one figure we are unable to identify the actual compliance rate for midwifery staff.	Health Board is not aware of the true compliance rate for midwifery staff.
Recommendations	**Priority**
2.1 Management should consider separating the safeguarding compliance information for midwifery and health visiting that is reported within the performance report. Separating out the two services will mean that issues regarding compliance specific to each service can be identified.	Medium
2.2 Management may also wish to consider enhancing the current reporting data by also reporting current compliance as a percentage and even setting a target percentage for compliance.	

Agreed Management Action	Target Date	Responsible Officer
2.1 and 2.2 We commenced separating all service groups in July 2021. This has enabled the corporate safeguarding team to produce individual compliance reports that clearly identifies each registrant's compliance and the overall percentage compliance for each service. The Quarter 2 Reports were distributed to the Heads of Service for the first time at the end of Q2 and will be reported at the next Strategic and Operational Safeguarding Groups. I accept that we should set targets.	2.1 and 2.2 completed	Jayne Wheeler-Sexton Assistant Director of Nursing Safeguarding

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services – NHS Wales Shared Services Partnership

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

AUDIT, RISK & ASSURANCE COMMITTEE	**Date of Meeting: 16 November 2021**
Subject:	**RISK MANAGEMENT FRAMEWORK, INCLUDING RISK APPETITE STATEMENT**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	Executive Committee, 3 November 2021

PURPOSE:

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with the Revised Risk Management Framework for comment ahead of presentation to the Board in November 2021.

RECOMMENDATION(S):

It is recommended that the Audit, Risk & Assurance Committee REVIEWS the Risk Management Framework included at **Appendix 1**, ensuring that it provides a true reflection of the organisation's risk management arrangements, ahead of presentation to the Board in November 2021.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

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

Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	

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

EXECUTIVE SUMMARY:

The Board is committed to using a systematic and holistic approach to risk management, and ensuring that effective risk management is an integral part of everyday management practices across the organisation.

BACKGROUND AND ASSESSMENT:

The Board approved its Risk Management Framework (RMF) in September 2019, which sets out the components that provide the foundation and organisational arrangements for supporting risk management processes across the organisation. The RMF identifies those individuals with responsibilities for the management of risk, and sets out the health board's key risk management structures and processes.

The RMF has been subject to review, to ensure it fully reflects current arrangements for risk management processes across the organisation. A Risk Management Toolkit has been developed, which provides guidance and templates to support services to actively manage their risks. The Toolkit is appended to the RMF, as Appendix B.

The revised RMF and supporting Toolkit will support a robust risk management culture across the health board, by setting out the approach and mechanisms by which the health board will: -

- Ensure that the principles, processes and procedures for risk management are consistent across the health board, and are fit for purpose;
- Ensure risks are identified and managed through robust risk management processes;
- Establish local risk reporting procedures to ensure an effective integrated risk management process across the health board's activities;
- Ensure strategic and operational decisions are informed by an

understanding of risks and their likely impact;
- Ensure risks to the delivery of the health board's strategic objectives are eliminated, transferred or proactively managed;
- Manage the clinical and non-clinical risks facing the health board in a co-ordinated way; and
- Ensure the Board and its Committees are suitably informed of the significant risks facing the health board, and the associated plans in place to treat those risks.

The RMF will help build and sustain an organisational culture that encourages appropriate risk taking, to continuously improve the quality of the services provided and commissioned by the health board.

Following review, the following changes are proposed within the Risk Management Framework:

Item Amended	**Page Number**	**Detail of Proposed Amendment**
Hierarchy of risk registers	9	Inclusion of Programme Risk Register
		Local and Project Risk escalation amended to specify that risks scored 9 and above are not automatically escalated, but are **to be considered** for escalation.
The Risk and Assurance Group	17	Level of risks considered by the Risk and Assurance Group revised from 9 to 12.
Risk Management Training	18	Training for all staff amended from *'Once only, as part of the induction process'* to *'Every 2 Years'*.
		Delivery of bespoke training delivered on a needs-based approach clarified and amended from *'Existing Staff/Services & Teams'* to *'Service Managers / Risk Owners'.*

The revised Risk Management Framework is attached to this report as **Appendix 1**. For ease of reference, updates to the previous version are included within the document in red font.

Risk Appetite Statement

The Risk Appetite Statement, included within the Risk Management Framework, sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a 'live' document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives or its capacity to manage risk are properly reflected. The Risk Appetite Statement is composed of two parts: a general written statement, supported by the cumulative risk appetite scores across the risk categories, in line with the Risk Management Framework.

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

The Risk Appetite Statement for 2019/20 was developed to reflect an increased appetite in relation to innovative and financial risks, which may be necessary to support achievement of the Board's ten-year strategy, 'A Healthy, Caring Powys'. In recognising the risks inherent in healthcare services, the proposed risk appetite statement starts at the basis of a low appetite. The Board's previous Statement stated that the Board had no appetite in a number of areas.

Following review, there are no changes suggested to the Risk Appetite Statement, previously approved by the Board in July 2019. However, it is recognised that given the impact of the pandemic, the Health Board will need to take informed decision making at the most appropriate time and so there may be circumstances where decisions are not made in-line with the Board's Risk Appetite.

NEXT STEPS:

Directorates, Risk and Assurance Group and Executive Committee will continue to monitor organisational risks, proposing risks for escalation to the CRR where appropriate, to ensure that the CRR articulates the strategic risks that are deemed to impact delivery of the organisation's strategic objectives as outlined in the Health Board's Annual Plan 2021/22.

RISK MANAGEMENT FRAMEWORK NOVEMBER 2021

Document Number:	CGP005	Classification	Corporate

Version No:	Approved by:	Date of Approval:	Date of Issue:	Review Date:
V3.0	Board			November 2022

Brief Summary of Document:	This document aims to set out the components that provide the foundation and organisational arrangements for supporting risk management processes in Powys Teaching Health Board.
Scope:	This framework applies to Board members; all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of services. Managers at all levels within the health board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the health board.
To be read in conjunction with:	• PTHB Assurance Principles • PTHB Strategic Commissioning Framework & Commissioning Assurance Framework • PTHB Health & Safety Policy and supporting documents
Owning Committee	Audit, Risk & Assurance Committee

Document Owner:	Board Secretary	Document Author:	Head of Risk & Assurance

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
2.2	2017 Version Updated to reflect changes in risk management arrangements and organisational realignment	September 2019
3.0	2019 Version Updated to reflect changes in risk management arrangements and organisational realignment	

Glossary of terms	
Term	**Definition**
Risk	The effect of uncertainty on objectives. An effect may be positive, negative, or a deviation from the expected. In addition, a risk is often described as an event; a change in circumstance; or, a consequence.
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks, with a view to increasing the probability of success and reducing the likelihood of failure.
Risk management framework	Set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation.
Risk assessment	A systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk treatment	The development, selection and implementation of risk treatment strategies and controls.
Risk appetite	The amount of risk that an organisation is willing to pursue or retain.
Risk tolerance	The organisation's readiness to bear a risk after risk treatment, in order to achieve its objectives.
Risk owner	The person with the authority and accountability to make the decision to treat, or not to treat the risk.
Strategic risks	Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder.
Operational risks	Risks that are by-products of the day-to-day running of the Health Board and include a broad spectrum of risks including clinical risk; financial risk (including fraud); legal risks (arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc. Operational risks are managed by the department or directorate which is responsible for delivering services.

CONTENTS

1. The Board's Statement

The Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal controls.

The Board is committed to having a risk management culture that underpins and supports the business of the health board; providing and securing high quality care in a safe environment; that is: complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the health board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's Appetite for Risk (see Risk Appetite Statement at Appendix A);
- Adopting an integrated and systemic approach to risk management that includes risks related to clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and appropriately managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses that is used for organisation-wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and
- Providing appropriate training to staff to ensure effective implementation of risk management arrangements.

2. Purpose of the Risk Management Framework

This document sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;

- that the wellbeing of patients, staff and visitors is optimised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

3. Scope of the Risk Management Framework

This Framework applies to Board members; all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of both clinical and non-clinical services.

Managers at all levels within the health board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the health board.

4. The Board's Appetite for Risk

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which the health board operates.

The Board has greatest appetite to pursue innovation, and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

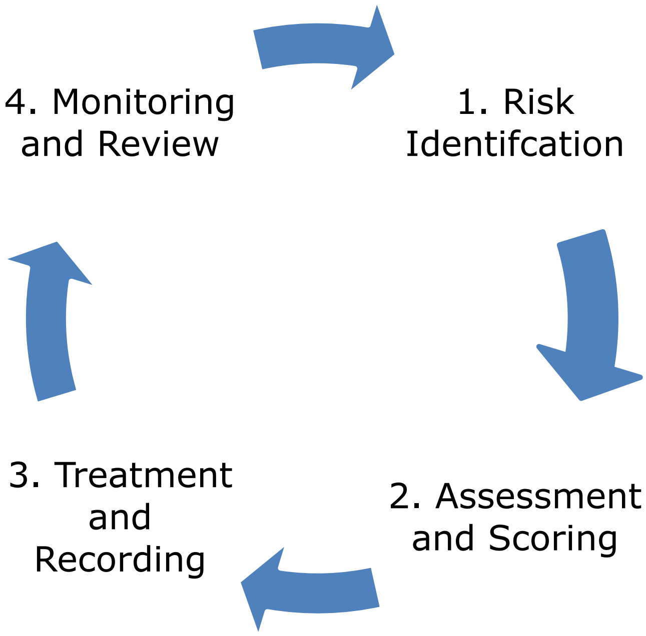
The Board's Risk Appetite Statement, which is included at Appendix A, sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives, or, its capacity to manage risk, are properly reflected.

5. The Risk Management Process

Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

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



1. Risk Identification

The health board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care.

2. Assessment and Scoring

Assessment and scoring of risk are used to determine the level of risk, using the health board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. Treatment and Recording

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a risk

register, which is a formal record of the risks that the health board has identified.

4. Monitoring and Review

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

The health board's detailed guidance in support of the risk management process is included in the risk management toolkit on the staff intranet and includes guidelines to Identify, Assess, Treat and Monitor risks.

6. Levels of Risk

The Risk Management Framework defines three levels of risk:

1. **Strategic Risks** – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.

2. **Operational Risks** – Risks that arise as a result of the day-to-day running of the health board and include a broad spectrum of risks comprising clinical risk (e.g. arising from incidents and complaints), financial risk (including fraud); legal risks (e.g. arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.

3. **Project Risks** – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

Powys Teaching Health Board is predominantly a commissioning organisation, buying services on behalf of the population from a wide range of providers including primary care contractors; independent sector care homes; ambulance services; district general hospitals; and, other specialist hospitals. The health board's **Commissioning Assurance Framework** helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients. Through this process, risks may be identified for recording in local or directorate risk registers or the Corporate Risk Register, dependent upon the level and type of risk. This approach would also apply to those risks identified through the health board's **Improving Performance Framework** for the services directly provided by the organisation.

The Health Board also contracts out for many non-clinical services such as construction, waste management, health courier services, hospital laundry and pest control. These services are managed through the Management of Contractors Policy, and procurement for PTHB is supported by NHS Shared Services.

7. Risk Recording and Escalation

A risk register is a management tool that provides a comprehensive and dynamic understanding of an organisation's risk profile. Effectively used, a risk register will not only drive risk management but should be used to inform decision-making processes. Risk registers are also used to provide assurance that risks are being managed appropriately and effectively.

Recording of Strategic Risk

Strategic risks are recorded in the Board's Corporate Risk Register. The Corporate Risk Register provides an organisational-wide summary of significant risks that have been in the main escalated from Directorate Risk Registers. The criteria for a risk to be included in the Corporate Risk register is:

- The risk must represent an issue that has the potential to hinder achievement of one or more of the health board's strategic objectives;
- The risk cannot be addressed at directorate level;
- Further control measures are needed to reduce or eliminate the risk;
- A considerable input of resource is needed to treat the risk (finance, people, time, etc).

The risks contained in the Corporate Risk Register are aligned to the Board Assurance Framework. The Board Assurance Framework provides a structure and process that enables the health board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic and annual objectives. It ensures that the assurance mechanisms operating across the health board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives. Further detail on the Board Assurance Framework is provided in the **Assurance Principles Document**.

The Corporate Risk register and Board Assurance Framework are reviewed by the Executive Committee in advance of presentation to the Board at each of its meetings.

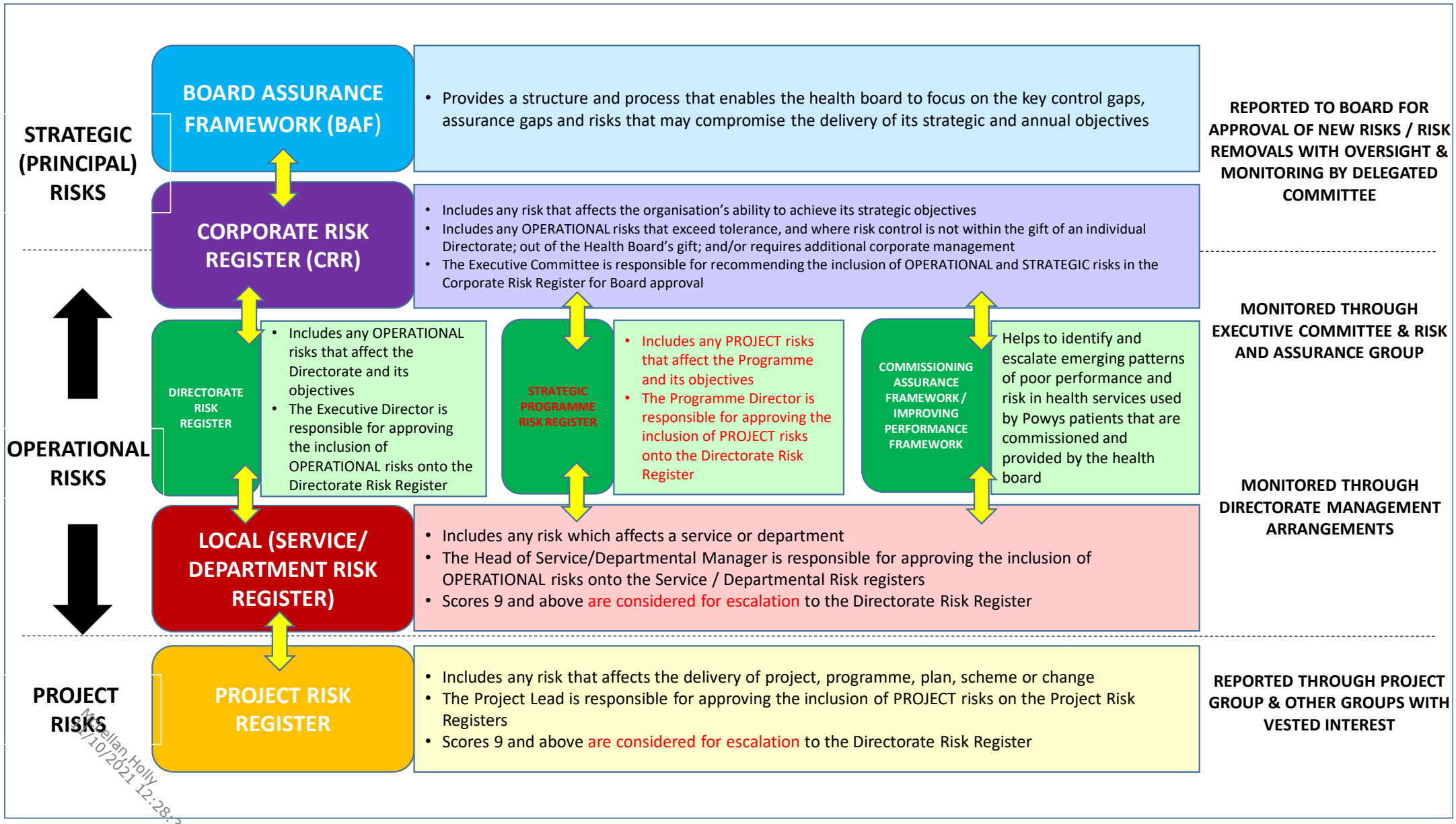
Recording of Operational Risk

Operational risks, including health and safety risks, where they cannot be immediately addressed, are managed by the department or directorate that is responsible for delivering services, and are captured in local risk registers. If risks cannot be managed to a level that is acceptable at a local level, they are escalated to the relevant Directorate Risk Register. Each Directorate will maintain a comprehensive Directorate Risk Register, which will be informed by relevant local Risk Registers, and is formally reviewed at an appropriate Directorate meeting.

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

any risks that should be considered for inclusion in the Corporate Risk Register.

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



8. Accountabilities and Responsibilities

8.1 The Board

The Board (Executive Directors and Independent Members) have collective responsibility for the setting and ensuring delivery of strategic objectives. Key strategic risks are identified and monitored by the Board. The BAF and CRR provide a central record of risks to the delivery of its strategic objectives. It is the duty of the Board to discuss and advise on the format and content of the BAF. It is also the duty of the Board to appropriately monitor Powys THB's significant risks, associated controls and assurances.

The Board is also responsible for ensuring that the health board consistently follows the principles of good governance; ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driving the delivery of the health board's strategic objectives. This is the meaning of 'assurance' and is a fundamental principle of good management and accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk.

In the context of this Framework the Board will:

- demonstrate its continuing commitment to risk management through the endorsement of this Framework;
- ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
- take a lead role in 'horizon scanning' for emerging threats/risks to the delivery of the health board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
- oversee and participate in the risk assurance process;
- ensure communication with partner organisations on problems of mutual concern including risks;
- ensure that appropriate structures are in place to implement effective risk management;
- commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
- ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data; and
- receive reports from the committees of the Board in line with terms of reference and workplans of those committees.

The Terms of Reference for the Committees that report to the Board are included on the health board's website:
https://pthb.nhs.wales/about-us/the-board/committees-partnerships-and-advisory-groups/powys-teaching-health-board-committees/committee-meeting-calendar/

8.2 Individual Responsibilities

All members of staff, and those working on behalf of the health board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework.

The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

Chief Executive Officer (CEO)

The CEO is the Accountable Officer of the health board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance. The CEO has overall accountability and responsibility for:

- ensuring the health board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the health board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Board Secretary

The Board Secretary is the delegated lead for risk management in the health board, and is accountable for leading on the design, development and implementation of the integrated Board Assurance Framework and Risk Management Framework. The Board Secretary will:

- lead the embedding of an effective risk management culture throughout the health board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a health board basis;
- lead the development of, and Chair, the Risk and Assurance Group (established by the Executive Committee);
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Corporate and Directorate level risk registers;

- develop and oversee the effective execution of the health board's Assurance Framework;
- develop and implement the health board's Risk Management Framework; and
- produce the health board's Annual Governance Statement.

Head of Risk and Assurance

The Head of Risk and Assurance is accountable to the Board Secretary, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the health board, which link to the health board's Assurance Framework;
- support the management and development of the health board's Assurance Framework and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Corporate Risk Register and Board Assurance Framework, for Executive Committee and Board;
- support the development and functioning of the Risk and Assurance Group; and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the Assurance Framework of the organisation.

Executive Directors

Executive Directors are accountable and responsible for ensuring that their respective directorates are implementing this Framework, and related policies/procedures. Each Director is accountable for the delivery of their particular area of responsibility, and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives.

Specifically, they will:

- lead the embedding of an effective risk management culture throughout the health board;
- communicate to their directorate, the Board's strategic objectives; and, ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;
- co-ordinate the risk management processes which include: risk assessments; incident reporting; the investigation of incidents/near misses; and, the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;

- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, **Clinical Executive Directors** (Medical Director, Director of Nursing & Midwifery, Director of Therapies & Health Sciences, and the Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

Independent Members

Independent Members have an important role in risk management. This role is restricted to seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to Executive Directors and senior management. The role of Independent Members is not to manage individual risks, but to understand and question risk on an informed and ongoing basis.

Additionally, Independent Members chair Board level committees, and in line with the relevant committee Terms of Reference, should provide assurance to the Board that risks within its remit (determined by the CRR and BAF), are being managed effectively by the risk owners, and report any areas of concern to the Board.

Clinical Directors, Assistant Directors and Heads of Service

Clinical Directors, Assistant Directors and Heads of Service are responsible for implementation of the Risk Management Framework and relevant policies and procedures, which support the health board's risk management approach.

As Senior Managers of the organisation, Clinical Directors, Assistant Directors and Heads of Service take the lead on risk management, and set an example through visible leadership of their staff. These responsibilities include:

- Taking responsibility for managing risk;
- Ensuring that risks are assessed where they are:
  - Identified within the working activities carried out within their management control;
  - Identified within the environment within their control;
  - Reported from the staff within their management control.
- Identifying and managing risks that cut across delivery areas;
- Ensuring all incidents/accidents and near misses are reported;
- Monitoring mitigating actions and ensuring action owners are clear about

their roles, and what they need to achieve;
- Discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach;
- Ensuring risks are updated regularly and acted upon;
- Communicating downwards what the health board's strategic risks are;
- Using the risk management process to support prioritisation and decision making;
- Ensuring staff are suitably trained in risk management;
- Promoting a risk aware culture in which staff are encouraged to identify and escalate risk;
- Ensuring that risk management is included in appraisals and development plans where appropriate;
- Ensuring the adoption and operation of the risk management framework across their work area.

Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility, and must be supported and enabled to manage these risks within a structured risk management framework. Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this Framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the health board's approach to risk management and governance. They will support the application of this Framework and its related processes, and participate in the monitoring and auditing process.

All Staff

All staff will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety, and all others that may be affected by the health board's business;
- report all incidents/accidents and near misses;
- comply with the health board's incident and near miss reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work, and the notification to their line manager of any perceived risk that may not have been assessed; and
- be aware of the health board's Risk Management Framework and processes, and the local strategy and procedures, and comply with them.

Contractors employed by the health board e.g. capital and estates specialists

It is the responsibility of each contractor employed by the health board to ensure that any staff working on their behalf is fully conversant with the risk management requirements for the activity for which they are engaged.

8.3 Internal Audit

The relationship between risk management and Internal Audit is critically important. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;
b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;
c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;
d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

8.4 Local Counter Fraud Services

The health board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The health board's Annual Counter Fraud Work Plan, as agreed by the Audit, Risk and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit, Risk and Assurance Committee as appropriate.

The LCFS works with the Chief Executive, Executive Directors and Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the health board's escalation process.

8.5 Committee Duties & Responsibilities

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Audit, Risk and Assurance Committee
The Audit, Risk and Assurance Committee is responsible for overseeing risk management processes across the organisation, and will have a particular focus on seeking assurance that effective systems are in place to manage risk; that the organisation has an effective framework of internal controls to address strategic (principal) risks (those likely to directly impact on achieving strategic objectives); and, that the effectiveness of that framework is regularly reviewed.

The Committee is responsible for monitoring the assurance environment and challenging the levels of assurance in respect of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied upon, and reviewing the internal audit plan in-year as the risk profiles change.

The Executive Committee
The Executive Committee has responsibility for ensuring implementation of the risk management process, and has responsibility for agreeing the risks on the CRR and the BAF, prior to consideration and approval by the Board.

The Executive Committee has the responsibility to discuss the BAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks, the current controls and assurances in place and the actions to address any gaps in these, prior to the BAF being submitted to the Board for consideration and approval.

It is also the role of the Executive Committee to agree that risks are being managed to an acceptable level, balancing priorities, resources and the risk to the health board, and recommending the best course of action to manage the risks, to the Board. The Board must be provided with assurance that everything that can be done is being done to reduce the risk, and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the health board. Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures will be regularly reviewed to ensure that they remain effective.

The Risk and Assurance Group
The Risk and Assurance Group is a management group of the Executive Committee. The Group reports to the Executive Committee and advises on any risk management issues, including all significant risks arising from activities within the organisation.

The Group is responsible for leading the implementation of the risk, control and assurance processes established within the organisation. The Group will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating all clinical and non-clinical risk management issues affecting the health board (scored ~~9~~ 12 and above), making recommendations to, and advising the Executive Committee and Board accordingly;
- Reviewing, updating and monitoring the Corporate Risk Register (CRR), and maintaining clear links with the Assurance Framework;
- Recommending the escalation and de-escalation of risks from/to the CRR for Executive Committee approval, ensuring significant risks are appropriately prioritised;
- Reviewing proposed significant risks from risk leads, escalating to the Executive Committee for inclusion in the CRR where appropriate;
- Reviewing risks arising from the results of investigations into losses, untoward incidents, near misses and accidents;
- Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the assurance framework appropriately.

Directorate Risk Management Arrangements

All directorates must have the necessary arrangements in place for good governance, quality, safety and risk management.

Directorates, through management, have responsibility for risks to their services and for putting in place appropriate arrangements for the identification, assessment and management of risks. Directorates are also responsible for developing local arrangements for monitoring risk registers and communicating risk information.

9. Risk Management Toolkit

To support delivery of the Risk Management Framework, a toolkit is available for staff on the intranet. The toolkit is a means by which the Risk Management Framework is operationalised to put into effect the full range of activities outlined. The toolkit includes:

- Risk Management Process
- Risk Assessment Procedure
- Risk Scoring Matrix
- Risk Register Procedure
- Risk Register Template & Guidance

10. Risk Management Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members	Risk Awareness Training & Review of Risk Appetite	Annual
Risk & Assurance Group / Senior Managers	Risk Awareness Training, including Risk Assessment and Risk Register Training	Every 3 Years
All ~~New~~ Staff	Risk awareness training and an understanding of the role of risk management in the organisation	~~Once only, as part of the induction process~~ Every 2 Years
~~Existing Staff/Services & Teams~~ Service Managers / Risk Owners	Bespoke training delivered on a needs-based approach	Ad hoc / as required

11. Monitoring the Effectiveness of the Risk Management Framework

Compliance with this Framework is monitored by the Executive Committee and the Audit, Risk & Assurance Committee.

The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The health board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process.

12. References

Airmic/Alarm/IRM (2010) A structured approach to Enterprise Risk Management (ERM) and the requirements of ISO 31000. London: Association of Risk Managers/Public Risk Management Association/Institute of Risk Management. Available at: https://www.theirm.org/media/886062/ISO3100doc.pdf.

IIA (2013) The Three Lines of Defence in Effective Risk Management and Control. Altamonte Springs: The Institute of Internal Auditors Inc. Available at: https://na.theiia.org/standards-guidance/Public%20Documents/PP%20The%20Three%20Lines%20of%20Defense%20in%20E ffective%20Risk%20Management%20and%20Control.pdf

Hopkins, P (2015) Fundamentals of Risk Management. 3rd Ed. London: Kogan Page Ltd.

Welsh NHS Confederation (2009) The Pocket Guide to Governance in NHS Wales. Good Governance Institute. Available at: http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf.

RISK APPETITE STATEMENT – NOVEMBER 2021

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

The Board places fundamental importance on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy: '*A Healthy, Caring Powys*'.
The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.
The Board has greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Risk Category	Description
APPETITE FOR RISK: Low (Risk Score 1-6)	
Quality & Safety of Services	The provision of high quality services is of the utmost importance to the Health Board, and we have a cautious appetite to risks that impact adversely on quality of care. We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of incidents of avoidable harm to our patients or staff. This means we are not open to risks that could result in poor quality care or clinical risk assessment, non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or tasks safely and, nor any incidents or circumstances which may compromise the safety of any staff member or group.
Regulation & Compliance	We will not accept risks that could result in the organisation being non-compliant with UK law or healthcare legislation, or any of the applicable regulatory frameworks in which we operate.
APPETITE FOR RISK: Moderate (Risk Score 8-10)	

Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours Framework, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.
Finance	We have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.
APPETITE FOR RISK: High (Risk Score 12-15)	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Medium Term Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

This Statement will be regularly reviewed and modified so that any changes to the organisation's strategy, objectives or our capacity to manage risk are properly reflected. It will be communicated throughout the organisation in order to embed sound risk management and to ensure risks are properly identified and managed.

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

Risk Management Toolkit

Version 1.0
November 2021

Contents

Introduction

Risk management in healthcare includes the whole spectrum of things that have the **potential** to go wrong. This includes slips, trips and falls involving staff, patients and the public; administrative errors that could impact on patient care; and, clinical incidents that could have a direct effect on the outcome of patient care. It also includes the management of the business risks associated with the running of the organisation including financial, ethical and information technology risks; as well as delivery of organisational and service plans.

Risk assessment is the method whereby hazards in the workplace are identified, quantified and managed, and is a proactive process focused on the risks that really Matter, the ones with the **potential to cause harm**.

This document has been produced to provide practical guidance for staff on risk assessment techniques and the compilation of risk registers. In addition to using this guidance, all staff with the responsibility for managing risks should also attend risk management training. Further information on risk management training is available on the health board's website.

Why is Risk Management Important?

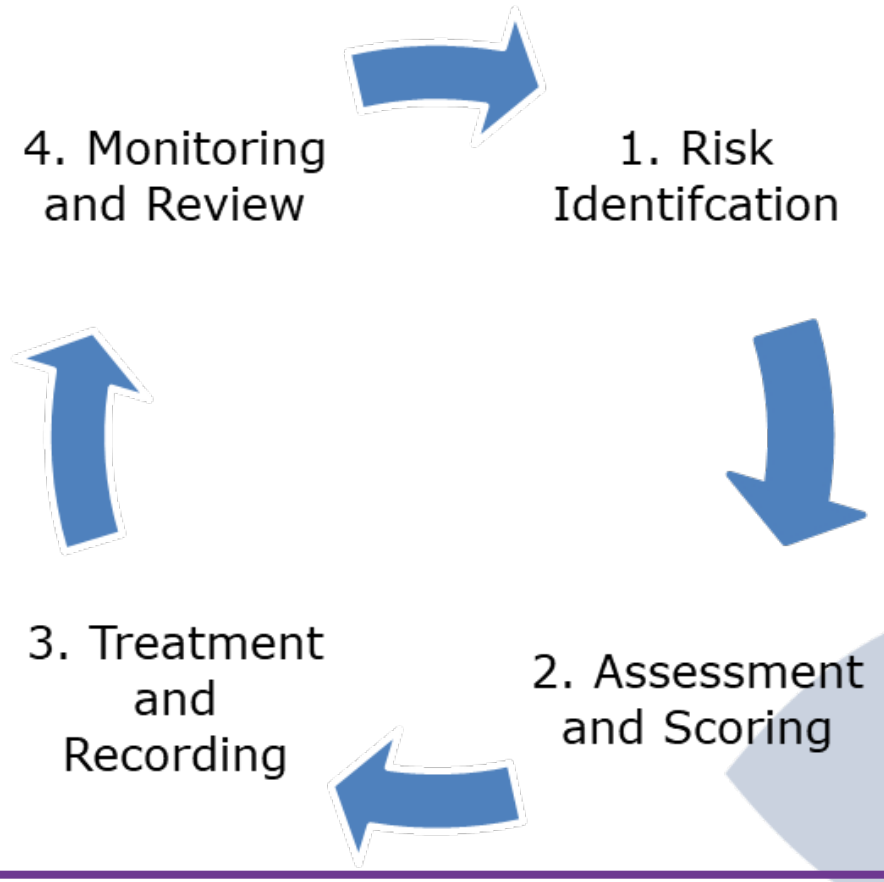
Risk management consists of defined steps which help us to understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation, and needs to be seen as integral to effective management practice. It is recognised that risk is present in any organisation, and therefore needs to be continuously managed in a systematic and consistent manner in all areas: patient; staff; health and safety; environmental; organisational; financial; and, commercial.

The risk management process can be applied to any situation where an undesired or unexpected outcome could be significant or where opportunities are identified.

Significant benefit from good risk management practice will come via ownership of risk management throughout the organisation. T his is where the importance of promoting a culture of openness within a learning environment is paramount. Staff must be trained, encouraged and supported through strong leadership to take a proactive role in identifying and reporting risks and "near misses‟, and taking appropriate actions to resolve problems at source, wherever possible.

The Risk Management Process

The Risk Management Process is a continuous cycle, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:



STEP 1:
Risk Identification

Step 1: Risk Identification

It is important that all staff are aware of the difference between a risk and an issue. All staff, with the support of their manager must determine if the situation is an:

a) **Issue**: An actual event that has **already** occurred or is still occurring, that may affect achievement of strategic or local objectives, or generate other risks; or a

b) **Risk**: The **potential** of an event occurring with the combined likelihood and consequence of harm, injury, damage or loss occurring, or impacting the achievement of the health board's objectives or strategic goals.

Step 1: Risk Identification

The following are examples to be considered when assessing potential risks to your Directorate/Team/Service/Location/etc.:		
Safety	**Reputational**	**Resource**
• Risks that could result in accidental death, disability or severe distress to patients and/or staff; • Risks that could result in unintentional harm; • Risks that may be less serious but are more frequent or could affect a large number of patients/staff.	• Risks that could lead to adverse publicity or affect the reputation of the Organisation; • Risks that could lead to litigation or may be the cause of a formal complaint; • Risks that could affect the Directorate / Department or Organisation in meeting corporate objectives.	• Risks that could result in financial loss to the Organisation; • Risks to service provision; • Risks to equipment / buildings.

Step 1: Risk Identification

Identification of risks occurs via a number of mechanisms and may be both proactive and reactive from a number of sources, including, but not limited to:

Proactive		Reactive	
Internal Sources	**External Sources**	**Internal Sources**	**External Sources**
• Risk Assessments • Annual Planning • Programme and Project Activities • Patient and Staff Surveys • Training Needs Analysis • Self-assessments • Clinical Audit	• National Recommendations • Partnership Risk Registers • External Engagement & Consultation	• Incidents, Complaints, Claims • Internal Audit • Performance Processes • Discussion at internal meetings	• Safety Alerts • Changes to legislation • Regulatory Inspections • External Audit

Step 1: Risk Identification

Risks should be articulated clearly and concisely. A clear risk description is important to ensure corresponding actions for treatment are effective. A simple tip is to consider describing the risk in terms of cause and effect, as set out in the following steps:

1. **What could go wrong?**
   In risk language this is called the "event"
2. **Work out Why**
   In risk language this is called the "cause"
3. **Work out what this means for you**
   In risk language this is called the "effect" or "impact" or "harm"
4. **Write the Risk Statement (Description)**
   This is a statement putting together the event, cause and effect

Step 1: Risk Identification

RISK STATEMENT EXAMPLES			
1. What could go wrong?	**2. What could be the cause of this?**	**3. What would be the effect/impact?**	**4. Risk Statement (Description)**
Poor quality care provided to patients	• High staff sickness rate • Inability to recruit sufficient staff • Inability to release staff for statutory and mandatory training	• Adverse harm to patients • Loss of public confidence in services • Breach of Staffing Levels Act	There is a risk that safe staffing levels are not maintained, compromising patient safety and care
Staff could fall over storage boxes	• Medical records stored in boxes unsafely in office accommodation	• Staff absence due to injury • Breach of Health & Safety At Work Legislation • Litigation Claims for Injury	There is a risk that the unsafe storage of medical records could cause potential harm to staff and loss to the organisation

STEP 2:
Assessment and Scoring

Step 2: Assessment and Scoring

Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **IMPACT** and its **LIKELIHOOD**.

Potential impacts are ranked by their severity. Each impact is given a ranking from 1 (Negligible) to 5 (Catastrophic). Using the matrix to score your risks helps to ensure the consistent scoring of risks across the organisation.

By rating your risks, you can indicate which are the most serious and reflect this in your range of proposed responses. Rating also helps you prioritise your risks.

The matrix is available on the following pages.

Step 2: Assessment and Scoring

Measures of Likelihood:

Descriptor	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not a persisting issue / circumstances	Will undoubtedly happen / recur, possibly frequently

Step 2: Assessment and Scoring

Measures of Impact:

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service sub-optimal Informal complaint / inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Step 2: Assessment and Scoring

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating 4 Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective / loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption **Environmental impact**	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Step 2: Assessment and Scoring

Likelihood x Impact = Risk Score

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Possible 3	3	6	9	12	15
	Unlikely 2	2	4	6	8	10
	Rare 1	1	2	3	4	5
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		IMPACT				

Step 2: Assessment and Scoring

Be aware that more than one measure of impact may apply to a risk, for example: -

Risk: *There is a risk that safe staffing levels are not maintained, compromising patient safety and care*		
Impact: Adverse harm to patients **MAJOR**	Impact: Loss of public confidence in services **MODERATE**	Impact: Breach of Staffing Levels Act **MODERATE**

In this instance, the score would reflect the highest rating; in this case, **MAJOR**

Step 2: Assessment and Scoring

Risks are measured according to their **IMPACT** should the risk materialise, and the **LIKELIHOOD** of the risk materialising.

IMPACT x LIKELIHOOD = RISK SCORE

Risks should be measured at the following **three** stages: -

1. **INITIAL Risk Score**
   The risk score when the risk is first identified – this will not change
2. **CURRENT Risk Score**
   The latest risk score – this should reflect the latest level of risk each time that the risk is reviewed
3. **TARGET Risk Score**
   The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions

Step 2: Assessment and Scoring

Risk Appetite is known as the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives. The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

The Board places fundamental importance on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy, 'A Healthy, Caring Powys'.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Board has greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Health Board's Risk Appetite Statement is available on the following pages.

Step 2: Assessment and Scoring

Risk Category	Description
APPETITE FOR RISK: Low (Risk Score 1-6)	
Quality & Safety of Services	The provision of high quality services is of the utmost importance to the Health Board and we have a cautious appetite to risks that impact adversely on quality of care. We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of incidents of avoidable harm to our patients or staff. This means we are not open to risks that could result in poor quality care or clinical risk assessment, non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or tasks safely and, nor any incidents or circumstances which may compromise the safety of any staff member or group.
Regulation & Compliance	We will not accept risks that could result in the organisation being non-compliant with UK law or healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

Step 2: Assessment and Scoring

Risk Category	Description
APPETITE FOR RISK: Moderate (Risk Score 8-10)	
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours Framework, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.
Finance	We have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.

Step 2: Assessment and Scoring

Risk Category	Description
APPETITE FOR RISK: High (Risk Score 12-15)	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Medium Term Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

STEP 3:
Treatment and Recording

Step 3: Treatment and Recording

When you have identified, assessed and scored your risk, the next stage is to decide and document an appropriate response. The response should describe how the Target Risk Score will be achieved. In general, there are four potential responses to address a risk once it has been identified and assessed – commonly known as the 4 T's: -

1. **Tolerate** – the risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated LOW, or if the health board's ability to mitigate the risk is constrained, or if taking action is disproportionately costly. If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised.
2. **Transfer** – risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk, e.g. Welsh Risk Pool. This option is particularly suited to mitigating financial risks or risks to assets. It is important to note that reputational risk cannot be fully transferred.

Step 3: Treatment and Recording

3. **Terminate** – the only response to some risks is to terminate the activity, giving rise to the risk or by doing things differently. However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.
4. **Treat** – this is the most common response to managing a risk. It allows the organisation to continue with the activity, giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance that the risk will be reduced to an acceptable level. Action plans must be documented on the risk register, have a nominated owner and progress monitored by the appropriate risk forum.

Step 3: Treatment and Recording

There are two types of risk treatment: -

1. **Controls** – what are we currently doing about the risk?
2. **Mitigating actions** – what more do we need to do?

Mitigating actions must: -

- Be clearly defined, to enable ongoing monitoring
- Have an owner assigned to deliver the action, and the owner should be notified of the action they are responsible for
- Have an agreed deadline for implementation, to enable ongoing monitoring
- Be incorporated into service plans, to enable ongoing monitoring, and to ensure the work is prioritised

Step 3: Treatment and Recording

All risks should be recorded on a risk register, which is documented in an Excel spreadsheet.

Risk Ref	Date risk added to the Register	Step 1	Step 2	Step 3	Step 4			Step 5		Step 6	Step 7			Step 8	Step 9			Step 10	Step 11	Step 12
		Risk: Description of the Risk [insert a short description of the risk and where relevant, the incident that highlighted it]	Cause: This is caused by...	Effect: So what? What are the consequences for the Service or Health Board, should the risk materialise?	Initial Risk Score			Risk Owner (Executive Director)	Risk Manager (Assistant Director / Service Manager)	What has been done to manage the risk to date? [Steps already taken]	Current Risk Score [What is the residual risk now that these actions have been completed?]			What more can we do? When will it be done by? [Assess whether more can be done to manage the risk at your level – what will be done? Who will take it forward? Date for completion]	Target Risk Score [What is the desired level of risk, based upon the PTHB Risk Appetite?]			Will we be able to manage the risk to an agreed level, or does it need to be escalated?	When will we review the actions (step 8) to ensure they are working?	Monthly Review: Date reviewed and rationale behind re-rating or score remaining as is
					Likelihood (1 - 5)	Impact (1 - 5)	Risk Rating				Likelihood (1 - 5)	Impact (1 - 5)	Risk Rating		Likelihood (1 - 5)	Impact (1 - 5)	Risk Rating			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			
							0						0				0			

The risk register should be held in a central location, with version control to provide an audit trail and access to historical information.

A risk register template is available on the Health Board's website.

Step 3: Treatment and Recording

A risk register is a log of all risks that threaten the Health Board's success in achieving declared aims and objectives. It is a dynamic living document, populated through the Health Board's risk assessment and evaluation process. The risk register needs to be regularly updated, to provide a structure for collating and categorising the following information: -

- Rank and report key risks
- Inform the decision making process
- Track mitigating actions – progress and effectiveness
- Keep risks visible
- Escalate risks that cannot be managed at the current level

STEP 4:
Monitoring and Review

Step 4: Monitoring and Review

Monitoring and review is an important part of the risk management process, and involves regular checking or re-evaluation. The results should be recorded and reported within the risk register. Effective monitoring and review supports the risk management process by: -

- Ensuring that mitigating controls are effective and efficient in both design and operation;
- Obtaining further information to improve risk assessment;
- Analysing and learning lessons from risk events, including near-misses, changes, trends, successes and failures;
- Detecting changes in the external and internal context, including changes to risk criteria and to the risks, which may require revision of risk treatments and priorities;
- Identifying changes to a risk score as a result of a change in controls;
- Identifying interim measures for risk treatments that have long lead times, e.g. where a high risk has a resolution timeframe of two years;
- Horizon scanning to identify new emerging risks.

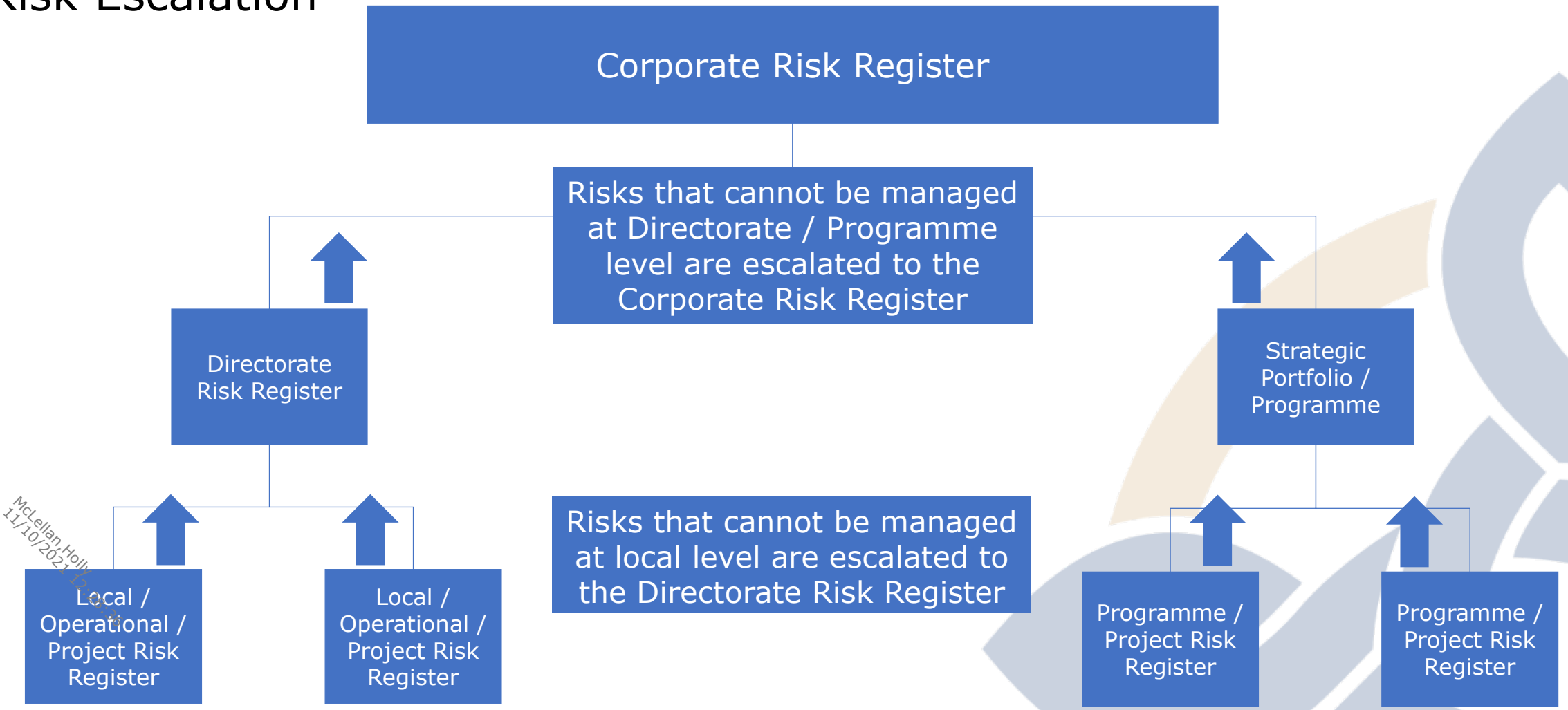
Step 4: Monitoring and Review

Risk monitoring should be undertaken on a regular basis, and incorporated into management team meetings as a standing agenda item for regular discussion and review of the risk information.

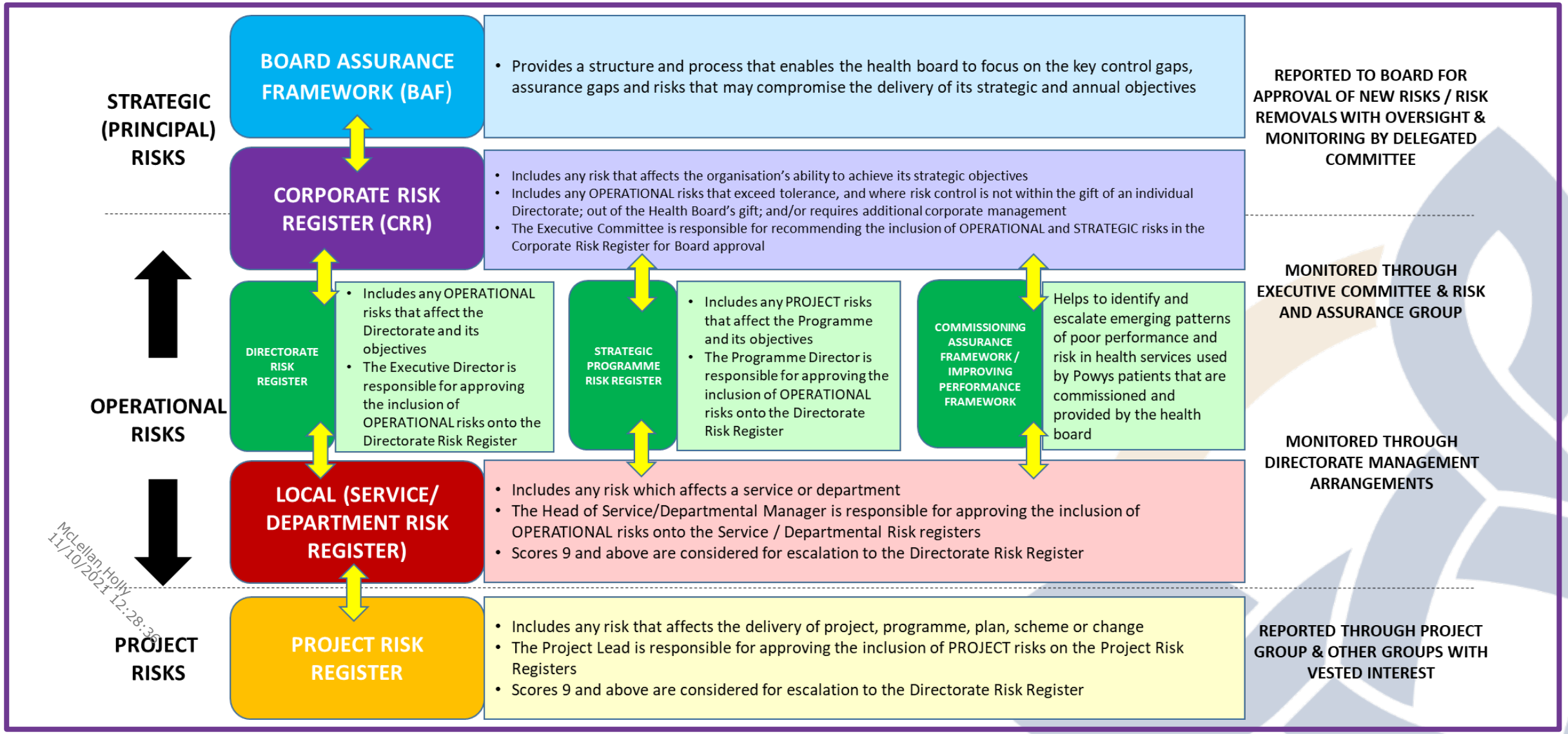
This discussion may identify that the consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. The health board uses hierarchical risk registers to ensure that risks are managed, escalated and reported at the appropriate organisational level. The following pages provide the process for escalating risks, and the risk management hierarchy as outlined in the Risk Management Framework.

Step 4: Monitoring and Review

Risk Escalation



Step 4: Monitoring and Review



Step 4: Monitoring and Review

Risks that are proposed for consideration for escalation to the Corporate Risk Register are subject to a risk assessment. The corporate risk assessment is a more comprehensive risk assessment, to provide the Board with detailed information including the risk impact; evidence to support the risk and the current score; controls in place to manage the risk; and, further mitigating actions required to manage the risk to target level. The corporate risk assessment is outlined on the next page, and is available on the health board's website.

Step 4: Monitoring and Review

Risk that:			**Lead Director:** **Assuring Committee:**	
Risk Impacts on: Organisational Priorities underpinning XXXX			**Date last reviewed:**	
Risk Rating (likelihood x impact): Initial: Current: Target:			**Rationale for current score:**	
Date added to the risk register XXXX				
Controls (What are we currently doing about the risk?)			**Mitigating actions (What more should we do?)**	
•			**Action**	**Lead** / **Deadline**
Assurances **(How do we know if the things we are doing are having an impact?)**			**Gaps in assurance** **(What additional assurances should we seek?)**	
•			•	
Current Risk Rating			**Additional Comments**	

For further information in respect of Risk Management, please visit the health board's website, or email the Head of Risk & Assurance.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.4

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 16 NOVEMBER 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, 3 November 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 Executive Committee is asked to note the current position of outstanding audit recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

Strategic Objectives:	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	
	4. Develop Workforce Futures	

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

BACKGROUND AND ASSESSMENT:

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

INTERNAL AUDIT

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

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

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

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

Overdue Internal Audit Recommendations								
Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21	2021/22		TOTAL OUTSTANDING
	Number				Number			Number
Priority 1	0	0	0	High	2	0		1
Priority 2	5	1	9	Medium	6	0		28
Priority 3	1	0	9	Low	1	0		20
Not Yet Prioritised	0	0	1					1
TOTAL	6	0	19		9	0		34

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

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		
	2021/22	TOTAL OUTSTANDING
	Number	Number
Overdue	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:

At the last meeting of the Audit, Risk and Assurance Committee, members requested a deep-dive into progress against outstanding audit recommendations.

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	1	2	1							✓
TOTAL			**25**	**70**	**32**	**25**	**69**	**32**	**0**	**1**	**0**	**0**	**1**	**0**	

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	Not Yet Prioritised	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	1	0								✓
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1								✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0								✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3								✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3								✓
192006	Records Management	No Assurance	6	0	0	3	0	0	3	0	0	0	3	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3								✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	3	0								✓
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2								✓
192010	111 Service	Reasonable	2	3	0	2	3	0								✓
192011	Catering Services Follow-up	Reasonable	0	3	2	0	3	2								✓
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	1	3	1	1	0	0	0	0	1	0	×
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4								✓
192014	Care Homes Governance	Limited	1	2	3	0	0	3	1	2	0	0	3	0	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	1	3	1								✓
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	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	1								✓
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	2	0	0	0	1	0	0	1	0	×
TOTAL			**23**	**63**	**32**	**17**	**53**	**29**	**6**	**10**	**3**	**0**	**9**	**9**	**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	2	4	0	0	1	0	1	0	0				×
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	1	1	0	2	0	0	2	1	0	0	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	1	1	2	0	0				0	0	0	×
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	1	0	0	0				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	2	0				0	0	0	×
202112	Grievance Process	Reasonable	0	1	0	0	1	0										✓
202113	Safeguarding during COVID-19	Reasonable	0	1	1	0	1	1										✓
202114	Implementation of digital solutions	Reasonable	0	3	0	0	1	0	0	1	0				0	1	0	×
202115	Winter pressures and flow management	Reasonable	0	3	1	0	1	0	0	0	0				0	2	1	×
202116	Llandrindod Wells Project	Limited	0	5	1	0	5	1										✓
202117	Covid-19 Mass Vaccination Programme	Not Rated																✓
TOTAL			**5**	**26**	**25**	**3**	**17**	**9**	**2**	**6**	**1**	**1**	**2**	**1**	**0**	**3**	**15**	

2021/22 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	H	M	L	
212201	Access to Systems	Reasonable	1	1	1	1	0	0	0	0	0	0	1	1	x
TOTAL			**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	

2018/19 External Audits

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

2019/20 External Audits

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

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	2	3	Not Yet Prioritised		
202151	Effectiveness of Counter-Fraud Arrangements	3	2	1	0	0	0	1		×
202152	Structured Assessment 2020	11	7	0	0	1	1	2	4	×
202153	Audit of Accounts	6	5	1	0	0	0			×
TOTAL		**20**	**14**	**2**	**0**	**1**	**1**	**3**	**4**	

***Not Yet Due**

Local Counter Fraud Services Pro-Active Exercises

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

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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	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		40	#NUM!	Sep-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	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		40	#NUM!	Sep-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	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		40	#NUM!	Sep-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	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		41	#NUM!	Sep-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	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		40	#NUM!	Sep-21	26/02/2019

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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, sent to HB employed prescribers on GMC advice.	Sep-20		41	12	Sep-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	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		29	#NUM!	Sep-21	26/02/2019
192006	Records Management	No Assurance	Board Secretary		R3	The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures should be developed, but aligned to the policies regarding records management and tracking. Practices should be consistent from one site to another. The health board should strengthen the current processes for the transport of health records through the introduction of standard packaging and labelling requirements along with a standard signatory system for collection and delivery. The health board should investigate the access issues to Wye Valley NHS Trust's digital records, including the extent this applies to other NHS organisations, and revisit the information sharing protocol to ensure a better flow of patient information. The health board should ensure robust business continuity arrangements are in place to minimise the impact of system outages, WCCIS in particular, and work with the local authority to ensure the effective implementation of the integrated system, including the merging of multiple records and removal of duplicate records to create one single record.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Review and update procedures and guidance to support effective tracking of records. • Ensure adequate Business Continuity Planning arrangements are in place relating to records management. • Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation. • Develop a business case for the digitisation of active records. • Review Information Sharing Protocols in place for commissioned services.	Mar-20	Dec-20	Overdue	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. The Information Services Department lead on the rollout of Intelligence Tracking. Intelligence Tracking guidance exists, is updated in accordance with system changes and is regularly communicated to all users of WPAS. Training is provided to all new users and refresher training is undertaken. Drop-in sessions are also available to users on an ongoing basis. KPI and DQ reports are sent routinely to service leads. Future reporting requirements to be confirmed.	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed.	31-Dec-20		18	9	Sep-21	15/11/2019

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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		17	#NUM!	Sep-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		17	#NUM!	Sep-21	14/11/2019
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 which was complete; however this work was then superseded by the intended transfer to the Citizens Voice Body in 2022. Follow up discussions will take place in line with organisational governance to review the current position in relation to Health Care Research Wales.	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		17	1460	Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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	Overdue	2	Partially complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of contracts, Standard Operating			Sep-21		9	0	Sep-21	
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.	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. AI, 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	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	Jul-21		17	2	Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion.	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion, 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		18	5	Sep-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 each of the key priority deliverables within the Organisational Development Framework. For each action there will be action owners or leads along with defined timescales which will ensure the ability to monitor and evaluate progress against each action.	Mar-20	Sep-20	Overdue	3	Partially complete		The Organisational Development Framework has been reviewed and refreshed. As part of this work, an action plan is being developed however, further discussion with the Executive team is required. This will be tabled for discussion at informal Execs.		This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		18	12	Sep-21	
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	Nov-21	Deadline Revised	3	Partially complete		Lessons learnt framework complete and due to be presented at Innovative Environment Group (IEG) 25 November 2021 following Llandrindod approved format.	Delayed due to covid	Lessons learnt have been implemented in real time through continual improvement	Nov-21		12	#NUM!	Sep-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 COVID19 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	Mar-22	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		6	#NUM!	Sep-21	26/09/2020

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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	Mar-22	Deadline Revised		Partially complete		Electronic Referrals is being covered with the 'All Wales' work being undertaken on the Welsh Admin Portal and the next Phase of clinical prioritisation within the Welsh Clinical Portal. There is also ongoin work to add additional referral services to WCCG for GP's to refer electronically.	This is driven by the WCP programme led by DHCW				6	#NUM!	Sep-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		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!	Sep-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		6	#NUM!	Sep-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	Dec-21	Deadline Revised	3	Partially complete		Management Plan being revised alongside refreshed Policy and Procedures approach	COVID-19 delays	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and introduce site specific management plans.	Dec-21		8	#NUM!	Sep-21	26/09/2020

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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					12	#NUM!	Sep-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.					9	#NUM!	Sep-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.		6	#NUM!	Sep-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		6	#NUM!	Sep-21	26/09/2020

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
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	Partially complete		Reablement agreement reviewed. The review of the Overarching Agreement Deed of Variation has been delayed due to covid-19					5	1460	Sep-21	26/09/2020
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	Nov-21	Deadline Revised	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. At current progress rates, >90% completion will be achieved by target date, which will conform to compliance needs for minimum personnel.	Attendance to sessions limited by absence and role requirements. Number limitations of training rooms from C-19 social distancing. Normal regulatory compliance responsibilities (FRAs, training & audits)	Fire evacuation drills have been continuing.	Nov-21		2	#NUM!	Sep-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		All policies outstanding have been reviewed and approved, these are now live on the intranet. PTHB Health & Safety policy to be considered for approval at Board on 25th November 2021. Management of Contractors policy approved September 2021. First Aid at Work Policy approved August 2021. Security Measures Policy due for approval in November 2021. Management of Violence and Aggression Policy in development further to WHC 2021 012. Revised Policies include implementation plan. Risk Mgt Framework template returned to	1 outstanding policy	Policies were extant whilst being reviewed.	Anticipate sign off of PTHB Health & Safety Policy in November 2021.	Health & Safet	6	3	Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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		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		Overdue	2	Partially complete		Health & Safety Group Terms of Reference reviewed by the Group in August 2021. Revisions to Terms of Reference incorporate Internal Audit recommendations. Revised Health & Safety Policy addresses reporting structures, coordination and accountabilities throughout the organisation. H&S Group terms of reference incorporated into revised PTHB Health and Safety Policy, for approval by Board November 2021.			Anticipate sign off of PTHB Health & Safety Policy in November 2021.		0	1460	Sep-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	Nov-21	Deadline Revised		Partially complete		Minor amendment to Capital procedures to clarify the purpose of the change control process. Amendments have been circulated to Capital Control Group in order to gain offline approval.	Delays due to COVID	Updated procedures only to clarify existing process	Nov-21		3	#NUM!	Sep-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	Mar-22	Deadline Revised		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.					0	#NUM!	Sep-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	Mar-22	Deadline Revised		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.					0	#NUM!	Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2	We concur with management and recommend the development of a documented framework that the health board can use in future collaborative change programmes to assist in the management of the programme and to ensure the use of a consistent and controlled approach.	This recommendation is accepted and a collaborative change programme framework will be developed and considered through the PTHB Executive Group for Strategic Planning and Commissioning.	Sep-21	Mar-22	Deadline Revised		Partially complete		Standard PIDs have been agreed for the 9 Renewal Programmes including key stages in collaborative change such as identification of stakeholders, engagement and communication, consultation and formal written notice. This will be summarised in a Change Programme Framework and submitted to the RSPB (Executive Committee)	Delayed due to prioritisation of Renewal Portfolio due to pandemic				0		Sep-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	Dec-22	Deadline Revised		Partially complete		A Digital Governance process was established in April 2021, and has now been effective for 6 months with KPI reporting into the Digital Transformation Board. A paper for Execs on the process has been submitted to DoF and communications to staff and the process to be available on the Intranet by Dec 2021					0		Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
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	Closed	2	Closed		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. This work is therefore closed.	National work on ACD now developing this.	All financial commitments are reviewed and authorised, as appropriate, by the DPCCMH.	Unable to specify as national work.	
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	Closed	3	Closed	reporting activity is in place to monitor stress related absence through NOSS dashboards and workforce performance reporting it is therefore suggested that this action is closed. Progress of work underway includes updates on the agreed activity that has been completed. There are two outstanding actions based upon the original management response as follows: -The establishment of the Stress	-Bi-directional ESR/Cohort interface not yet progressed and no date confirmed by Medgate, this is due to lack of progress at a national level. - The work within the stress steering group is now going to be included as part of the wider wellbeing at work group. This will include discussions regarding triangulation of stress related absence data. This has been delayed as it forms part of the organisational Health and Wellbeing work which is still being formally agreed. - Trends are monitored relating to stress related absence via the NOSS reporting dashboard (which is reported via the Health & Safety Group) and through regular workforce performance reporting - Sickness absence is monitored with	- Bi-directional interface dependent upon national implementation. No date confirmed. - Stress at Work Group - This work has been superseded as it built into the overall Health & Wellbeing action plan which will include a wellbeing at work group which is currently being agreed.	Referrals to NOSS are monitored via the reporting dashboard. Workforce performance reporting is undertaken at directorate level.	Unable to provide date for bi-directional interface at this stage as this is dependent upon the national roll out.	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
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	Complete	2	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. Draft reports prepared to capture end to end reporting - will be presented to OOH Performance Management Group by the end of Q3 2021 to	Reliant on input and agreement from 3rd parties: Advanced, Shropdoc &	Monthly data continued to be received from 111 & Shropdoc which provides assurance on the 2nd line triage and face to face contact. This includes breach reasons and patient outcomes.	Sep-21	Draft BI reports available. Will be reviewed and signed off by OOH Performance Mgt group in end of Q3 meeting
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	Complete	2	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. Draft BI reports completed by Information Team - to be presented to OOH Performance Mgt group in end of Q3 to ensure meeting requirements against the all wales standards	reliant on WAST	Quarterly data continues	Sep-21	Draft BI reports available. Will be reviewed and signed off by OOH Performance Mgt group in end of Q3 meeting
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	Complete	2	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. 111 provide local data at Powys quarterly OOH performance Management Group meetings when requested - as a minimum on a yearly basis	Sep-20	Reports available from PTHB Concerns team (if submitted via this route) or 111 service

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
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	Complete	2	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. PTHB reporting on metrics as pe the above.			Sep-21	Risk register available on request. OOH report capturing this detail also presented to Executive Committee earlier this year.
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		Closed	3	Closed	This has now been superseded by the intended transfer to the citizens voice body in 2022.	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.	
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	Closed	2	Closed	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. This work is therefore closed.	National work on ACD now developing this.		All financial commitments are reviewed and authorised, as appropriate, by the DPCCMH.	Unable to specify as national work.	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
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	Closed	3	Closed	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 November. this work will be considered as part of the national work on Accelerated Cluster Developme nt (ACD). This work is therefore closed					
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		Complete	3	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. Reports have been set up to reflect the approach described.	Oct-20	
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		Complete	3	Complete		S33 Performance reported to JPB 2x yearly.				
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		Complete	3	Complete		S33 Agreements QA by Chief Executive upon signing.				

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Assistant Director of Estates & Property	R1	The Fire Safety Policy should be updated to: a) Demonstrate compliance with the current regulations [WHTM 05-01 (2019)]; b) Reflect the current fire safety management structure within the THB	Should there be substantial changes to legislation, then policy documents would be updated and presented to Board for ratification. Where only minor updates, a decision would be made as to whether they would warrant a full review of the policy or rather an update to the operational procedures. For the changes in WHTM 05-01 (2019) the latter applied. Noting the impact of recommendation 2, the Fire Safety Policy will be updated.	Jan-21	Sep-21	Complete	1	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	Yes
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		Complete	1	Complete			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.			
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		Complete	1	Complete						
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	Complete		Complete		6 monthly report to be submitted to RPB in November 21.			Sep-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	Complete		Complete		ToR have been updated and signed off by the partnership.			Sep-21	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	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		Complete		Complete		The register has been made available via the IMT Digital Transformation Team channel following similar format to that used in IG. Being available in the Team Channel allows it to be maintained and updated,				
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		Complete		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. 10.10 2021 HoS responded and provided assurance that Improvement plans in place.				
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		Complete		Complete		The IBG process has a robust mechanism for reviewing benefits which may or my not include PREMS or PROMS depending on the case. There will be a 6/12/18 month review of cases and this will vary depending when the agreed scheme comes on line. So for example 6 months from date approved my not be sufficient to evauation its success if it has taken 5 months to recruit. The data reported will be based on the information provided by the service and based on the benefits listed in the initial case, which will then be reported to Executive Directors. The success of monitoring the benefits will be assessed over the next 12 months and at this point the recommendation is closed.			Reporting of the benfitis from apporved cases will be undertaken in line with the IBG process.	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
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	Complete		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 via meeting minutes & action logs
202116	Llandrindod Wells Project	Limited	Director of Planning and Performance	Assistant Director of Estates & Property	R3	Whilst recognising the impact of the COVID19 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	Complete		Complete		Lessons learnt framework presented and approved at Innovative Environment Group (IEG) August 2021	Delayed due to covid	Lessons learnt have been implemented in real time through continual improvement	Aug-21	
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Assistant Director of Digital Transformation	R1	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.	We are informed the decision from WG regarding the business case will be made by the end of Aug 2021	Sep-21		Complete		Complete		The business case was approved Oct 20th.				

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 COVID19 situation).	Oct-21			Not yet due	3	No progress							#NUM!	1460	Sep-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!		Sep-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!		Sep-21	
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!		Sep-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!		Sep-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!		Sep-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!		Sep-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?					
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!		Sep-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!		Sep-21	
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!		Sep-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!		Sep-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!		Sep-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!		Sep-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!		Sep-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?					
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!		Sep-21	
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!		Sep-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		Partially complete		Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements.				Yes via meeting minutes & action logs	#NUM!		Sep-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		Partially complete		Still awaiting direction from WG, which is expected November 2021. Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Will ensure KPI's are in line with national requirements when released.					#NUM!		Sep-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?					
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!		Sep-21	
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R2	Staff should be reminded to provide accurate information for staff who move roles. Consideration should be given to replacing the paper forms with electronic and removing the free text option to ensure that moves are properly reported.	We are working on using Power Automate and E-Forms. There is a change to be made within DHCW which has been logged for the use of power automate, once the change is made we will look to introduce a process which provides more specific information in more appropriate timeframe.	Mar-22			Not yet due		No progress								#NUM!	1460	Sep-21	
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R3	The setup of users should transition into normal practice and transfer from the PCC project team to the PCC service desk to action requests.	This is a work task within the Digital Project plan to complete the hand over.	Mar-22			Not yet due		No progress								#NUM!	1460	Sep-21	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
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		23	6	Sep-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		23	#NUM!	Sep-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		27	6	Sep-21	
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.				Sep-21	
202153	Audit of Accounts	Director of Finance, Information and IT	3	We recommend that management review and implement consistency in creation of purchase order conventions and to remind all staff with receipting responsibility of the necessity to ensure receipts are entered in the same convention as the purchase order. This will negate examples of the significant accounting entries highlighted during the audit taking place.	This will require a joint approach with the procurement team in Shared Services and receipting staff within the Health Board to ensure that the required process is followed correctly. This will include general communication to all users of the system to mitigate errors by providing some further training on the process and offering further support to any user who has further issues with the process.	Dec-20	Oct-21	Deadline Revised		Partially complete		12/04/21 This work has been delayed due to covid - however part of oracle upgrade due in July 2021 a training programme will be developed for users which will should help to mitigate some of these errors. 05/08/21 the oracle upgrade has been delayed on a national basis until October 2021 but on line 'video's will be available 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			Sep-21	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
											Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
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	Closed	3	Closed	This work has been superceded by a review of the All Wales Attendance at Work policy at a national level.	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.		12	#REF!	Sep-21	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	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?					
202152	Structured Assessment 2020	Board Secretary	23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	• Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.	Mar-22			Not yet due	2	No progress									Sep-21	
202152	Structured Assessment 2020	Director of Nursing & Midwifery	41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received six formal concerns about commissioned services in quarter one. Work is ongoing to improve effective management of concerns as the Health Board has found it difficult to meet the target of responding to 75% of formal concerns within 30 working days.	• 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-19. CQFIP up to 2022.	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021.	Implementation overseen by QGG and EQS.					Sep-21	
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									Sep-21	
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 routinely collected throughout as reported on in the annual patient experience report. A Task and finish group has been set up to write a new framework, the group is now established, the TOR have been refreshed and a mapping exercise has been arranged. The work is back on target A business case is being written for access to the new All Wales Patient Experience IT system.	There are no dedicated staff to work on patient experience, it relies on the capacity of operational teams and the Quality Team. We have poor IT systems to collect patient experience , making it a paper heavy and time consuming task.	on track	Mar-22				Sep-21	

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	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?					
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 and the chair. While there is guidance on the intranet around the payroll timetable, the initial action of completing the information on ESR is down to the manager. Training should be provided to all managers on how to deal with a leaver/changes form, and when they should be submitted ie. When a colleague gives their notice/requests a change of hours/commences or resumes from sick leave, the paperwork should be completed and submitted there and then, and before the next payroll cut-off date in all cases.	Mar-22			Not yet due		No progress							#NUM!	1460	Sep-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 recovery of overpaid amounts.	Mar-22			Not yet due		No progress							#NUM!	1460	Sep-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!	1460	Sep-21	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Audit, Risk & Assurance Committee	**Date of Meeting: 16 November 2021**
Subject :	**WELSH HEALTH CIRCULARS**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	Executive Committee, 3 November 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 Welsh Health Circulars (WHCs).
RECOMMENDATION(S):
The Audit, Risk & Assurance Committee is asked to discuss and note the current position, considering those WHCs where no progress has been made.

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

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

EXECUTIVE SUMMARY:

Previously, work was been taken forward to implement robust systems for recording and tracking WHCs from Welsh Government. The circulars were re-introduced in September 2014 to replace ministerial and health professional letters.

The Health Board has now implemented a tracking tool for monitoring the status of WHCs, which reflects the tracking tool also adopted for the monitoring of audit recommendations and regulatory reviews and inspections.

DETAILED BACKGROUND AND ASSESSMENT:

WHCs are received from Welsh Government by the Corporate Governance Team, where they are logged and then distributed to the appropriate Executive Director for action.

Appendix 1 provides the Committee with an overview assessment of current outstanding WHCs, and the progress made to action them.

Appendix 2 provides the Committee with an overview of WHCs actioned since the last reporting period.

The position reported to Committee at 31/08/2019, 29/02/2020, 30/04/2021 and 31/10/2021 in respect of progress of implementation of WHCs is as follows: -

	2018				2019				2020			2021	
	Position at 31/08/2019	Position at 29/02/2020	Position at 30/04/2021	Position at 31/10/2021	Position at 31/08/2019	Position at 29/02/2020	Position at 30/04/2021	Position at 31/10/2021	Position at 29/02/2020	Position at 30/04/2021	Position at 31/10/2021	Position at 30/04/2021	Position at 31/10/2021
No Progress	0	0	0	0	4	8	3	0	1	2	0	0	0
Partially Complete	3	2	2	1	4	5	4	2	0	2	2	1	8
Complete	45	46	46	47	15	25	31	36	1	13	15	5	9
TOTAL NUMBER ISSUED	**48**	**48**	**48**	**48**	**23**	**38**	**38**	**38**	**2**	**17**	**17**	**6**	**17**

NEXT STEPS:

Progress of implementation of WHCs will continue to be monitored, and Executive Directors will be asked to consider those outstanding WHCs, and to ensure that all outstanding actions are completed within the required timescales.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2018-022	Sharing Patient information between healthcare professionals – a joint statement from the Royal College of Ophthalmologists and College of Optometrists	03/09/2018	To note that on 20 March 2015 the Royal College of Ophthalmologists and the College of Optometrists issued a joint statement encouraging ophthalmologists to share clinical information with the referring optometrist. To ensure hospital policies and procedures encourage this communication so that it becomes standard practice for planned and unplanned ophthalmology care in Wales.	Medical Director		Partially Complete	Clarification of the current situation was sought from localities in September 2018. The north Powys locality confirms the destination of clinic letters is instructed by the consultant. Sending information back to the referrer (as well as the patient's GP) is inconsistent. The locality has agreed to draw the consultants' attention to the requirements of the new WHC. A response from the mid/south Powys locality is still being pursued. Update - The joint statement clarified best practice as writing to the referring optometrist as well as the GP. We can ensure that that is being done in Powys hospitals, but providers out of the county will have their own policies, hence I expect that the picture across Powys is variable. With the new EPR optometrists will be able to look at eye care records for their own patients, including clinic letters, so this will become moot. Of course this will not apply to our English providers.
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery Meetings.	Medical Director		Partially Complete	5 year National Action Plan 2019 – 2024 underpinning the UK AMR Strategy 20: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024
2019-034	National Optimal Pathways for Cancer (2019 tranche 1)	02/10/2019	Executive Board note and discuss the NOPs as part of the implementation of the single cancer pathway. Executive leads for cancer use the NOPs to support the planning, delivery and performance monitoring of cancer services. Directors of Planning incorporate NOPs into their planning assumptions, recognising that they won't all be immediately achievable but should be worked towards in the medium term. Site specific local, regional and national MDTs to adopt the NOPs or justify reasons for local and limited variations	Medical Director		Partially Complete	A key renewal priority of PTHB is cancer services. A Renewal Cancer Transformation Programme Board has been established, chaired by the Medical Director. The priorities for the Programme Board have been agreed by PTHB and the Executive Committee as set out in the PTHB Annual Plan. This includes work in relation to the Optimal Pathways. A Project Manager has been funded and employed by the Welsh Cancer Network to work with PTHB to review compliance with the nationally agreed Optimal Pathways for Powys residents. This is a particularly complex issue for PTHB as it has no DGH level services and half of its patient flows involve providers in England. The initial priority will be the GI pathways.
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Medical Director	Immediate	Partially Complete	The Director of Clinical Strategy and Director of Finance met with the national lead for PROMs with regard to the planned approach. We continue to provide data for the national tdabc work for cataracts. The special situation for Powys as a commissioning organisation is recognised and our plans to "measure what matters" in line with validated datasets going forward acknowledged. The inclusion of value based health care into our annual plan provides the key driver to take forward this work. Some specific target areas being developed (but not complete) are:- • Diabetes • Frailty • Eye Care (Cataracts) • Orthopaedics • Cancer • Physio (linked to ortho) Given our make up there is a clear link to our provide organisations and a requirement to link up re information around PROMS/PREMS etc.
2020-014	Ear Wax Management	29/09/2020	Determine and report on current service provision across Wales. Develop a national integrated pathway for the safe and effective management of ear wax to provide consistent patient outcomes across Wales and ensure: ▪ Equitable access; ▪ Efficient and effective use of NHS resources; cost effective and prudent; ▪ Consistent seamless management across primary, community and secondary care settings; ▪ Self-management where clinically appropriate, empowering people to better manage their own care; ▪ Compliance with NICE guidance and Audiology Quality Standards. https://gov.wales/sites/default/files/publications/2019-10/quality-standards-foradults-hearing-services-the-assessment-and-audit	Director of Primary, Community and Mental Health		Partially Complete	Business Case for the model had been approved by Executive Committee. Model wil now be recruited to and implemented. Likely service will not be in place until late in Q4 2021/22. WG have been informed of this progress and position. Paper due into executives during June 2021.
2021-002	Board Champion Roles	19/01/2021	Local Health Boards and NHS Trusts should undertake the following action: Identify the individuals currently fulfilling the Champion roles stated in this WHC as to be discontinued and advise them of this decision. Ensure the identification of individuals to perform the roles where the requirement remains.	Board Secretary		Partially Complete	There are three roles which are to be confirmed. These will be reviewed at the time of reviewing committee membership and other commitments of Independent Members, recognising imminent changes in Board Membership.
2021-008	Revised National Steroid Treatment Card	01/06/2021	Based on guidance from an expert working group,1 a steroid treatment card should be given to those patients receiving exogenous glucocorticoids at risk of adrenal insufficiency.	Director of Primary, Community and Mental Health	15/10/2021	Partially Complete	Chief Pharmacist leading and action plan being developed. New steroid cards obtained. These will be distributed to primary care, community pharacies and relevant areas withing PTHB community services by 15/10/21. Brief guidance will be provided with the steroid cards detailing who should receive the card. This will be followed by more comprehensive guidance to support clinicians as soon the Medicines Management Team has capacity to do this. The action can be marked as complete after 15/10/21

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to provide updates at three monthly intervals from April 2021. Health Boards will be aware that there are two cohorts of children that will need "mopping up" due to the Covid-19 pandemic, communication of how this will be managed will follow with the "Standard Operating Procedure" and related documentation.	Director of Primary, Community and Mental Health		Partially Complete	Led by the PTHB Head of Audiology, in conjunction with School Nursing service with Powys, this has already progressed some key elements. Expectation of quarterly updates prior to full implementation no later than April 2022.
2021-021	Introduction of Shingrix® for Immunocompromised Individuals (From September 2021)	27/08/2021	From 01 September 2021, general practices should offer the non-live shingles vaccine Shingrix® to all those who are eligible for shingles vaccination but are clinically contraindicated to receive the live vaccine Zostavax® due to their immunocompromised status. In line with the current requirements of the shingles programme, the vaccine should be offered to those becoming eligible at 70 years old and to unvaccinated individuals in their 70s who have not yet reached their 80th birthday.	Director of Public Health	15/10/2021	Partially Complete	Circular was sent to primary care by WG. Medicines Management have confirmed that PGD for Shngrix is in place. Awaiting confirmation from PTHB Primary Care that there are no changes required to existing service agreements with primary care. No further actions required.
2021-022	Publication of the Quality and Safety Framework	17/09/2021	Can you please share this Framework, link attached below, with all health and care staff within your organisations and continue to embed the ethos of good quality, safe care above all else.	Director of Nursing and Midwifery		Partially Complete	Met on 27 September 2021 about this and a paper would be presented to the Executive Committee Mid October 2021.
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Partially Complete	Shared with Therapies to consider how this will be applied to PTHB practice. Work in progress to determine how this pathway applies to and will be rolled out across the HB.
2021-027	NHS Wales Blood Health Plan	27/09/2021	It is essential that blood and blood components are used only when needed and where no other suitable alternative exists. The Plan therefore sets direction of optimising blood health and transfusion practice under three core aims that draw on the principles of prudent healthcare: ▪ supporting individuals to manage their health and wellbeing, avoiding unnecessary intervention; ▪ using evidence and transparent data to drive service planning and improvement to reduce inappropriate variation; and	Medical Director	End November 2021	Partially Complete	Blood transfusions in PTHB are exceptionally rare as PTHB has no intrinsic Pathology Service and the logistics to support them are very complex. The principles laid out in WHC 2021/027 will be brought to the PTHB Policy Group for endorsement and incorporation in PTHB practice and process. The document has been shared with planned care to consider elements that may be applicable to practice.
2021-028	AMR & HCAI Improvement Goals For 2021-22	27/09/2021	Health boards should ensure IP&C measures and patient pathways of the COVID pandemic IP&C response are in place with plans for outbreak management and preparedness for Autumn and Winter 2021-22.	Medical Director		Partially Complete	Chief Pharmacist and Assistant MD leading this piece of work. To be discussed at AMS meeting on 12 October 2021.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2018-004	UK Policy Framework for Health and Social Care Research	01/02/2018	To highlight the publication of the UK Policy Framework for Health and Social Care Research.	Medical Director	01/11/2019	Complete	• The Research Governance policy was approved in May 2021 and has been published on the intranet. • The policy includes a set of approved Standard Operating Procedures as appendices. • An R&D audit template has been finalised and this will be implemented in late 2021/22 for new studies on an annual basis to ensure compliance with the Research Governance Policy and UK policy framework. • The Research Governance policy has been circulated to key stakeholders within the health board. • A generic R&D training presentation has been developed and is currently used in conjunction with bespoke research advice, training and support for health board researchers on a one to one or group basis, as appropriate. • The R&D Department continues to consult with key stakeholders including the Research Design and Conduct Service (RDCS) based in North Wales and the PTHB RIIC Hub.
2019-006	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2019/20	09/05/2019	Ensure full audit cycle is completed, with findings and recommendations from audit directly linked to quality improvement programme. Ensure staff have sufficient resources to participate in audits, reviews and national register included in annual plan.	Medical Director	Rolling audits to be completed 2020	Complete	As Powys Health Board is not a provider of emergency cardiac services, specialist cancer care or in-patient surgical care there are only a few audits on the NHS Wales National Clinical Audit plan for which the organisation qualifies to participate. For 2019/20 Powys Health Board did participate in all of the audits for which we had an eligible service with the exception of the National Cataract Surgery audit which we were unable to complete due to compatibility issues with our computer systems. These were the completed audits for the period 2019/20. National Diabetes Audit (Primary Care). It is pleasing to report that all Powys GP surgeries agreed to participate in the audit. Pulmonary Rehabilitation Audit (Pulmonary Specialist Nurses team). SSNAP Stroke (Partial) The Powys stroke rehabilitation team participate in the rehabilitation section of this audit as we do not provide acute stroke care in-county. National Audit for Care at the End of Life (Powys palliative care team completed the first round of this audit in 2019). Cardiac rehabilitation Audit (Cardiac Specialist Nurses). All Wales Audiology Audit The following audits were stood down by the organisers due to the pandemic; National Diabetes Footcare Audit Epilepsy 12 Audit
2019-024	Pertussis – occupational vaccination of healthcare workers	30/07/2019	From August 2019, healthcare workers in NHS Wales who have not received a pertussis-containing vaccine in the last 5 years and who have regular contact with pregnant women and/or young infants will be eligible for a pertussis containing vaccine as part of their occupational health care	Director of Nursing and Midwifery		Complete	Completed roll out of pertussis immunisation in groups 2&3 in January 2020. Continue to identify new staff that are unvaccinated on pre-employment and offer vaccination. Its widely declined.
2020-015	Policy on single use and reusable laryngoscopes	14/09/2020	Organisations must ensure laryngoscopes and such devices (handles and blades) are either: Single use application or decontaminated appropriately between each patient use.	Director of Nursing and Midwifery		Complete	Confirmation from service managers that our resus trolleys and dental and theatre services are all using disposable laryngoscopes. All our resus trolleys are checked and updated by the CTUHB resus team on an annual basis. All multi use specialist laryngoscopes for specialist intervention in theatres separate to the resus arrangements have now been replaced with single use ones. This will be kept under review with the Resus Training team and theatres.
2021-010	Amendments to Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales	16/09/2021	Your Board is required to incorporate and adopt this latest review into your organisations Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders). The WHSSC and EASC Standing Orders form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.	Board Secretary		Complete	Board approved changes July 2021 along with committee terms of reference in September 2021.
2021-015	HS Pay Bonus for Primary Care	28/05/2021	Broadly speaking, primary care staff (including locums) that provided primary care services for the purposes of the national health services in Wales during the period 17 March 2020 to 28 February 2021 and meet the eligibility criteria in The Primary Care (NHS Covid-19 Bonus Payment Scheme) Directions 2021 (the "Directions") are, subject to the terms of those Directions, included in the NHS Covid-19 bonus payment scheme to reflect their fundamental role during the coronavirus pandemic.	Director of Primary, Community and Mental Health		Complete	Processed by Shared Services Partnership

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2021-019	The National Influenza Immunisation Programme 2021-22	04/08/2021	Influenza vaccination maximised in priority groups who are most at risk of catching flu and suffering severe outcomes, or who are at higher risk of infecting other people. CEM/CMO/2021/19 indicated that the programme in 2021-22 will again include all people aged 50 to 64 years, who should be offered influenza vaccination alongside others as part of the main campaign.	Director of Public Health		Complete	Circular forwarded to all responsible parties, inc primary care. PTHB Influenza Vaccination Oversight Group meeting fortnightly to coordinate all elements of the vaccination programme set out in circular.
2021-023	Care Decisions for the Last Days of Life	22/09/2021	The aim of this Welsh Health Circular is to inform all health boards and trusts in Wales of the replacement of the current CDG with immediate effect. We want to ensure that staff are conversant with its requirements and fully equipped to provide the level of consistent care appropriate to patients and those important to them in the last days of life. Health boards are requested to support their organisation, voluntary sector services and partners to assist with the dissemination, uptake and implementation of the version 11 CDG. All health boards and trusts have key professionals who lead on and provide training and support in the use of the CDG for the Last Days of Life. We ask that particular attention is paid to settings where use of the CDG has in the past been less frequent and to support use of the tools for monitoring and audit of care in the last days of life and for measurement of outcomes and experience.	Medical Director		Complete	Cascaded to colleagues and asked that actions are considered. Principles and implications for practice to be tabled at the inaugural meeting of the revived PTHB End of Life Board chaired by the Medical Director. Lead area for roll out in PTHB is the specialist palliative care team. Already promulgated by specialist palliative care team and being embedded into practice. In addition, the letter will be put into the October Cancer Update letter which goes out to primary care for information for all clinicians. Patients wishes also incorporated into Treatment Escalation Plan documents.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

AUDIT, RISK & ASSURANCE COMMITTEE	**Date of Meeting: 16 November 2021**
Subject :	**Annual Governance Programme 2021/22 – Quarter 2 Update**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	Executive Committee, 3 November 2021

PURPOSE:

The purpose of this paper is to provide a progress update on delivery of the Annual Governance Programme for 2021/22, as at Quarter 2. The Annual Governance Programme outlines key governance priorities, informed by internal audit, external audit and the board's review of its effectiveness.

The Annual Governance Programme includes detailed actions for implementation. These actions are led by the Board Secretary, and are delivered in partnership with relevant members of the Board. Progress is reported to the Audit, Risk & Assurance Committee, in-line with the Committee's role in assuring the Board on governance, risk and assurance arrangements.

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee is asked to CONSIDER the latest position on delivery of the Annual Governance Programme for 2021/22, as at Quarter 2.

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

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

SUMMARY:

The purpose of this paper is to provide a progress update on delivery of the Annual Governance Programme for 2021/22, as at Quarter 2. The Annual Governance Programme outlines key governance priorities, informed by internal audit, external audit and the board's review of its effectiveness.

The Annual Governance Programme includes detailed actions for implementation and focuses on:

- Ensuring Clarity of Purpose, Roles and Responsibilities
- Ensuring an Effective Board
- Embedding a Risk and Assurance Culture

These actions are led by the Board Secretary, and are delivered in partnership with relevant members of the Board. Progress is reported to the Audit, Risk & Assurance Committee, in-line with the Committee's role in assuring the Board on governance, risk and assurance arrangements.

Quarter 2 Achievements

- Purpose, Roles and Responsibilities
  The Annual Governance Programme set out milestones for Quarter 2 in respect of ensuring Standing Orders were updated and reflective of amendments issued by Welsh Government. Updated Standing Orders

were approved by the Board in July 2021 and have been published to the Health Board's website.

- Board Effectiveness
  The Annual Governance Programme set out milestones for Quarter 2 in respect of commencing work on: fully establishing the Board's Advisory Fora (Stakeholder Reference Group and Healthcare Professionals' Forum); and the development of a high-level Partnership Governance Framework. Actions in respect of both areas of work have been deferred to Quarters 3 and 4 as a result of capacity constraints and competing priorities.
  In the absence of a Partnership Governance Framework, the Board has received a presentation on Partnership Arrangements with a summary report presented to the Planning, Partnerships and Population Health Committee.
  Whilst the Board has yet to establish its Stakeholder Reference Group and Healthcare Professionals' Forum, engagement with stakeholders, partners and professional groups continues utilising existing mechanisms. In addition, engagement activities established during the COVID-19 pandemic, such as Staff Engagement Events and Public Engagement Events have enhanced overall engagement.

- Risk and Assurance system
  The Annual Governance Programme set out milestones for Quarter 2 in respect of: undertaking an annual review of the Risk Management Framework and Risk Appetite Statement; and publishing a Risk Management Toolkit. A reviewed and updated Risk Management Framework, including Risk Appetite Statement, is scheduled for presentation to the Board in November 2021. A Risk Management Toolkit has been developed and published to the Health Board's Intranet and will also be promoted through the Risk & Assurance Group, constituted by key leaders within the organisation.

ANNUAL GOVERNANCE PROGRAMME

MILESTONES

2021/22

Quarter 2 Update

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status Q1	Q2	Q3	Q4	Comments
1. ENSURING CLARITY OF PURPOSE, ROLES, RESPONSIBILIIES AND SYSTEMS OF ACCOUNTABILITY							
a) Ensure that key supporting documents of the Board's governance framework continue to be fit for purpose at all levels, i.e. Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers	Adopt amendments to Standing Orders, as per nationally-led work	Director of Finance & IT (SFIs)					Action Complete – Approved by Board 28th July.
	Review the Board's Scheme of Delegation and Reservation of Powers to ensure it reflects Executive Director portfolios and Board Committee arrangements for 2021/22						Scheme of Delegation and Reservation of Powers is under review. Presentation to Board deferred to January 2022.
	Board Scheme of Delegation and Reservation of Powers presented to Board for approval in September 2021/22						
	Adopt revised Standing Financial Instructions as per nationally-led work						Action Complete – Approved by Board 28th July.
	Undertake an assessment of compliance with Standing Orders						Not yet due.
b) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of the organisation, along with strengthened internal control	Organisational Structures to be confirmed via Organisational Realignment Working Group	All Executive Directors					Work remains underway to map organisational governance arrangements at a Directorate/Team level to inform deployment and accountability arrangements.
	Levels of accountability, authority and autonomy to be confirmed and aligned to organisational policies and frameworks						
	Directorate Deployment and Accountability Frameworks to be developed, aligned to the Board's Scheme of Delegation and Reservation of Powers						

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Identify all existing partnerships and collaborations to inform development of a Framework	Director of Planning & Performance					Overview of partnership governance arrangements presented to board at Strategic Planning Session and Planning, Partnerships & Population Health Committee.
	Mapping of these partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes						
	Development and population of a Partnership Register						Due to capacity constraints, development of the Partnership Governance Framework has been delayed into Q3/4.
	Development of the Partnership Governance Framework for presentation to Board in December 2021						
d) Further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship	Embed Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee	n/a					Discussions are taking place nationally with regard to the development of electronic recording of interests. Work is also underway to develop an all-Wales Policy.
	Fully implement an electronic system to support recording and reporting of declarations made						
2. ENSURING BOARD EFFECTIVENESS							
a) Review and strengthen the Board's Committee Structure, aligning the	Review committee structure for implementation in 2021/22	Chair/Committee Chairs					Action Complete – Approved by Board 28th July.

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
Board's needs with its assurance and advisory infrastructure	Review committee terms of reference and operating arrangements with any changes presented to Board for approval in May 2021						Action Complete – Approved by Board 28th July.
	Review committee membership with any changes presented to Board for approval in May 2021						Action Complete – Approved by Board 28th July.
	Fully populate committee workplans, aligned to the Corporate Risk Register and Board Assurance Framework, for Board approval in May 2021						Action Complete – Approved by Board 29th September.
b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum (HPF) and the Stakeholder Reference Group (SRG)	Review Terms of Reference and membership of the Stakeholder Reference Group	• Director of Planning & Performance (SRG) • Clinical Directors (HPF)					Due to capacity constraints, this work has been delayed into Q3/4. Engagement with stakeholders, partners and professional groups continues utilising existing mechanisms. In addition, engagement activities established during the COVID-19 pandemic, such as Staff Engagement Events and Public Engagement Events
	Meeting of the SRG to be held						
	Appoint Chair of the SRG as an Associate Member of the Board						
	Review current engagement mechanisms with professionals to inform approach to HPF						
	Terms of Reference and Membership of HPF to be developed						
	Inaugural meeting of HPF to be held						
	Appoint Chair of the HPF as an Associate Member of the Board						

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
							have enhanced overall engagement.
c) Ensure openness and transparency in the conduct of board and committee business	Review effectiveness of live streaming board meetings	Chair					Live streaming of board meetings continues. Arrangements for members of the public to observe committees in place, in the absence of live streaming. Papers published to website as routine.
	Consider accessibility of those committee meetings required to be held in public						
	Ensure meeting agendas, papers and summary notes are published in a timely manner						
d) Further improve the quality of information to the Board and its Committees	Board & Committee report templates to be reviewed to ensure assurance reports are distinguished from reports for management	Director of Workforce & OD					Due to capacity constraints, this work has been delayed into Q3/4.
	Report Writing and Presentation Masterclasses to be held for senior management team, via the Management Development Programme						
e) Implement an annual development programme for board members, focussing on awareness sessions as well as training and learning to support the development	Board review of effectiveness to be undertaken in April 2021	• Chair • Director of Workforce & OD					Board review of effectiveness undertaken in Board Development session in April 2021, for period 2020-21. Period 2021-22 to be

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
of individual roles and the board as a cohesive team							undertaken March 2022.
	Implement a programme of development and a programme of briefings for 2021/22						Board Development and Briefing Sessions ongoing.
	Ongoing implementation of an Executive Director Development Programme						Programme of development ongoing.
	Design and implement training and development for Independent Members						IM specific training to be developed in Q4 to supplement a programme of induction.
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required	Work with Public Bodies Unit to prepare and deliver recruitment campaigns for upcoming vacancies	Director of Workforce & OD					Active work ongoing with Public Bodies Unit.
	Implement an Induction Programme for Board Member appointments when required						WG Induction Programme in place. Local Induction arrangements require further strengthening.
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and engagement	Design and implement a schedule of visits to a range of clinical and non-clinical services and county-wide health board sites	• Chair • Chief Executive					CEO/Executive Director visits re-commencing. IM visits to be planned in Q3/4.
h) Review and implement arrangements for the development, review,	Policy Management Framework to be reviewed, confirming policy approval routes	Executive Director Policy Owners					Due to capacity constraints, this work has been delayed into

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status Q1	Q2	Q3	Q4	Comments
approval and publication of policies delegated by the Board	Policies section of intranet/internet to be refreshed						Q3/4. Policy Review continues, led by Policy Owners, with updates published to the Intranet.
	Policy toolkit to be rolled out with awareness raising						
	Training programme to be developed and implemented to support the organisation in developing and reviewing policies						
i) Review Board Champion Roles, ensuring clarity on purpose and responsibility.	Review delegation of Champion roles to Board Members	Chair					Board Champions roles under review in light of recent and imminent changes in board membership. The outcome of the review will be reported to a future meeting of the Board.
	Adopt role specifications for Champion roles						
	Establish reporting arrangements for Champions to Board						
3. EMBEDDING AN EFFECTIVE SYSTEM OF RISK AND ASSURANCE							
a) Ensure that the Risk Management Framework continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	Undertake an Annual Review of Risk Management Framework, ensuring alignment with the Board's Assurance Framework Principles	n/a					A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2021.
	Risk Management Framework to be updated to reflect Risk Appetite Statement						
	Establish Committee Risk Registers						Committee priorities informed by strategic risks (corporate risk register). Further work

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
							required to refine operational risk registers to inform committee risk registers.
b) Promote a Risk Management Toolkit to support staff in the identification, recording and management of risk	Publish a Toolkit including the process for escalation and de-escalation, examples of best practice to support moderation and consistency in measurement	n/a					A Risk Management Toolkit has been developed and published to the Health Board's Intranet and will also be promoted through the Risk & Assurance Group, constituted by key leaders within the organisation.
	Toolkit to be updated in line with review of Risk Management Framework, Risk Appetite Statement and Board Assurance Framework Principles.						
c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks	Risk Appetite Statement to be considered by Board in June 2021	n/a					A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2021.
	Revised Statement to be presented to Board in July 2021 for approval						
	Corporate Risk Register, Risk Targets to be reviewed to ensure alignment with the Board's Risk Appetite						Corporate Risk Register review undertaken and approved by Board in July. Further work is

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
							ongoing to ensure that the CRR aligns with the Risk Appetite.
	Risk Management Framework to be updated to reflect Risk Appetite Statement and communicated with the organisation						A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2021.
d) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints System [DATIX])	Risk Management Module to be developed in-line with Once for Wales Management System Programme, in readiness for implementation in 2022	n/a					Once for Wales Management System implementation underway, aligned to national work. Risk & Assurance Group continues to meet where possible to maintain focus on operational risk management.
	Maximise the role of the Risk and Assurance Group to drive forward improvements in risk reporting arrangements						
e) Embed the Board's Assurance Framework, aligned to the Corporate Risk Register and Organisational Risk, where appropriate	Undertake an Annual Review of Assurance Framework Principles, ensuring alignment with the Board's Risk Management Framework	n/a					The Board Assurance Framework has not be stood back up during the pandemic. In its absence, the Board continues to receive its Corporate Risk Register at each
	Board and committee workplans aligned to Assurance Framework						
	Assurance Framework updated quarterly, in-line with integrated performance						

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q1	Q2	Q3	Q4	
	reporting and delivery of audit programmes						meeting and Board/Committee priorities have been determined based on risk.
f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.	Establish Assurance Maps to identify assurances in place and any gaps in place at 1st, 2nd and 3rd line of defence for those responsibilities delegated to Executive Directors	All Executive Directors					This work has been delayed in light of the pandemic. However, work in relation to delegation and accountability arrangements continues (as per action 1b).
	Gaps in assurance to inform the Board's Assurance Framework						

Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Powys Teaching Health Board

Audit year: 2019

Date issued: October 2021

Document reference: 2551A2021-22

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

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

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

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

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

Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Powys Teaching Health Board (the Health Board) carried out between April and July 2021. To test the 'floor to board' perspective, we examined the arrangements for Community

Services. We also reviewed the high-level arrangements for assuring quality of provider services.

Key messages

6 Overall, we found that **the Health Board is committed to ensure high quality, safe and effective services and has taken steps to improve its quality governance arrangements. There remains work to embed these arrangements, articulate the quality priorities of the organisation and ensure there are measures in place to demonstrate and monitor achievement to drive improvements across the full range of services provided and commissioned.**

7 There is a clear commitment to ensure the provision of safe and high-quality services supported by corporate frameworks and improving risk management. The Health Board has well established values and behaviours and staff feel supported to raise concerns. The introduction of the new Clinical Quality Framework is positive, and its roll out is starting to strengthen operational governance, alongside an increase in resources.

8 However, the quality priorities and success measures need to be clearer in order to measure impact and improvement. Work on capturing patient feedback needs to be more consistent and there needs to be better systems for demonstrating learning. Capacity constraints within the concerns team remain an issue which needs to be addressed. There is also scope to broaden the current performance reporting to ensure a clearer focus on quality matters covering the breadth of services provided, as well as developing a quality dashboard reflecting the unique nature of the Health Board.

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Commissioning Assurance Framework R1 The commissioning assurance framework is the mechanism to provide assurance on the quality of services provided to Powys residents. • Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes.
Clinical Quality Framework R2 The current clinical quality framework articulates the steps needed to improve clinical quality governance. It does not clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight. • Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps or gaps between groups.
Alignment of Frameworks R3 Currently the Health Board has a clinical quality framework (CQF), which focusses on developing the Health Board's quality governance arrangements, and a commissioning assurance framework (CAF) which sets the framework for providing assurance on the quality of services. The CAF has been predominantly focussed on commissioned services, however there is an intention for this approach to be implemented within directly provided services (in place for Mental Health Services and Maternity Services). There are potential synergies between these frameworks and the Health Board should consider repositioning these two frameworks to further build on the inter-relationships. • Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework.

Recommendations

Concerns and Complaints

R4 As a significant percentage of activity is delivered by commissioned services there needs to be greater clarity on the oversight of complaints from Powys residents on these services.

- Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.
- Update the Commissioning Assurance Framework to ensure clarity on responsibility for monitoring and reporting of complaints.

Performance Measures

R5 Our work found that there needed to be articulation of the quality measures in place across the range of services provided. These needed to be clearly identified with a baseline undertaken in order measure the success of the clinical quality framework.

- Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board, in order to measure success and demonstrate improvements.

DATIX

R6 Our work found that at a corporate level only some staff received training and support on how to use the DATIX system to report concerns and near misses.

- Ensure that all corporate staff receive training appropriate to their role.

Training

R7 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing; however, compliance often falls short of what is required.

- Ensure that all statutory and mandatory training compliance meets the required target.

Recommendations

Data Analytics

R8 Our work found that the Community Services Group did not have a quality dashboard to provide performance information, in addition we found within the Health Board there was no dedicated data analytics team for analysing and interpreting data on quality and safety. Without this information it is difficult to provide a performance baseline, assess progress or identify areas where performance needs to improve.

- Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **there is a clear commitment to ensure the provision of safe and high-quality services supported by corporate frameworks and improving risk management. There is scope to develop clearer quality priorities and articulate success measures to measure impact and improvement.**

Quality and patient safety priorities

12 **The Health Board is committed to ensuring quality from its commissioned and provided services and has developed supporting frameworks to achieve this, but they are yet to define measurable quality priorities and metrics or use quality impact assessments when reviewing service provision.**

13 The Health Board does not have standalone quality and patient safety priorities. Instead, it has signalled its commitment to deliver the highest quality clinical care to its local population through its strategy 'A Healthy Caring Powys', Integrated Medium Term Plan (IMTP) and Annual Plan for 2021-22.

14 Within the IMTP 'Quality and Citizen Experience' is an organisational priority for the Health Board. Linked to this are a number of priority actions, such as develop a serious incident improvement plan and establish a pressure ulcer scrutiny panel. The 2021-22 annual plan clearly states that clinical quality and improvement remain a priority as the Health Board moves towards recovery post COVID-19. The Powys Health and Care Strategy 'A Healthy Caring Powys' coproduced with Powys County Council and the Powys Regional Partnership Board in 2017 demonstrates stakeholder engagement in relation to the need to secure high quality and safe services to have maximum impact on population needs.

15 To support the achievement of quality services from both its provided and commissioned services the Health Board has established two frameworks which are discussed in further detail later in the report. The **Clinical Quality Framework** (CQF) agreed by the Board in 2020 sets out a programme of work to improve quality governance, which in turn supports the delivery of improved quality outcomes. The CQF outlines five organisational goals which have synergy with the Integrated Medium-Term plan and the Annual plans. The CQF is largely process driven, identifying improvement actions across the Health Board. Each of these areas has specific actions identified, as well as a nominated lead executive. The Health Board is essentially putting the foundation blocks in place to establish and strengthen processes and procedures to deliver on its vision. However, the Health Board has not defined outcomes or expected standards against which to measure and assess success. The stated actions within the current documents relate to processes, which need to be established in order to support effective quality

governance. From our work we did not identify any local targets or priorities within the community services group.

16 To support the delivery of commissioned services, the Health Board developed a **Commissioning Assurance Framework (CAF)** in 2018. The CAF describes a continuous assurance process to ensure that commissioned services are safe, personal, effective, and continuously improving. All providers bar one have signed up to this framework, and there are currently ongoing discussions as to the reasons for this with the aim of addressing this issue in the near future.

17 There is currently no reference to the use of Quality Impact Assessments (QIA) for productivity and efficiency schemes. These assessments ask organisations to consider the impact on quality and safety of potential service changes and redesigns. Although the podiatry service redesign approved by the Board in August 2020 did contain a detailed Equality Impact Assessment (EQI) which covered access to services and protected characteristics, there was no assessment on effectiveness and outcomes in relation to the change in service provision.

Risk management

18 **The Health Board has a clear risk management framework, and risk identification and management are maturing. Work is needed to update the Board Assurance Framework in light of the new strategic priorities and ensure a clearer line of sight from the directorate risk registers to the corporate risk register and ensure that mitigations in registers are sufficient for assurance.**

19 The Health Board revised its risk management framework in 2019. The Health Board has described its risk appetite and has clearly stated that it has no appetite for risks that materially impact on the quality and safety of services the Health Board provides or commissions. However, the Health Board's corporate risk register which covers both commissioned and provider services identifies a number of risks, of which 60% are linked to the quality and safety of services. Executives are currently refreshing the register by reviewing their portfolio of risks. The Health Board plans to develop committee risk registers, and work in this area had started but was paused due to COVID-19. A programme of work is underway to map the committees to the risks as well as other assurance sources, such as clinical audit.

20 Our 2020 structured assessment[1] reported that the Health Board had a maturing system of risk management, and as part of the response to the pandemic developed and regularly monitored a dedicated COVID-19 gold risk register. The risks from the COVID-19 gold risk register have been merged into the Health Board's corporate risk register.

[1] Audit Wales, Powys Teaching Health Board Structured Assessment 2020, November 2020

21 The Heath Board has a Board Assurance Framework (BAF), however, in light of the pandemic and the annual priorities of the Board changing the BAF not been reported since January 2020, in the meantime the corporate risk register has continued to be reported to Board with details of the current controls and mitigating actions articulated against each risk.

22 The Health Board does not currently use DATIX for risk management, instead they have developed a system of Excel templates to manage the risk management process across the organisation. Through our work we reviewed a sample of these in use which shows they have been adopted widely by the organisation although moving to an electronic system would provide a more robust evidence trail of changes to risk scores over time. The Health Board will be adopting the national Once for Wales Concerns Management system[2] during 2021, and this will also include use of the DATIX risk management module.

23 The Health Board's Risk and Assurance Group usually meets bi-monthly and reports to the Executive Committee. The Group was stood down in September 2020 due to COVID-19, but meetings are scheduled to resumed in July 2021. The Group's main purpose is to discuss and ensure consistency of risk scoring across the Health Board.

24 Training in risk management has been limited. At the time of our work, Independent Members (IMs) had not received any specific training on risks, or on their roles and responsibilities in relation to risk management. The planned roll out of training for staff on risk registers had been paused due to COVID-19, although the Health Board is engaging with other risk leads across Wales in the development of a standardised risk management training module for use.

25 In 2019, the Health Board invested in risk management capacity by appointing a Head of Risk and Assurance and identifying the right level of administrative support. This small, dedicated risk management team (two full-time equivalent staff) provides risk management training and support to operational teams. Within the Community Services Group there is a dedicated lead for risk management.

26 As part of our work, we reviewed the Community Services Group's risk register and that of the Director of Primary, Community and Mental Health (directorate). These registers were up to date, with evidence of risks being escalated appropriately from the Community Services register to the Primary, Community and Mental Health Register. However, there were some areas where mitigations were missing, and the evidence for the risk scoring reducing were not clear.

27 Our observation of the Community Services Group's patient experience and quality group found there was discussion on the directorate risk register, but this was focussed on the red risks only, rather than the totality of risk. There is potential for some risks not to receive sufficient discussion. There are multiple risks associated

[2] Once for Wales Concerns Management System Programme was developed from the recommendations in the Welsh Government Report 'The Gift of Complaints'. All Health Boards will be moving to this system at some point.

with some services, eg Radiotherapy, but because these are not flagged as red risks they do not attract much attention, consequently opportunities to take a more thematic analysis of risk in this area are missed. There is the potential for a more holistic view of the risks of the register and the exploring of themes to be raised.

Organisational culture

28 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

29 We found that **Quality improvement is important to the Health Board, however, resources are limited. There are well-established values and behaviours within the organisation and staff feel supported to raise concerns. There remains work to improve consistency of capturing patient feedback and demonstrating learning from this.**

Quality improvement

30 **The Health Board is committed to growing its quality improvement capacity. There has been better use of clinical audit, although there are opportunities to better utilise clinical audit as a source of assurance.**

Resources to support quality Improvement

31 Corporately, the Health Board has a very small, dedicated quality improvement team (0.5 FTE staff), providing staff training on quality improvement methods. Improving Quality Together (IQT) is the national quality improvement training programme for NHS staff in Wales. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. Information provided by the Health Board shows that a high proportion (74%) of staff had completed the IQT training Bronze level. The team also provides dedicated support to staff completing quality improvement projects for the IQT Silver level. However, only 1% of Health Board staff have achieved IQT Silver.

32 The quality improvement team has begun working with the Research, Innovation, and Improvement Hub. This joint venture between the Health Board and Powys County Council aims to co-ordinate and support research, improve services, and support new ways of working at a Powys wide level. The Health Board are using the Research, Innovation, and Improvement hub to look at innovative ways to share learning, although this work is currently in its early development stages. To

support the hub, the Health Board has recruited a small number of staff (2.4 FTE), these staff are not immediate members of the Health Board's quality improvement team. This resource is funded until March 2022 with the staff employed on fixed term contracts. The Health Board needs to evaluate the impact of this initiative and look to fund it on a more sustainable footing if it has proved successful.

33 The Health Board has increased resources to focus on value-based healthcare through the recent appointment of a Director for Strategy and value-based healthcare, as part of the Clinical Quality Framework activities. The aim for this role is to support prudent and values-based healthcare to shape quality improvement.

34 Progress on the development of the Clinical Effectiveness and Quality Improvement Strategy articulated in the CQF has been further delayed as a result of COVID-19. This work involves using a prioritised and risk-based approach to define and deliver a programme of clinical quality improvement targets. This remains a priority for the Health Board during 2021-22.

Clinical Audit

35 Clinical audit is an important way of providing assurance about the quality and safety of services. The Health Board has an approved clinical audit plan for 2021-22 covering national clinical audits and outcome reviews mandated by the Welsh Government. The plan also includes clinical audits based on local priorities and risks identified by senior clinical managers. COVID-19 affected the Health Board's ability to deliver the 2020-21 Clinical Audit Plan because of limitations on resources with staff being redeployed to focus on COVID-19. The Health Board reviewed the 2020-21 plan and risk assessed the outstanding audits and reprofiled new dates to ensure the work is completed, and incorporated this into the 2021-22 clinical audit plan.

36 Clinical audit findings and learning are shared with both operational and strategic groups or committees. Reports are presented to the Quality Governance Group (QGG) chaired by the Medical Director and Director of Therapies and Health Sciences and the Experience, Quality and Safety Committee (EQS). Clinical audit outcomes were also considered as part of a suite of information at the inaugural meeting and subsequent meetings of the new quarterly Learning from Experience Group, which is chaired the Director of Clinical Strategy. The composition of this group includes the Director of Therapies and Health Sciences as well as the Director of Nursing and Midwifery, which ensures mechanisms to share information between this group and the Quality Governance Group. This group has identified issues from national audits and has started to discuss some of the issues raised. Operationally, monthly clinical audit and improvement meetings within both the Women's and Children's Service Group and the Community Services Group identify and share learning. All these arrangements are only recent, and need to embed and realise the planned benefits, however, early signs are they are beneficial and have been well received by staff.

37 Corporate resources for clinical audit are limited with only 0.5 FTE staff, yet demand for clinical audit is growing. Work on reauditing to ensure that learning has been embedded and improved results is also an area where further work is needed. In addition, clinical audit should serve as an important source of assurance in the board assurance framework and corporate and operational risk registers, however, this was not evident from the documents reviewed.

Mortality reviews

38 Multidisciplinary mortality and morbidity review meetings provide a systematic approach for the peer review of adverse events, complications, or mortality to reflect, learn and improve patient care. This is a positive area for Powys, having been the only health board in Wales to pilot the new medical examiner role alongside five other organisations across the United Kingdom. There are clear processes in place for mortality and morbidity reviews, with results as well as learning routinely reported to the Experience and Quality and Safety (EQS) committee and the Learning from Experience Group. Examples of learning have been demonstrated, for example, concerns raised recently about completion of formal documentation for care at the end of life has led to the formation of a small group to determine the ideal set of notes and commit to updating organisational clinical policy.

39 Currently the Health Board's EQS does not have any oversight of mortality reviews undertaken within commissioned service providers for Powys residents. There is corporate oversight through the commissioning assurance framework where cases that have been subject to a serious incident investigation within a commissioned service are flagged to the Health Board. The Once for Wales concerns management system had been expected to establish the core functionality for the learning from mortality system, however, implementation has been delayed by factors outside the control of the Health Board.

Values and behaviour

40 **There is a well-established values and behaviours framework in place with plans to revisit this soon, staff feel supported to report their concerns, however, there is further work to support staff experiencing bullying and harassment.**

41 The Health Board's Values and Behaviours Framework was published in 2015 and sets out its vision for a quality and patient-safety-focused culture with a focus on continuous improvement, openness, transparency and learning when things go wrong. The Health Board plans to bring the framework up to date alongside its organisational development strategic framework for improving organisational effectiveness. Staff induction covers expectations in relation to the Values and Behaviours framework as well as the support staff can expect in order to deliver high quality care.

42 Our work revealed a varied picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. Of the staff who completed our survey[3], (81%) staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. Some staff (54%) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Most staff (65%) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

43 It is positive that staff responding to the recent NHS Wales staff survey[4] reported low levels of bullying, harassment, or abuse by another colleague, member of the public or line manager over the past year (14.6%, 10%, and 8.6%, respectively). However, action is still needed to address the concerns of staff experiencing bullying, harassment, or abuse, given that fewer than half (45.7%) agreed or strongly agreed that the organisation takes effective action when it did occur.

44 Staff are encouraged to use DATIX to report incidents and during our interviews there was a positive culture expressed on reporting incidents, however, corporately only some staff receive training and support on how to use the DATIX system to report concerns and near misses. The Community Services Group indicated in their survey that all their staff receive training or support in using the DATIX system to report incidents or near misses.

45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing, yet our annual Structured Assessment has found that compliance often falls short of that required. Within the Community Services Group, only (42%) of staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training. To improve compliance, the community services group told us that local managers are working with teams to improve the position post COVID-19.

46 Improving compliance with personal appraisal and development reviews is another area of focus for the Health Board. The Health Board achieved a rate of 69% compliance in May 2021, which is below the 85% target but was still the fourth best in Wales. This is lower than previous years, but completion has been affected by the pandemic response and staff being redeployed. There are routine meetings with directorates to improve compliance, and the achievement of this is on the agenda for directorate managers. Organisational scrutiny of this metric is undertaken at both Performance and Resources Committee and Board.

[3] We invited operational staff working across the community services group to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across community services, we have used them to illustrate particular issues.

[4] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 29%.

Listening and learning from feedback

47 **The Health Board has a range of formal mechanisms for capturing patient experience, however, these have been affected by COVID-19. Work is underway to develop a new Patient Experience Engagement Framework and Strategy and implement a new real time system to capture patient feedback. There remains work to do to show evidence of learning from feedback.**

Patient Experience

48 The Health Board's current patient experience strategy is out of date. As part of the Clinical Quality Framework there are plans to address this through the development of a new Patient Experience Engagement Framework and Strategy. The Health Board are aiming to develop arrangements for learning from patient experience to ensure that patient experience is used to inform staff and clinical service development. However, the Assistant Director, Quality and Safety has been diverted to operational work on concerns, and other staff have been diverted to other areas due to COVID-19, which has resulted in the patient experience engagement framework and strategy falling behind schedule, although work has recently restarted and is scheduled to be completed at the end of 2021.

49 The Experience, Quality and Safety Committee (EQS) receive regular thematic reports on concerns and incidents covering all services, these reports identify lessons learnt and highlight actions taken in response. Further detail is provided to the in-committee session of the EQS to enable a more in-depth discussion of issues with patient identifiable data. Currently these reports are only considered at a corporate level, however, there are plans for the next iteration of these reports to be considered by the service groups themselves to improve ownership of the actions as well as the concerns.

50 Through our work we have found a lack of clarity regarding the capture of concerns and complaints from commissioned services. Many services for Powys residents are provided by commissioned services and the current reports only identify complaints which are directly reported to the Health Board. There needs to be further clarity on who is responsible for concerns and complaints from commissioned services and ensure the Health Board are notified in all cases of concerns raised by Powys residents, and actions taken in response.

51 The Health Board has a well-established Patient Experience Steering Group that captures and monitors patient experience activity, across provided and commissioned services. The Group, which reports to the Executive team, meets quarterly. Service groups, such as the Community Service Group, submit regular updates on their patient experience activity to the Patient Experience Steering Group, and there are plans for the Community Service Group to present reports to Experience, Quality and Safety Committee by autumn. The patient experience and outcome measures include incidents and complaints and findings from patient surveys and feedback cards. There was evidence of themes being identified

through the Patient Experience Steering Group, but actions in response were not clearly identified.

52 Through our work, we reviewed evidence of work undertaken to evaluate patient experience, such as recent surveys on the new podiatry service, which demonstrates the Health Board's commitment to obtaining patient feedback. Following the concerns regarding maternity services at Shrewsbury and Telford NHS Trust (SaTH) targeted work was undertaken with Powys residents to understand their experiences to inform the ongoing discussions with the NHS Trust. The Health Board is also currently writing a proposal to purchase Civica software to enable real-time capture of patient experience.

53 As part of our work, we asked the Community Services Group about the mechanisms used to seek patient and staff feedback more generally, and how the learning from this feedback was disseminated. Methods used included patient questionnaires, and letters as well as direct questions, with the feedback disseminated through their patient experience report shared with the Patient Experience Group and there are plans for future reports to be presented to the Experience, Quality and Safety committee. The group indicated that the majority of patient experience activity had been negatively affected by COVID-19. This was due to limited staff resources, as well as access to patients being reduced as part of infection, prevention and control arrangements. Our staff survey indicates that more needs to be done to disseminate information on patient experience to staff, given that less than half (45%) of those responding to our survey indicated that they agreed or strongly agreed that they receive regular updates on patient feedback for their work area. The Health Board also needs to consider how it can capture any concerns staff have got about patient experience. We could not see any evidence that this information was routinely captured and considered.

54 The Health Board has delivered additional training on investigating complaints and incidents, but further roll out of this training has been affected by COVID-19. The Community Services Group were unable to tell us the percentages of staff who had received training on investigating complaints or undertaking root cause analysis.

Patient Stories

55 The Board also has mechanisms for understanding patient experience. Patient stories are told by individuals from their own perspective, and in a healthcare setting, provide an opportunity to understand their experience of the care received helping organisations to learn the good and bad and what can be done to improve the experience. At the time of our audit, patient stories had not been received at Board since January 2020, and the EQS last received a patient story in October 2020. There are plans to restart these within the next few months.

Safety Walkarounds

56 Safety walkarounds provide board members with an understanding of the reality for staff and patients, help to make data more meaningful, support the triangulation process, provide assurance from more than one source of information. At the time of our audit, the Health Board did not have an established programme of patient safety walkrounds, but signalled its intent to start these later in the year with a revised set of guidance to support Independent Members.

Governance structures and processes

57 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

58 We found that **the new clinical quality framework is starting to strengthen operational governance arrangements although the new arrangements need further time to develop and embed. Whilst there has been a small increase in quality governance resources, there are still capacity constraints within the concerns team which need to be addressed.**

Organisational design to support effective governance

59 **Recent developments have strengthened lines of accountability and oversight of scrutiny to improve flows of assurance but these need to be embedded.**

60 There is clear collective responsibility for quality and patient safety amongst the Executive leadership of the Health Board. Recent substantive appointments made to the Executive team including the Director of Nursing and Midwifery, Director of Therapies and Health Sciences and Medical Director have strengthened this. Furthermore, there is now a Deputy Director of Nursing, who leads on Quality and Safety to provide additional capacity and focus. The Health Board have stated their intent in the clinical quality framework to prioritise clinical leadership development to ensure they become a truly clinically led organisation.

61 In March 2021, the Health Board established a Learning from Experience Group as a place for the clinical leaders of the organisation to share information from a range of sources, including clinical audit and mortality reviews with a view to disseminating learning across the organisation. This group has met twice, and an upward report on its work has been provided to the Experience, Quality and Safety group outlining its activities and proposed actions. Early signs of the impact of this group are positive demonstrating the effective triangulation of issues from a range of areas.

Clinical Quality Framework

62 The Clinical Quality Framework (CQF) approved by the Board in 2020, sets out a programme of work to improve quality governance over three years. Progress in implementing the framework has been slower than planned because COVID-19 has placed pressures on the teams. Work is currently underway to review and reprioritise the actions and adjust the remaining timescales.

63 As part of the Clinical Quality Framework the Health Board will be agreeing and adopting a Clinical Quality Improvement methodology. In June 2021 a progress update to the Experience, Quality and Safety Committee reported the Health Board had yet to define and deliver a programme of quality improvement projects and work on agreeing and adopting an approach to clinical quality improvement including the methodology not yet started. There was no update on the revised timescales for this work, however, it remains a priority for the Health Board during 2021-22.

64 At a strategic level, the development and implementation of the CQF is overseen by the Quality Governance Group (QGG). The QGG established in 2019 was initially chaired by the Chief Executive to oversee the Health Board's governance approach. Recently the terms of reference for this group have been revised and although its remit remains the same, the leadership has changed to the Director of Nursing and Midwifery and the Medical Director, with attendance from all the Assistant Directors of the Service groups as well to enable a clear line of sight from service to Board. The QGG will also now directly report to the Experience, Quality and Safety committee, as opposed to through the Executive committee. The Experience, Quality and Safety committee provide Board oversight of implementation of the clinical quality framework, receiving regular milestone reports which identify progress, and areas behind target.

Commissioning Assurance Framework

65 The Health Board is primarily a commissioning organisation. The largest proportion of its budget is devoted to securing health care services, including unscheduled and planned care from neighbouring NHS Wales health boards and NHS trusts in England. To assure themselves and their resident population of the safety, quality, and sustainability of these commissioned services, the Health Board developed a commissioning assurance framework (CAF) in 2018. The CAF describes a continuous assurance process to ensure that commissioned services are safe, personal, effective, and continuously improving. The experience of patients is also reviewed as well as numbers of complaints and incidents in order to detect deteriorating quality. All of the Health Board's directorates feed into this process, and there are regular reports and commissioning assurance meetings held with providers to discuss performance, quality and safety and patient experience. The CAF uses a rating system for providers across four domains: access, finance and activity, quality and safety and patient experience. Each provider is rated by the Health Board against the four domains using a red/amber/green process. Special

measures and levels of Government intervention are recorded. All this information is then captured in a high level dashboard to show at a glance the provider rating. Services provided by organisations who have been escalated as part of the respective arrangements within NHS England and Wales, and/ or those who score level 4 on the CAF, are scrutinised and monitored by the Performance and Resources Committee and the Quality Governance Group.

66 To ensure a quality focus, the Health Board has a Quality and Safety Commissioning lead, who reports to the Assistant Director, Quality and Safety in order to support the CAF process in assessing quality and safety issues within commissioned services. The Quality and Safety commissioning lead attends all commissioning review meetings with providers. The CAF currently does not include any measures on the standards of care provided or patient outcomes.

67 However, due to the pandemic the usual commissioning arrangements have not been in place since March 2020. Since July 2021 work has stepped up to restore the CAF but there remain significant limitations and escalation arrangements cannot operate in the usual way; this has affected quality reporting as well as information on patient experience.

Community Services Group

68 The structure of the Community Services Group supports multidisciplinary working through a Head of Nursing and a Head of Therapies. The Group has also recently appointed a lead clinician for quality and safety and is supported by the Assistant Medical Director to provide medical leadership. Also, there are no senior nurse roles for the inpatient wards, which leaves a potential gap in specialist ward nursing oversight and maintenance of nursing practice and quality culture.

69 The service groups across the Health Board have started to formally set out their quality governance arrangements and patient safety structures. This work has been ongoing since 2020, but is at varying degrees of implementation across the organisation as a result of capacity being diverted to respond to the pandemic. At the time of our audit, three of the five service groups had produced their quality governance and patient safety structure setting out the processes for oversight of quality and patient safety. Pace has picked up recently and there is a desire to get the new arrangements functioning. Further work is planned regarding delegating aspects of corporate reporting including concerns and incidents into service groups to improve oversight, ownership, and scrutiny of performance at a service group level by improved upward reporting within the next three months.

70 We reviewed the governance arrangements within the Community Services Group and observed one of their patient experience and quality groups. These meetings take place bi-monthly and have a standardised agenda. There is currently no quality and patient safety dashboard in place. At the time of our work, there was no formal sharing of the minutes from the quality and patient safety meetings to the executive Quality Governance Group. There was also no formal sharing of minutes

to the directorate meetings, although there was upward reporting on an exception basis.

Resources and expertise to support quality governance

71 **Health Board resources to support quality governance are limited, and historical capacity constrains within the concerns team are affecting the timeliness of responses to complaints, but recent operational appointments are positive.**

72 The Health Board reviewed the available resource to support improvement to quality governance arrangements at both a corporate and operational level. It found that service group governance needed strengthening to ensure sufficient capacity and capability at the local level. Following this the Health Board invested in additional operational capacity across some service groups to support quality improvement activities such as clinical audit, and complaints and incident handling. For example, the Community Service Group recently appointed (June 2021) a quality lead ensuring parity with other service groups.

73 Health Board resources for both patient experience and concerns are limited. There is no dedicated patient experience team, with the concerns team taking the lead in this area. This was highlighted by the Public Services Ombudsman for Wales[5] in his special report in October 2020 which tasked the Health Board with undertaking a review of the complaints handling team and its ability and capacity to deal with complaints under the Putting Things Right (PTR) regime in an effective and timely way. The capacity of the concerns team has been limited for a significant time and complaint response times within 30 days have historically been low. However, the latest performance data for May 2021 was more positive, with over 90% of complaints being responded to within 30 days. There is a backlog of concerns which needed to be addressed, an increasing number of concerns related to possible harm from COVID-19 and the rise in concerns relating to commissioned services and General Practice. The lack of capacity has been recognised, and temporary staff are in post and plans to make substantive appointments within the next six months.

74 At the time of our audit work, the Health Board was undertaking an internal review of the wider elements of PTR in response to the Public Services Ombudsman's report. The Health Board has identified a number of actions and developed an action plan, which EQS committee considered in July 2021. The plan identifies a number of actions during 2021 including training and the development of a new team structure which is currently being considered. The Health Board is monitoring its work on PTR though weekly accountability and assurance meetings where case management and complex issues are discussed by the Chief Executive, Director of

[5] Public Services Ombudsman for Wales, Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board, October 2020

Nursing, Deputy Director of Nursing and the Assistant Director, Quality and Safety. There are also weekly meetings with operational teams to monitor work on addressing concerns.

75 The Assistant Director, Quality and Safety has had to step into a more operational role due to the capacity constraints within the concerns team. This is affecting their ability to work on other areas of their remit, including patient experience, DATIX and also the commissioning lead for quality and safety. Currently there are increasing demands on the concerns team.

Arrangements for monitoring and reporting

76 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

77 We found that **there is scope to broaden the current reporting to ensure a clearer focus on quality matters covering the breadth of services provided and reflecting the unique nature of the Health Board.**

Information for scrutiny and assurance

78 **There is a commitment from the Health Board to ensure that information is available to provide information for scrutiny and assurance and commentary on harm from COVID, however the introduction quality dashboards at both the corporate and operational levels would strengthen oversight.**

79 There is a clear commitment and understanding from the Health Board that the identification and work in assessing harm from COVID-19 is vital. Papers from the EQS, and the QGG along with our interviews acknowledge the need for the Health Board to work to identify these. However, understanding and assessing harm represents a significant challenge for the Health Board as with others. The Health Board has identified a number of proposed assessment methodologies in order to understand harm across the four harms[6] and work is ongoing in these areas. However, these assessment methodologies focus on secondary care indicators, and there are no proposed measures related to primary and community care, such as childhood vaccinations or on the wider population health impacts. This work is in its early stages and there remains further work to do as with other Health Boards in Wales.

80 The Health Board has undertaken work to better understand the issues around nosocomial transmission of COVID-19. Reports have been produced and learning identified in relation to the improvements needed in data quality of some reporting systems.

[6] Organisations should be monitoring potential harm across the four quadrants set out in the quarterly operational planning framework.

81 Data systems within the organisation do produce information and local teams have access to these and support to interpret information and develop bespoke reports. However, there are limitations and the current systems lack the ability to produce statistical charts or year-on-year comparisons. There is no dedicated data analytics team for analysing and interpreting data on quality and safety, either corporately or operationally.

82 At an operational level, the Quality and Patient Experience meetings within the Community Services Group provide oversight of the quality and performance within the service group, which then informs the routine Primary Care, Mental Health and Community directorate meetings. Some of these meetings were stood down during COVID-19 and the reporting focussed more on COVID-19-related risks on a more frequent basis and routine quality indicators less frequently. The routine meetings are now re-established. We observed one of the Community Services Quality and Patient Experience groups, and this aligned to the expected agenda as described within their quality governance framework. Information was provided on patient experience which included Serious Incidents as well as complaints and compliments. There were also highlight reports from each area identifying issues and concerns for escalation. However, the group did not have a performance dashboard of quality metrics in place. Although the governance structure does set out expectations of quality reporting in line with the NHS delivery Framework and identification of measures, these are not currently reported.

83 As there are currently no patient safety dashboards in place it is difficult to see an overall summary across service groups or identify any trends and issues. Workforce issues such as sickness are not presented to enable triangulation of sources of information. In addition, due to the nature of the Health Board it is challenging to compare its performance on quality measures against others. It can be difficult therefore to ensure sufficient context to identify if reported figures are of concern.

Coverage of quality and patient safety matters

84 **There is scope to broaden coverage at the corporate and operational level of quality and patient safety matters, and to ensure sufficient coverage on primary care as well as secondary services.**

85 Performance reporting within the Health Board aligns to the current national delivery framework with the 84 measures in place mapped to the Healthier Wales quadruple aims. These reports presented to Board clearly identify trend information, and commentary is provided to explain performance and actions being taken to address areas where performance is not in line with expectations. The current performance report, although in line with the NHS delivery framework, does not have any specific broader measures of performance in areas such as District Nursing, and there are no locally agreed measures in place. There are no other performance reports relating to quality and patient safety reported to the Board.

86 The agendas of the EQS committee are balanced and informed by routine reports on concerns and complaints. A Putting Things Right report is produced for every meeting and data is interpreted and information on performance as well as commentary on actions taken following concerns and incidents is provided. The EQS also receives updates on commissioned services that are in escalation through the CAF process. Currently, performance on services is contained in corporate reports but there are plans underway as part of the Clinical Quality Framework (CQF) for the service groups to produce and present their own performance reports to EQS and QGG which will enable better Independent Member and executive scrutiny. A report on clinical audit progress is also received at the EQS routinely to provide assurance on progress delivering the Health Board's clinical audit plan.

87 The Community Services Group delivers a unique portfolio of services including general community nursing and therapy services, alongside unscheduled care, and minor injuries, including outpatients, elective surgery, endoscopy and diagnostic ultrasound and radiography services. Current quality reporting identified within their quality governance and patient safety structure does not cover all these services, with information largely focused on hospital-based service settings in response to the NHS Wales national delivery framework. Previous audit work has identified the need for more tailored performance metrics for district nursing services, but progress to address this issue appears limited.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Commissioning Assurance Framework R1 The commissioning assurance framework is the mechanism to provide assurance on the quality of services provided to Powys residents. • Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes.	The Health Board will undertake a review of the Commissioning Assurance process to ensure: (i) it identifies/reflects patient/service risks post COVID-19; and (ii) it is accessible (in a user-friendly format) to engage a wider range of staff to enable them to inform the corporate view of patient/service risks.	March 2022	Director of Planning and Performance and Director of Nursing and Midwifery

Recommendation	Management response	Completion date	Responsible officer
Clinical Quality Framework R2 The current clinical quality framework articulates the steps needed to improve clinical quality governance. It does not clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight. • Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps between groups.	Changes to the Board's assurance committees for 2021/22 have been approved by Board (July 2021) and are currently being implemented. A review of the management groups enabling Committees is currently underway. On approval of a revised management group structure, the Clinical Quality Framework will clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight.	March 2022	Board Secretary and Director of Nursing and Midwifery

Recommendation	Management response	Completion date	Responsible officer
Alignment of Frameworks R3 Currently, the Health Board has a clinical quality framework (CQF), which focusses on developing the Health Board's quality governance arrangements, and a commissioning assurance framework (CAF) which sets the framework for providing assurance on the quality of services. The CAF has been predominantly focussed on commissioned services, however there is an intention for this approach to be implemented within directly provided services (in place for Mental Health Services and Maternity Services). There are potential synergies between these frameworks and the Health Board should consider repositioning these two frameworks to further build on the inter-relationships. • Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework.	The Clinical Quality Framework sets out the Health Board's primary strategic approach to continuous development of high-quality services for the people of Powys. The Commissioning Assurance Framework will be more closely aligned to the Clinical Quality Framework. The Commissioning Assurance Framework will be applied to services directly provided by the Health Board.	31 December 2021 March 2022	Director of Nursing and Midwifery

Recommendation	Management response	Completion date	Responsible officer
Concerns and Complaints R4 As a significant percentage of activity is delivered by commissioned services, there needs to be greater clarity on the oversight of complaints from Powys residents on these services. • Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.	The current commissioning assurance mechanisms will be strengthened to ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.	30 September 2021	Director of Nursing and Midwifery

Recommendation	Management response	Completion date	Responsible officer
Performance Measures R5 Our work found that there needed to be articulation of the quality measures in place across the range of services provided. These needed to be clearly identified with a baseline undertaken in order measure the success of the clinical quality framework. • Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board in order to measure success and demonstrate improvements.	Within the Clinical Quality Framework (Goal 5) Health Board has committed to 'Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care' (Goal 5). This workstream will focus on: • reviewing and developing performance monitoring arrangements for clinical services; aligning to work undertaken on the Commissioning Assurance Framework; • reviewing and developing ward/department and service-level dashboards; • developing arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance; and • developing/integrating a valid and robust organisational benchmarking approach, using national/international comparators where available.	September 2022	Director of Public Health

Recommendation	Management response	Completion date	Responsible officer
DATIX R6 Our work found that at a corporate level only some staff received training and support on how to use the DATIX system to report concerns and near misses. • Ensure that all corporate staff receive training appropriate to their role.	As part of the implementation of the new Once for Wales Concerns Management System there is a full programme of training that is being delivered across the organisation and includes all relevant staff who require access. This training programme will be monitored and reported on to ensure full coverage. Developments will also link to the national programme re implementation, training and module release.	March 2022	Director of Finance and IT
Training R7 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing; however, compliance often falls short of what is required. • Ensure that all statutory and mandatory training compliance meets the required target.	Statutory and Mandatory training compliance was 81% as of August 2021, which shows an increase of 1% when compared to the previous month (80%). The Workforce & OD team continue to work with managers to improve Statutory and Mandatory Training compliance. Particular focus will be given to those areas who are below the current organisational compliance rate of 85%. Directors will take a personal role in ensuring statutory and mandatory training within their function continues to improve to meet the 85% standard.	31 March 2022	Director of Workforce & OD with Executive Directors

Recommendation	Management response	Completion date	Responsible officer
Data Analytics R8 Our work found that the Community Services Group did not have a quality dashboard to provide performance information, in addition we found within the Health Board there was no dedicated data analytics team for analysing and interpreting data on quality and safety. Without this information it is difficult to provide a performance baseline, assess progress or identify areas where performance needs to improve. • Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance.	Within the Clinical Quality Framework (Goal 5) Health Board has committed to 'Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care' (Goal 5). This workstream will focus on: • reviewing and developing performance monitoring arrangements for clinical services; aligning to work undertaken on the Commissioning Assurance Framework; • reviewing and developing ward/department and service-level dashboards; • developing arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance; and • developing/integrating a valid and robust organisational benchmarking approach, using national/international comparators where available.	September 2022	Director of Public Health

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Breakdown of Respondents	Number of Responses
Administration and Clerical	**3**
Allied Health Professional	**23**
Ancillary	**15**
Healthcare Support Worker	**21**
Management	**6**
Nursing or Healthcare Assistant	**13**
Registered Nurse	**51**

Breakdown of Respondents	Number of Responses
Other	**5**

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[7]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
1. Care of patients is my organisation's top priority.	61	52	13	11	1	138
2. I am satisfied with the quality of care I give to patients.	64	55	7	6	1	135

[7] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[8]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
3. There are enough staff within my work area/department to support the delivery of safe and effective care.	18	32	33	32	16	134
4. My working environment supports safe and effective care.	38	57	20	14	4	133
5. I receive regular updates on patient feedback for my work area/department.	16	45	36	28	7	132

[8] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[9]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients.	42	50	24	7	3	126
7. My organisation acts on concerns raised by staff.	21	56	30	18	7	132
8. My organisation encourages staff to report errors, near misses or incidents.	51	58	19	5	0	133
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation.	27	47	36	6	1	117

[9] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[10]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again.	34	54	30	3	2	123
11. We are given feedback about changes made in response to reported errors, near misses and incidents.	19	41	43	24	2	129
12. I would feel confident raising concerns about unsafe clinical practice.	45	63	14	8	4	134
13. I am confident that my organisation acts on concerns about unsafe clinical practice.	36	49	27	12	2	126

[10] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[11]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Working in my organisation						
14. Communication between senior management and staff is effective.	19	46	43	18	10	136
15. My organisation encourages teamwork.	32	69	20	9	5	135
16. I have enough time at work to complete any statutory and mandatory training.	16	41	31	37	11	136
17. Induction arrangements for new and temporary staff (eg agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care.	19	58	37	12	15	131

[11] Not all respondents answered every question therefore the total respondents may vary by question.

Archwilio Cymru
Audit Wales

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

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

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

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

Archwilio Cymru
Audit Wales

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

Date issued: November 2021

Document reference: 2001A2020-21

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

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

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

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

Contents

Audit, Risk & Assurance Committee Update

About this document

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Accountability Report and Financial Statements	Audit work is complete.
Audit of the 2020-21 Charitable Funds Account	Audit work due to commence in November.

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

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted TBC
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	Phase 1 – Completed and report presented to ARAC in July

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	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 2 -Report due out for clearance January 2022
Renewal Programme Executive Lead – Director of Planning & Performance	This local work will examine the arrangements put in place to deliver the Health Board's renewal programme.	Scoping TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Whole system commentary and data analysis currently being completed Further work not yet started

Good Practice events and products

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

5 In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here. This includes the material from our COVID-19 Learning Week held in March 2021.

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

NHS-related national studies and related products

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

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Taking Care of the Carers	October 2021
A Picture of Healthcare	October 2021
A Picture of Social Care	October 2021
Picture of Public Services 2021	September 2021

Archwilio Cymru
Audit Wales

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

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

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

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

Audit, Risk and Assurance Committee	**Date of Meeting: 16 November 2021**
Subject :	Interim Report for Losses and Special Payments for the period 1st April 2021 to 31st October 2021
Approved and Presented by:	Director of Finance & ICT
Prepared by:	Head of Financial Services and Assistant Director, Quality and Safety
Other Committees and meetings considered at:	None

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

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

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

EXECUTIVE SUMMARY:

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

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

DETAILED BACKGROUND AND ASSESSMENT:

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

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

This paper provides an interim report for the period 1st April 2021 to 31st October 2021.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Concerns Team structure has changed in recent months reflecting work focussing on capacity and capability. Three new posts are now in place (1) Concerns and Public Services Ombudsman Coordinator, (2) Redress, Inquests and Compensation Claims Coordinator and (3) Senior Administrator Concerns Team. Role (2) has responsibility for this area of work, contributes to the management of the claims and redress cases on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support is provided via Legal & Risk Services on the management of individual cases.

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

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery (the Chief Executive prior to the appointment of the substantive Executive Director of Nursing). All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. The Executive Team received an update on a case by case basis for the period August 2020 to June 2021 at the Executive Committee on 14th July 2021. A summary position on overall open cases was provided to the Experience, Quality & Safety Committee in July and September 2021, and thereafter bi-monthly. The next detailed paper is scheduled for the Executive Committee January 2022.
- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2021 to 31 October 2021, the THB made payments in respect of 8 cases totalling £83,351.70 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year to date the THB has received no reimbursements in respect of cases that exceeded the £25,000 THB liability.

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

	No. of payments/Receipts	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	16	8	£83,351.70
Total	**16**	**8**	**£83,351.70**

There were no receipts from Welsh Risk Pool in respect of Clinical Negligence and Personal Injury cases over 25k during 1st April 2021 to 31st October 2021.

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 11 open which are inclusive of clinical negligence (8) and personal injury (3) claims, with NWSSP Legal and Risk Services instructed to act on behalf of the health board. The health board also have 2 potential claim files open which are currently being considered.

Redress (Putting Things Right)

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

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

	No. of payments/receipts	No. of cases	£
Redress Payments	23	16	£11,193.70
Total	**23**	**16**	**£11,193.70**
Redress Receipts	0	0	£0.00
Total	**23**	**16**	**£11,193.70**

There are currently 17 open redress cases at variable stages:-

- 3 cases awaiting expert opinion
- 2 cases awaiting instructions from complainant solicitors
- 12 cases at various stages of review/progression

There has been one approved reimbursement payment of £750 during 2021/22, this reimbursement is awaited. Learning in respect of further cases submitted for reimbursement of monies are currently being considered by the Welsh Risk Pool Services.

General Medical Practice Indemnity (GMPI)

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2021 to 31st October 2021 are included in **Appendix Aiii.**

	No. of payments/receipts	No. of cases	£
GMPI Payments	2	1	£612.00
Total	**2**	**1**	**£612.00**
GMPI Receipts	0	0	0.00
Total	**2**	**1**	**£612.00**

There are currently 2 open GMPI cases at variable stages of review/progression.

There has been no reimbursement from Welsh Risk Pool during 2021/22.

Other Special Payments

Details of the payments are included in Appendix Aiv.

	No. of payments/receipts	No. of cases	£
Other Special Payments	3	3	£37,318.43
Total	**3**	**3**	**£37,318.43**

Conclusion

The Audit Committee is asked to note the above interim report for 2021/22 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

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

Appendix Ai

Losses And Special Payments for 2021-22 Financial Year 1st April 2021 to 31st October 2021			Appendix Ai			
Claim Type	Payment Type	Welsh Risk Pool Ref	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Defence	MN/030/1166/AV	Apr-21	£2,446.20		
Clinical Negligence	Claimant Costs	MN/030/1166/AV	Apr-21	£16,000.00	£18,446.20	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1564/AS	Jun-21	£10.00	£10.00	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1454/OF	Jun-21	£4,032.00	£4,032.00	Interim payment case ongoing
Personal Injury	Defence	PI/030/1432/AH	Jun-21	£720.00	£720.00	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1178/AV	Aug-21	£648.00		
Clinical Negligence	Defence	MN/030/1178/AV	Aug-21	£270.00		
Clinical Negligence	Defence	MN/030/1178/AV	Sep-21	£720.00		
Clinical Negligence	Defence	MN/030/1178/AV	Sep-21	£180.00		
Clinical Negligence	Defence	MN/030/1178/AV	Sep-21	£360.00	£2,178.00	Interim payment case ongoing
Clinical Negligence	Damages	MN/030/1441/RR	Sep-21	£25,000.00		
Clinical Negligence	Claimant Costs	MN/030/1441/RR	Sep-21	£30,000.00	£55,000.00	Interim payment case ongoing
Clinical Negligence	Defence	MN/030/1509/OF	Oct-21	£1,860.00	£1,860.00	Interim payment case ongoing
Personal Injury	Defence	PI/030/1556/AH	May-21	£427.90		
Personal Injury	Defence	PI/030/1556/AH	Jun-21	£330.00		
Personal Injury	Defence	PI/030/1556/AH	Jul-21	£347.60	£1,105.50	Interim payment case ongoing
		TOTAL		£83,351.70	£83,351.70	

Appendix Aii

Redress Losses And Special Payments for 2021-22 Financial Year 1st April 2021 to 31st October 2021				Appendix Aii
Payment Date	**Redress Reference**	**Laspar Reference**	**Nature of Payment**	**Amount**
Apr-21	4464	216C4MN0004	Damages	£1,500.00
Apr-21	4596	216C4MN0009	Defence	£9.90
Apr-21	4596	216C4MN0009	Damages	£1,000.00
May-21	4596	216C4MN0009	Defence	£29.70
May-21	3925	206C4MN0007	Damages	£1,600.00
Jul-21	3492	196C4MN0012	Defence	£360.00
Jul-21	3111	196C4MN0006	Damages	£300.00
Apr-21	3222	196C4MN0007	Defence	£207.90
Aug-21	3222	196C4MN0007	Defence	£1,720.00
Aug-21	3292	196C4MN0005	Defence	£1,890.00
Sep-21	42947	216C4MN0006	Defence	£1,705.00
Jul-21	3966	196C4MN0013	Defence	£108.90
Jul-21	4445	216C4MN0007	Defence	£19.80
Aug-21	4445	216C4MN0007	Defence	£99.00
Apr-21	4449	216C4MN0008	Defence	£39.60
Jul-21	4449	216C4MN0008	Defence	£29.70
Aug-21	4449	216C4MN0008	Defence	£49.50
May-21	4165	226C4MN0001	Defence	£79.20
Jul-21	4165	226C4MN0001	Defence	£39.60
Apr-21	42248	226C4MN0002	Defence	£198.00
Aug-21	163	226C4MN0003	Defence	£69.30
Jul-21	167	226C4MN0004	Defence	£49.50
May-21	52	226C4MN0005	Defence	£89.10
			Total	**£11,193.70**
Reimbursements from Welsh Risk Pool				
Receipt Date		**Laspar Reference**	**Nature of Reimbursement From Welsh Risk Pool**	**Amount**
				£0.00
			Total	**£0.00**

Appendix Aiii

GP Indemnity Losses And Special Payments for 2021-22 Financial Year

1st April 2021 to 31st October 2021

Appendix Aiii

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount
Jul-21	GPM/030/1555/CAP	Defence	£12.00
Sep-21	GPM/030/1555/CAP	Defence	£600.00
		Total	**£612.00**

Reimbursements from Welsh Risk Pool

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

Appendix Aiv

Other Losses And Special Payments for 2021-22 Financial Year

1st April 2021 to 31st October 2021

Appendix Aiv

Payment Date	Laspar Reference	Nature of Reimbursement	Amount
Apr-21	216C4EG0001	Agreement of lesser amount in respect of fraud case	£1,515.60
Jun-21	216C4EG0002	Loss of personal hearing aids whilst on ward	£2,939.30
Aug-21	216C4EG0003	Agreement of lesser amount in respect of dental clawback as based on legal advice - Amount approved by Welsh Government	£32,863.53
		Total	**£37,318.43**

Archwilio Cymru
Audit Wales

Picture of Public Services 2021

Report of the Auditor General
for Wales

September 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Act 2006.

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

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

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to providing staff and other resources for the exercise of the Auditor General's functions, and to monitoring and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/ or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

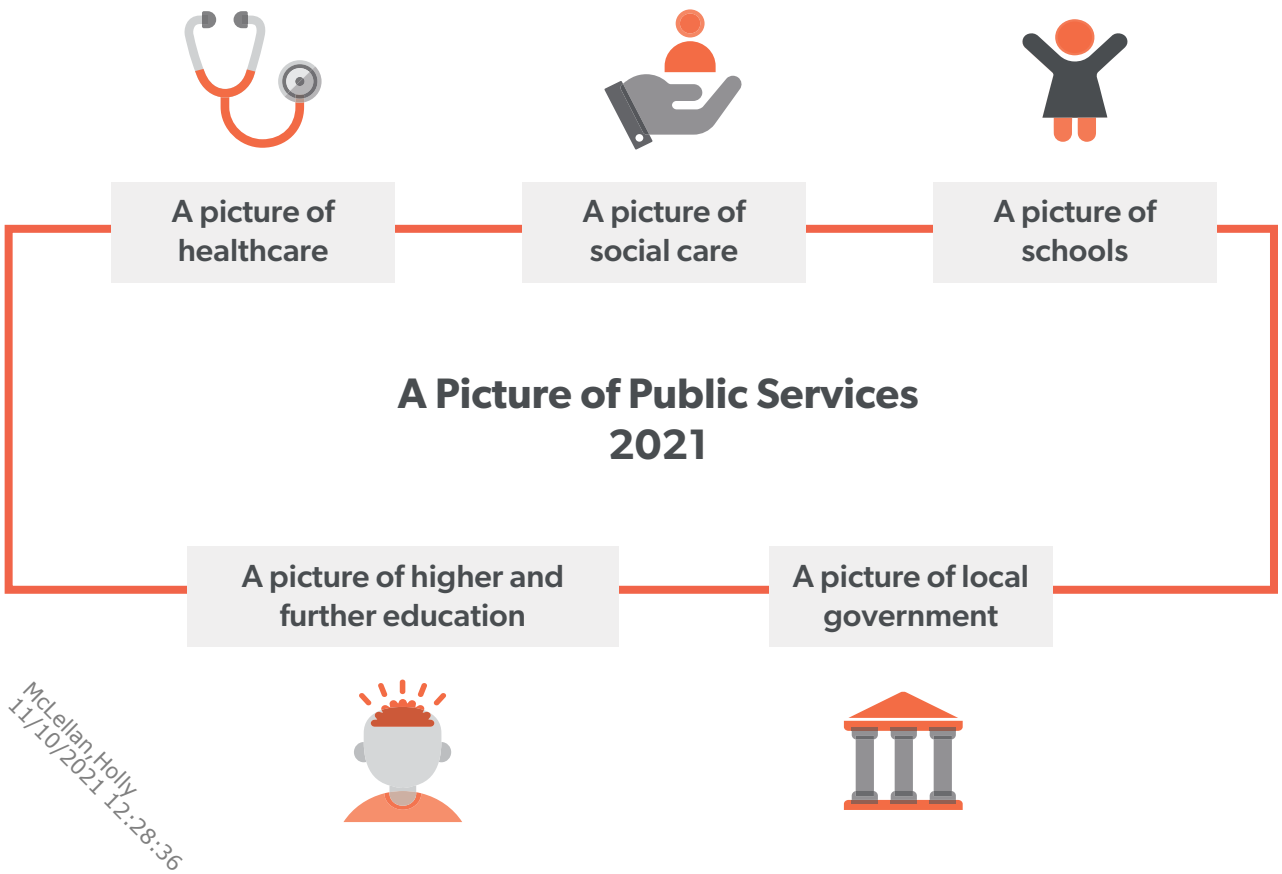
Contents

About this report

This report is part of a series of Picture of Public Services 2021 outputs (**Exhibit 1**). It summarises some key trends in public finances and sets out our independent perspective on some of the key issues for future service delivery. Our aim in producing this report is to support scrutiny of public services in the Senedd, within individual public bodies and in wider society. It also provides insight than can help with collective planning of public service delivery.

The report draws on our published work and research by other organisations (**Appendix 1**). Underpinning this report is a series of sector-specific summaries setting out some key facts and analysis, which we will publish during September and October 2021.

Exhibit 1: Picture of Public Services outputs



Auditor General's foreword

1 The COVID-19 pandemic has had a devastating impact on many families and communities, yet it has also brought out much of the best in our public services. All of us at Audit Wales pay tribute to the dedication and extraordinary efforts of public servants across Wales through this tumultuous period.

2 As we emerge from the pandemic, public services in Wales face many challenges. They are grappling with three over-arching crises of global proportion: the public health crisis of COVID; the environmental crisis of climate change; and an economic crisis.

3 After a long period of austerity and the economic hit from the pandemic, the coming years will offer little respite for the public finances. For services already stretched before COVID-19 hit, the pandemic has created new challenges like its longer-term health impacts, backlogs of patients on waiting lists and lost learning in schools, colleges and universities. As they respond, there is expectation that public services will also address some of the big issues of inequality in our society. And they must do so at a time when an emerging set of constitutional issues post-Brexit may complicate the response, especially to the economic challenges in Wales.

4 Yet this daunting agenda is not without opportunity. The pandemic has demonstrated great strengths in the public service in Wales. The opportunity now is to build on the progress made in rapidly transforming the way services are provided during the pandemic to tackle the long-standing challenges that have pre-occupied Welsh public services for some time.

5 In these circumstances, it is essential that public services get the most value out of the available resources. Value is not just about delivering more outputs more efficiently. Value for money is also about outcomes: making progress in improving the wellbeing of individuals and communities. As Auditor General, I will report on the performance of the public services in delivering that value from the public money they use.

6 This report is by no means the full story of what has happened over the past decade, or of what is to come. But it sets out some of the most important areas for public service delivery where I will be expecting to see progress in the coming years (**Exhibit 2**).

Exhibit 2: key areas of public service transformation

	Systems and culture to support new approaches to service delivery
	Purposeful collaboration
	Long-term financial and service planning that supports a rigorous and realistic approach to prevention
	Harnessing digital technology to make services more accessible
	Using data and information to learn and improve across the whole public service system

Adrian Crompton
Auditor General for Wales

Key facts

£17.6 billion

total funding available to Wales through the block grant in 2019-20 (before the impact of the COVID-19 response)

+16%

increase in funding for healthcare, 2010-11 to 2019-20

-3%

reduction in the revenue funding available to the Welsh Government, 2010-11 to 2019-20

-17%

reduction in core Welsh Government funding for local government, 2010-11 to 2019-20

-3%

reduction in schools revenue spending, 2010-11 to 2019-20

ZERO

net carbon emissions the Welsh Government wants to achieve in Wales by 2050 at the latest

52%

proportion of the Welsh Government's 2019-20 revenue budget allocated to health

- 26,000 (8%)

fall in size of the public service workforce in Wales, 2010 to 2020

£5.1 billion

amount the Welsh Government allocated to the COVID-19 response in 2020-21

£1.20

amount Wales gets for devolved public services for every £1 spent on equivalent services in England

£152 million to £292 million

amount Wales Fiscal Analysis estimates the NHS will need each year for four years to address the waiting list backlog

£600 million to £900 million

amount the Education Policy Institute estimates could be needed to support education recovery over three years

+ 126,000 (74%)

forecast growth in people aged 80 and over living in Wales, 2018 to 2043

This report is split into three parts

1 Read about what happened with public services in 2010-11 to 2019-20

2 Read about the response to COVID-19 in 2020-21

3 Read about some of the key challenges and opportunities for public services in the coming years

After a decade of squeezed budgets and rising demands, many services were already stretched before the pandemic hit

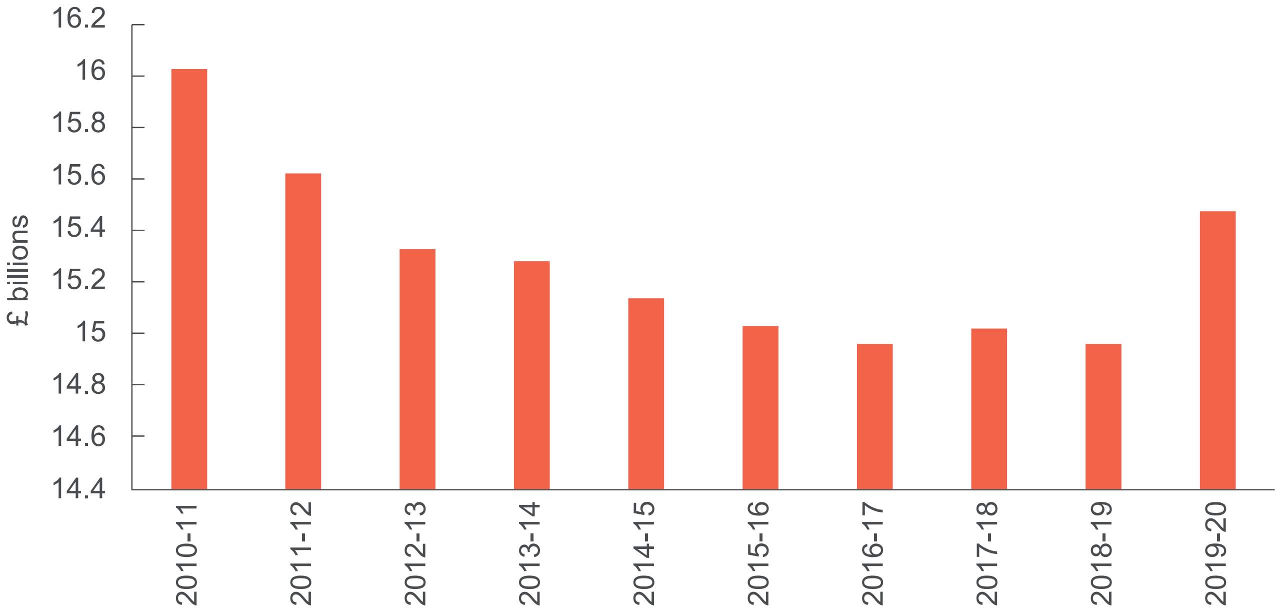
01

1.1 This part of the report looks at the position of public services in the period 2010-11 to 2019-20: before the COVID-19 pandemic started. It provides important context around trends in public finances, priorities, demand pressures and capacity constraints. These trends help to explain why some public services were already stretched before the pandemic hit.

Austerity defined the previous decade for public services, although cuts were less severe than expected

1.2 Austerity was a defining feature of the previous decade for public services. Funding was tight, although not as challenging as expected when we reported in 2015[1]. At that time, UK government spending plans showed the Welsh Government's budget falling by 4% in real terms between 2015-16 and 2019-20. Actually, the Welsh Government's day-to-day revenue funding rose slightly: it was 3% higher in 2019-20 than 2015-16, reflecting a significant uplift in 2019-20 (Exhibit 3). Even so, the 2019-20 revenue budget was 3% below 2010-11 in real terms.

Exhibit 3: Welsh Government revenue budget, 2010-11 to 2019-20 (real terms, 2019-20 prices)

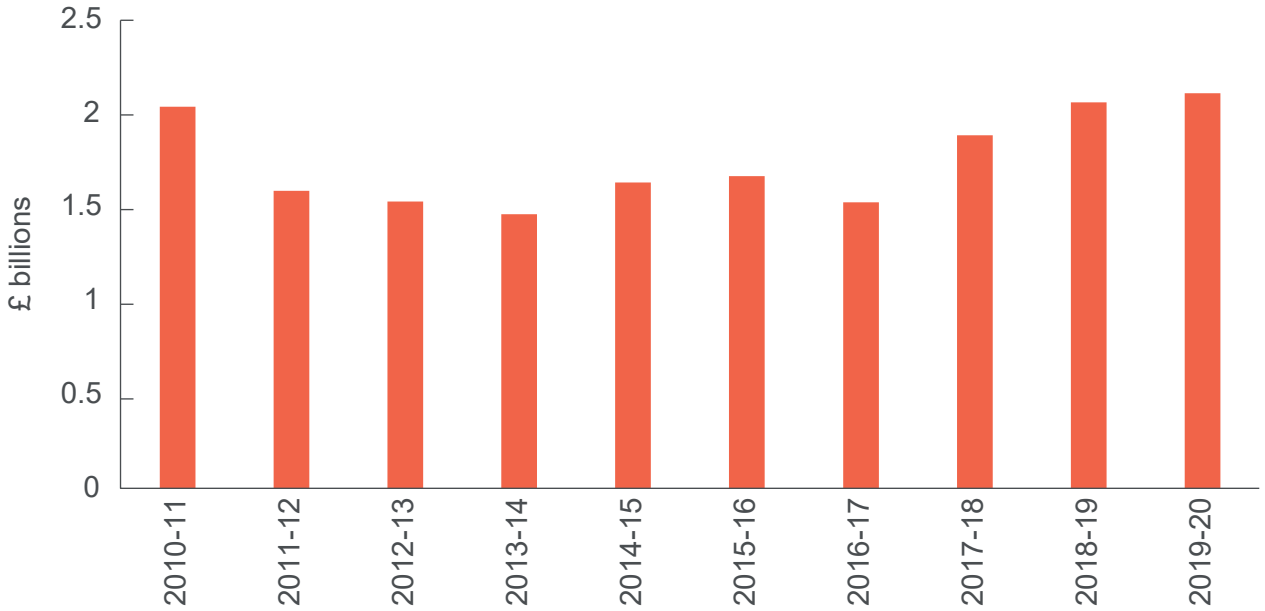


Source: HM Treasury Public Expenditure Statistical Analyses, StatsWales and the Welsh Government's budget

1 Auditor General for Wales, A Picture of Public Services 2015, December 2015

1.3 For capital spending to pay for investments in infrastructure, the picture is different. The Welsh Government's 2019-20 capital budget had increased by 27% compared to 2015-16 (**Exhibit 4**). By 2018-19, the capital budget was higher than 2010-11.

Exhibit 4: Welsh Government capital budget, 2010-11 to 2019-20 (real terms, 2019-20 prices)

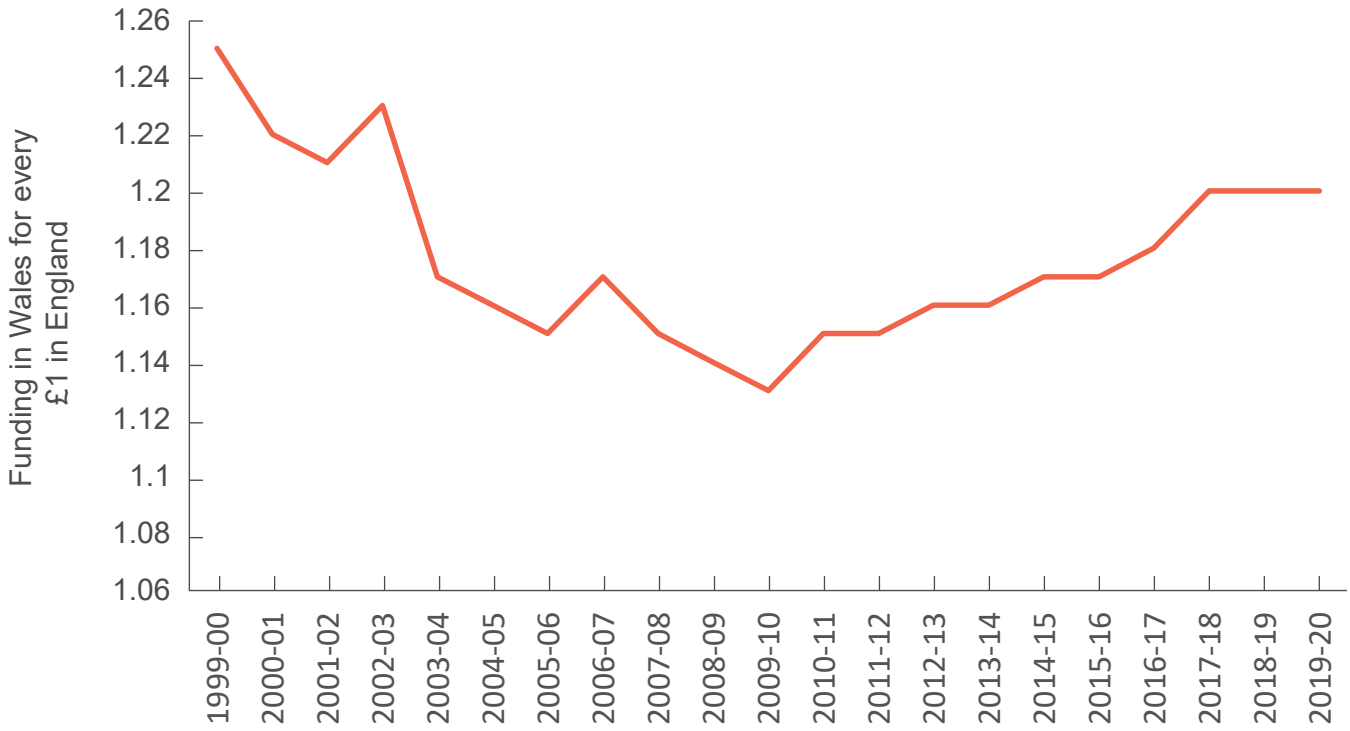


Source: HM Treasury Public Expenditure Statistical Analyses

1.4 Funding for Wales and the other devolved nations is determined by the Barnett formula[2]. Prior to 2010-11, the way in which the formula worked meant that levels of funding per person for devolved services in Wales and England were gradually getting closer together. Since 2010-11, the picture has reversed: in 2019-20, Wales had around £1.20 per head for every £1 for equivalent services in England (**Exhibit 5**).

2 The Barnett formula allocates funding to the devolved administrations. It is based on a combination of changes in spending in England, the relative size of the population and, in Wales, a 'needs-factor' that aims to ensure Wales always gets at least 115% of funding for equivalent services in England.

Exhibit 5: devolved funding per head of population relative to England, 1999-00 to 2019-20



Note: this chart shows the amount of funding per head of population that the Welsh Government gets to spend for every £1 for equivalent services in England.

Source: the agreement between the Welsh Government and the United Kingdom Government on the Welsh Government's fiscal framework (also known as the Fiscal Framework)

Funding for the NHS and social care has increased while most other areas have seen reductions

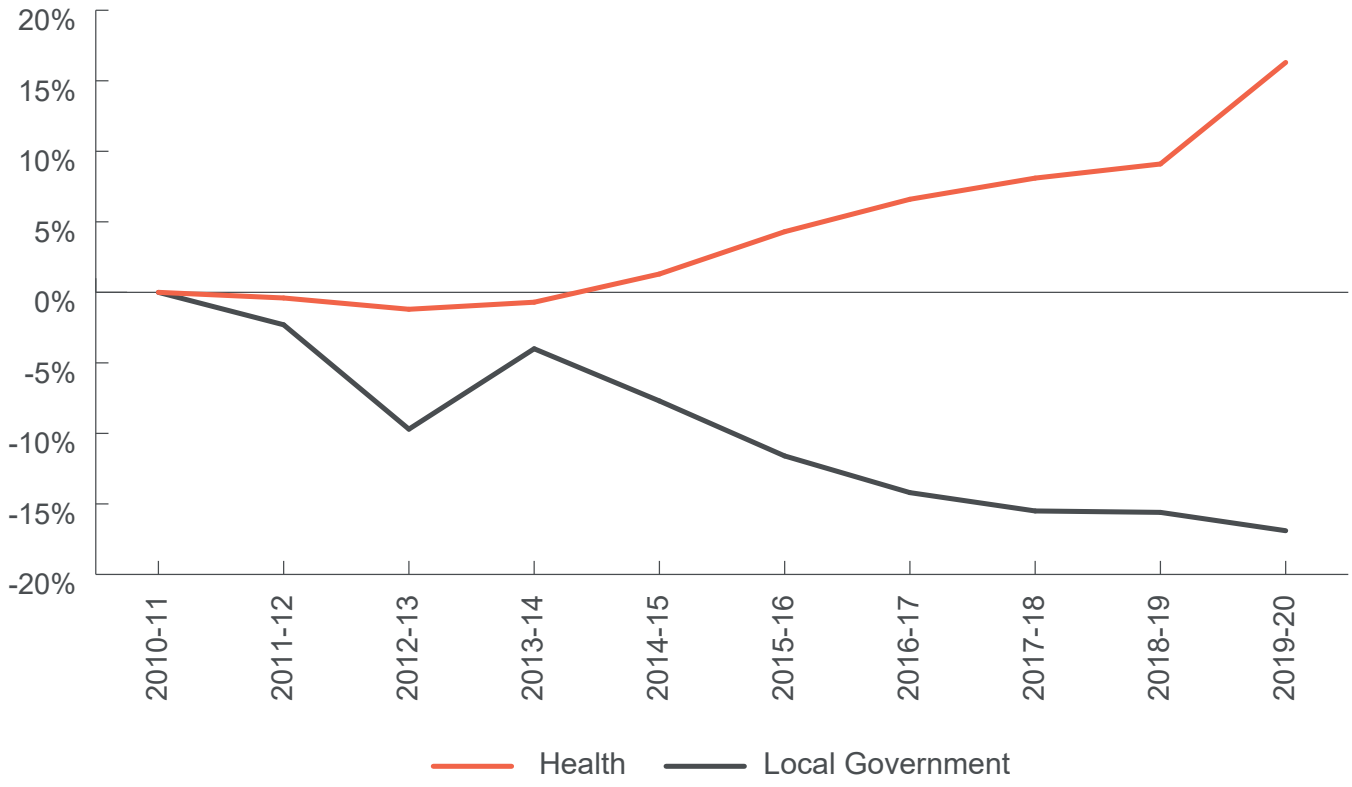
1.5 The Welsh Government chooses how to allocate the overall budget between its various spending departments and then to individual programmes. In 2019-20, health and social care took up just over half (52%) of the total revenue budget.

1.6 Between 2010-11 and 2019-20, Welsh Government revenue funding for NHS Wales has increased 16% in real terms while revenue funding to local government[3] fell by 17%. Over the same period, many of the Welsh Government sponsored bodies have also had reductions in their funding from the Welsh Government. We looked at four of the larger sponsored bodies that have been in place for that period[4] and found that they saw an average cut in grant in aid of 18%.

3 Welsh Government revenue funding for local government includes the core revenue support grant, the distribution of non-domestic rates and other non-specific grants. These fund the core services offered by local government, such as schools and social care. The figure does not include grants for specific programmes and projects which go to local government.

4 These were National Museum of Wales, the Arts Council of Wales, the National Library of Wales and Sport Wales. The largest sponsored body is Natural Resources Wales, which was set up in 2013, and is not included in our overall calculation. Its accounts show grant in aid from the Welsh Government fell by 29% in real terms between 2015-16 and 2019-20, but with part of the context being an expectation that merging multiple bodies to form Natural Resources Wales would lead to cost savings.

Exhibit 6: change in core Welsh Government revenue funding for health and local government, 2010-11 to 2019-20 (real terms, 2019-20 prices)



Note: the local government funding is adjusted for 2010-11 to 2013-14 to reflect changes to the council tax support scheme. The local government funding has not been adjusted to reflect 'de-hypothecation' where previously stand-alone grants have been included into the core funding.

Source: Audit Wales analysis of Welsh Government budgets and StatsWales

1.7 To lessen the impacts of reduced Welsh Government funding, councils have significantly increased the income they raise through council tax. The total amount raised by council tax increased by 35% on top of inflation between 2010-11 and 2019-20.

1.8 Nonetheless, total revenue expenditure across local government fell by 8% over the period. These cuts have not fallen equally across local services. Real terms spending[5] on social care for families has increased by 43% and for older people by 14%. Spending on schools fell by 3%. The deepest cuts have come in leisure and culture and library services which have seen cuts of over 40% and regulatory services, such as development control, building control, trading standards and consumer protection which have seen cuts of over 30% over that period.

1.9 Choices made by the governments in Wales and England are reflected in the cuts experienced by different parts of the public services in the decade prior to the pandemic. Our analysis of HM Treasury spending data[6] shows that spending per person by local government in England fell by 24% between 2010-11 and 2019-20 compared to 10% in Wales. Spending per person on health in Wales increased by 7% over the same period but went up by 10% in England.

With demand, cost and other pressures, many public services were already stretched when the COVID-19 pandemic hit

Across many service areas, funding has lagged behind demand and cost pressures over the past decade

1.10 All public services face cost pressures each year. These arise from a combination of factors, such as inflation on the price of goods and services they buy, wage rises and rising demand. Independent reviews in 2014 and 2016[7] showed that the NHS faces cost pressures of around 3-4% each year on top of inflation. Between 2010-11 and 2019-20, funding for the NHS increased by an average of 1.7% a year, in real terms. These demand and cost pressures are part of the story that explains why, despite increased funding, the NHS has had to improve productivity and deliver cost savings each year and some health boards have struggled to live within their means.

5 In this report, our analysis of local government spending on services uses the 'gross' expenditure figure. This is the total amount spent without deducting income from fees, charges and other sources.

6 We have used the HM Treasury Country and Regional Analysis dataset. These figures are on a per head of population basis, cover revenue and capital and are calculated on a different basis from our analysis of Welsh Government revenue funding to health and local government in paragraph 1.6.

7 Nuffield Trust, A decade of Austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26, June 2014; and Health Foundation, The path to sustainability: funding projections for the NHS in Wales to 2019/20 and 2030/31, October 2016

1.11 Local government faces cost pressures across a range of areas. For example, the social care sector faces rising demands in care for older people and children and families and pressure to increase the sometimes very low wages of social care staff[8]. The Health Foundation estimated pressures of 4.1% a year in adult social care. Since 2010-11, social care spending has gone up by an average of 2% a year in real terms. There is variation within that overall figure: spending on services for children and families went up by an average of 4.1% a year compared to an average increase of 1.5% for services for older people and a 0.9% rise for services for adults under 65.

1.12 Other sectors and service areas have also faced cost pressures. The fact that most have seen real terms cuts strongly suggests that, right across public services, funding has not matched cost pressures over the period of austerity.

Comparison to England in terms of need and spend shows some interesting and perhaps unexpected patterns

1.13 The assessments of annual cost pressures referenced above consider how much funding is required to sustain existing levels of service but do not ask whether standing still is sufficient to meet needs. Experts tend to calculate need relative to England, in part because England, through the Barnett formula, is the benchmark for levels of funding. Wales has higher levels of need for public services than many other parts of the UK.

1.14 In 2010, the Holtham Commission estimated Wales' level of need compared to England to be around 115%[9]. In other words, for every £1 spent on services in England, per head of population, £1.15 would be needed for Wales. In our 2019 report on public spending trends, we estimated Wales' relative needs for healthcare compared to England were around 118%[10].

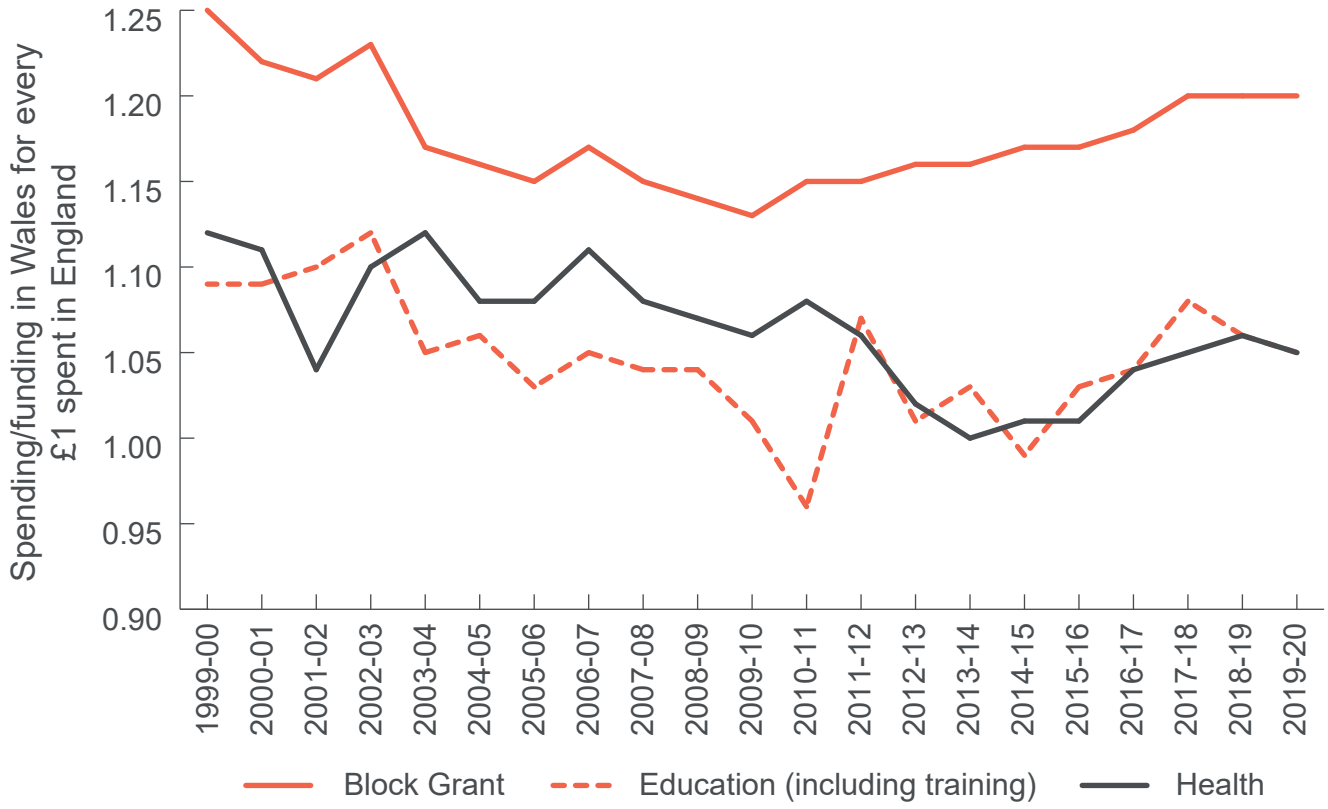
1.15 Since the start of devolution, the Welsh Government has received at least 115% of funding per head in England, with the exception of 2008-09 and 2009-10 when funding dropped to 114% and 113% respectively. In 2019-20, Wales received around 120% of funding per head of levels in England (**Exhibit 7**).

8 London Economic Wales, Short to medium term operational and cost pressures affecting social care in Wales: Final report to the Welsh Government, March 2020 Table 2

9 Independent Commission on Funding and Finance for Wales, Fairness and accountability: a new funding settlement for Wales, July 2010

10 Auditor General for Wales, Public Spending Trends in Wales 1999-00 to 2017-18, October 2019

Exhibit 7: spending on health and education per head of population in Wales and overall devolved funding relative to England, 1999-00 to 2019-20



Source: Audit Wales analysis of HM Treasury Country and Regional Analysis data and the agreement between the Welsh Government and the United Kingdom Government on the Welsh Government's fiscal framework (also known as the Fiscal Framework)

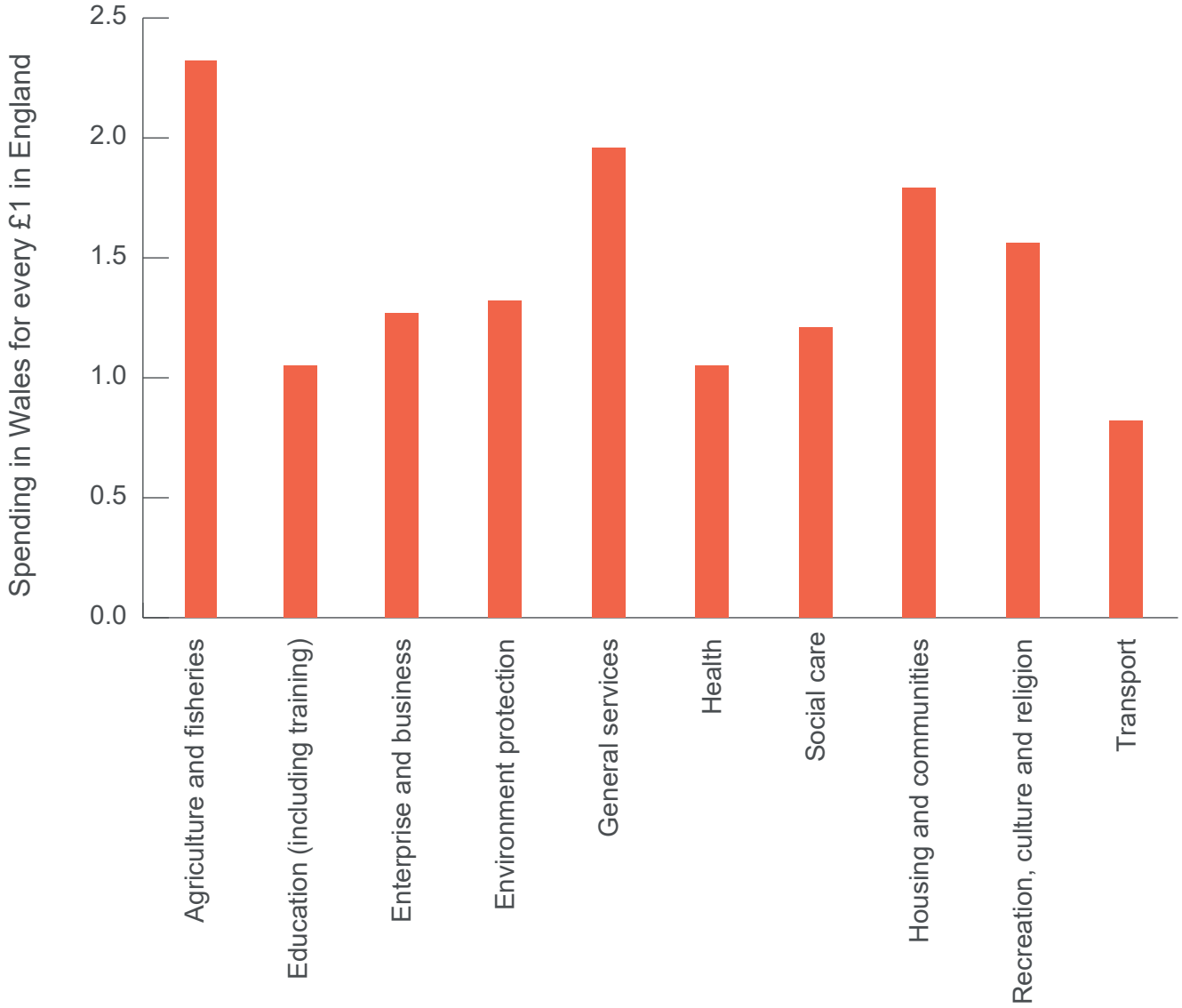
1.16 The relative level of funding has not translated through to equivalent levels of spending on the two largest service areas: health and education. In 2019-20, Wales spent £1.05 for every £1 spent on health and education[11] in England (**Exhibit 7**).

1.17 The wider international context is OECD data showing that spending on health in the UK is the second lowest of all the G7 countries[12].The flip side of different spending priorities on health and education is that spending in Wales on other areas of service is much higher than in England. **Exhibit 8** shows significantly higher spend, per head, in Wales on social care, agriculture, general services, economic affairs, housing and community and culture, recreation and religion.

11 Comparative analysis by the Institute for Fiscal Studies shows that spending per school pupil in Wales is lower than spend per pupil in England.

12 Organisation for Economic Co-operation and Development, Health at a Glance 2019, November 2019

Exhibit 8: comparative spending per head of population in policy areas which are mostly devolved, Wales and England, 2019-20



Note: these figures cover mostly devolved spending but may include some direct UK government expenditure, for example on transport where there is a mixture of devolved and non-devolved spending. More detail on the categories can be found in our Public Spending Trends data tool.

Source: Audit Wales analysis of HM Treasury, Country and regional analysis, November 2020

Capacity in many services was stretched before the pandemic hit

1.18 Many public services had stretched capacity before the pandemic hit. Office for National Statistics data shows that the total public sector headcount in Wales, including non-devolved services, fell by 26,000 (8%) from 324,000 to 298,000 between 2010 and 2020[13]. As we highlight below, within that overall picture there are specific workforce challenges facing different sectors. There have also been challenges with other aspects of capacity such as hospital beds, school places, and care home infrastructure in social care.

1.19 The NHS has seen a rise in overall staffing levels but has recruitment challenges and has been reliant on agency and temporary staff. For many years, bed occupancy has been above the recommended level of around 82% to 85%. Before the pandemic, Wales had amongst the lowest levels of critical care beds per head of population in international comparisons[14].

1.20 When the pandemic hit, the NHS created extra bed capacity by stopping non-urgent activity and repurposing existing capacity, such as operating theatres and recovery rooms, as critical care units. As our September 2020 report on planned care noted, stopping all non-urgent planned care was not entirely novel. Health boards have done it in a planned way to manage winter pressures in emergency care and in an unplanned way by cancelling operations at short notice.

1.21 There is a widespread and long-standing recognition of the need for social care reform. The challenges of rising demand, particularly from older people and children's services, are compounded by low financial margins in care homes for older people and difficulty finding placements for children and young people who are taken into care. The sector faces multiple staffing issues including low pay, high turnover rates, and falling staff numbers in some areas. Equally, there is widespread recognition that the pandemic has revealed the limitations of the social care system.

1.22 Schools have struggled with mismatched capacity; surplus places in some schools while others are over-subscribed. However, the number of surplus spaces has reduced since 2009. There are shortages in staff in some subjects and particularly for the Welsh-medium sector. The system for initial teacher training has been overhauled but the number of trainee teachers has been lower than required in each of the last six years to 2019-20. Over the last ten years, staffing levels and full-time student numbers in further education have remained broadly stable, but part-time provision has fallen dramatically due to funding constraints. However, in higher education, student numbers have increased at a greater rate than staffing levels.

13 Office for National Statistics, Public Sector Employment dataset, July 2021

14 In 2019-20, there were 154 critical care beds – the lowest per head of the population in the UK and amongst the lowest in Europe: Faculty of Intensive Care Medicine and Intensive Care Society, Guidelines for the Provision of Intensive Care Services, Edition 2, June 2019

1.23 Over the last ten years, staffing numbers in local authorities have fallen and skills deficits have emerged. Office for National Statistics data shows that the headcount in local government in Wales reduced by 19% from March 2010 to March 2020[15]. Our work has identified that staffing reductions mean councils do not have adequate numbers of staff with expertise in cross cutting policy and planning areas, and planning authorities lack staff with specialist skills, such as in design and infrastructure.

1.24 There is a similar picture in the Welsh Government. Between 2010 and 2020, the average number of full time equivalent Welsh Government staff decreased by 8%. Our work has identified that staff shortages have impacted on the Welsh Government's policy delivery in some key areas in recent years, and we have highlighted that gaps were created when staff were redeployed to deal with the challenges of Brexit. There have also been reductions in staff at the larger Welsh Government sponsored bodies (**paragraph 1.6**), ranging from 3% to 19%.

15 Office for National Statistics, Employment in local government in Wales, March 2008 to December 2020, May 2021

Public services had to adapt rapidly to the pandemic and the Welsh Government allocated over £5 billion in 2020-21 in response

02

2.1 This part of the report covers 2020-21, with a particular focus on the response to the COVID-19 pandemic. It describes some of the ways in which public services have adapted to the pandemic. It sets out the funding allocated to the response by the Welsh Government, breaking that down by different areas of spending. It also summarises the overall picture of aspects of the response set out in some of our recent audit work.

The COVID-19 pandemic severely disrupted public services and the wider social, economic and cultural life of Wales

2.2 COVID-19 has had a tragic impact on individuals and communities. As at mid-June 2021, more than 5,500 people had died with COVID. More than two-thirds of those deaths happened during the second wave in the autumn and winter of 2020-21. Almost half (45%) of those who died lived in the area covered by Aneurin Bevan and Cwm Taf Morgannwg University Health Boards. As at mid-June 2021, Wales had the highest number of deaths with COVID-19 on the death certificate, per 100,000 population, in the UK.

2.3 As set out in **paragraph 1.20**, the NHS stopped all but the most urgent non-COVID activity. Operating theatres and wards were repurposed to create extra critical care space for the most ill patients. GPs and other primary care services moved to online or telephone where possible. In social care and in the NHS, visits to patients and residents were severely curtailed.

2.4 The education system changed drastically. The Welsh Government lifted the requirement on schools to deliver the full national curriculum in March 2020. Students and pupils have had periods of online learning. Some have also had periods in the classroom and lecture halls with measures in place to mitigate against the spread of the virus, restricting some learning opportunities such as extra-curricular activities, trips and laboratory experiments. Schools have been transformed with classrooms re-arranged to encourage distancing, start times, end times, playtimes and lunchtimes all re-arranged to reduce mixing of pupils and parents.

2.5 Other local services, from leisure to waste and recycling facilities, have also experienced periods of stopping and re-opening with protective measures in place. Some staff from closed services have been re-deployed to other aspects of the COVID-19 response, such as preparing and delivering food parcels for vulnerable and isolating households. Inside the civil service, staff have been redeployed to support the response in various ways.

The Welsh Government allocated £5.1 billion on the COVID-19 response in 2020-21

2.6 In 2020-21, the Welsh Government created a £6 billion funding pot specifically for COVID-19-related activity. Over the year, it received an extra £5.7 billion in revenue through the Barnett formula due to COVID-19 spending in England. The Welsh Government added to UK government funding by re-prioritising £256 million from existing departmental budgets[16]. Some of the key movements in funding into the COVID-19 pot were:

- £50 million which was intended to improve NHS waiting times;
- £30 million previously set aside for the Childcare Offer for Wales;
- £16 million for higher education funding; and
- £12 million apprenticeship funding.

2.7 The Welsh Government allocated[17] around £5.1 billion of this extra money in 2020-21 on services to respond to the public health crisis, to support businesses and communities, to replace lost income for some public services and to prepare the ground for the recovery (**Exhibit 9**). Of the remaining funding in the COVID-19 pot, the Welsh Government converted £305 million into capital[18] and carried forwards £485 million into 2021-22[19].

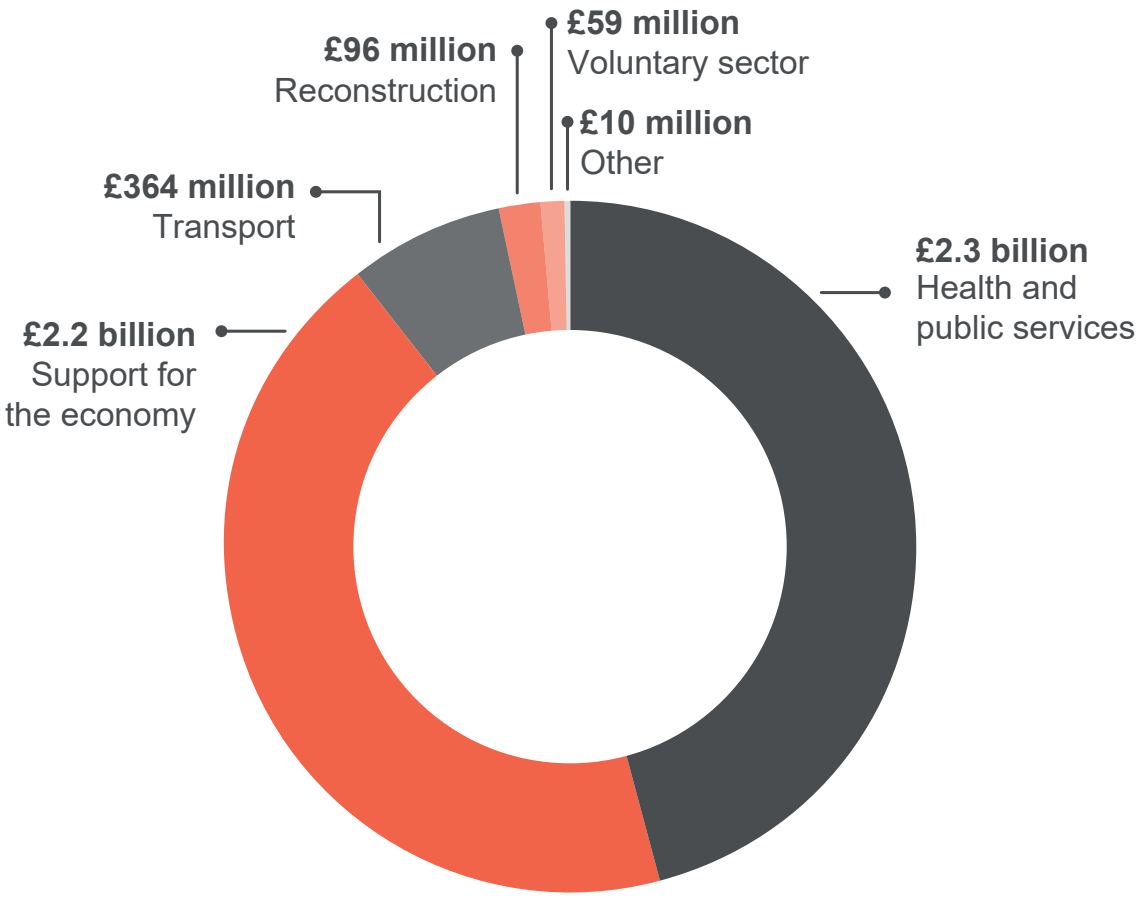
16 In the first supplementary budget the Welsh Government had re-prioritised £245 million of EU Structural Funds to support the response but once the full funding from the UK government came through, it decided it no longer needed this funding for the COVID-19 response in 2020-21.

17 Here we set out the funding 'allocated' by the Welsh Government, by which we mean the sum set aside for specific areas of spending. In some cases, the actual spend, or outturn, may be different by the end of the year.

18 The £305 million capital was included as part of a wider £772 million allocation of capital funding in the third Supplementary Budget. The allocation included £188 million capital to support the COVID response and 'reconstruction' and a £270 million allocation to the Development Bank for Wales.

19 The UK government announced additional funding through the Barnett formula late in 2020-21 and agreed that the devolved administrations could carry this money into the following financial year.

Exhibit 9: split of the Welsh Government's £5.1 billion COVID-19 allocation to services for 2020-21



Note: 'Reconstruction' covers several funding pots the largest components of which relate to education (**paragraph 2.10**).

Source: Audit Wales analysis of Welsh Government data

2.8 The Welsh Government has allocated £2.3 billion to supporting the NHS and other public services in dealing with the pandemic. This figure includes an £800 million stabilisation fund for the NHS alongside specific funding for programmes such as vaccinations, Test, Trace and Protect and PPE. The funding also includes a £660 million[20] Crisis Fund for local government, which covers a range of general costs as well as specific items such as free school meals, additional costs in social care, and supplementing the loss of income from fees with services closed.

20 Although the Welsh Government allocated £660 million, by the end of the financial year it reports having spent £587 million.

2.9 The Welsh Government allocated £2.7 billion to support the economy, the transport sector and the voluntary sector. This funding includes around £1 billion for the Economic Resilience Fund, around £730 million in grants related to non-domestic rates for small and medium businesses, £350 million in rates relief for retail, hospitality and leisure businesses and £130 million to support the higher education and further education sectors. The Welsh Government also allocated £170 million to support rail services and £95 million for bus services. The Welsh Government has allocated £59 million to support voluntary services. This includes £29 million for Third Sector Support, £15 million for the Discretionary Assistance Fund and £13 million towards provision of food for people who were shielding.

2.10 The Welsh Government allocated £96 million in 2020-21 to support what it is calling 'reconstruction'. This is made up of a range of smaller pots of funding, the largest being £11 million to cover free school meals during the holidays, and £10 million for three education programmes: to support children during exam years; to support the further education sector; and for mental health, student support and a hardship fund for the higher education sector.

2.11 Compared to the UK government's equivalent spending in England, Wales Fiscal Analysis notes that the Welsh Government has spent less of its COVID-19 funding on the NHS while spending more supporting businesses and communities[21]. In part, these differences may be down to the Welsh Government being able to secure better value for money. For example, on Personal Protective Equipment and Test, Trace, Protect, the Welsh Government appears to have got similar or better results compared to England while spending proportionately less.

21 This comparison does not include the furlough scheme which is run and funded by the UK Government.

Our COVID-related work paints a broadly positive picture of aspects of the way Welsh public services responded but this is not necessarily indicative of the overall management of the pandemic

2.12 In response to the pandemic[22], our key initial piece of work was a COVID-19 Learning Project. This involved gathering emerging intelligence on good practice from public services' response and sharing learning in real time through a combination of blogs and updates to our audited bodies. Examples included public bodies working together and with communities to deliver food parcels, provide information to the public on how and where they could get tested and a range of other practical responses. As the pandemic progressed and the first wave came to an end, we identified examples and lessons for public services as they started to re-open services to the public. In November 2020, we produced a short report on the work to provide free school meals to pupils while at home[23].

2.13 Since early 2021, we have published more detailed reports on areas of the response: the Test, Trace and Protect programme, the supply and procurement of PPE, NHS governance arrangements during the pandemic, and the rollout of the vaccinations programme[24]. All these reports paint a broadly positive picture of aspects of the response, although all highlight lessons to learn as well. They show public bodies rapidly putting in place collaborative systems and flexible governance arrangements.

2.14 These reports reflect only aspects of the response to COVID-19 in Wales. While our reports paint a positive picture of aspects of the management and governance of individual programmes, they should not be taken as a positive view on the response in the round. Our report on the supply and procurement of PPE, for example, highlighted some of the weaknesses with the pre-pandemic preparations and that we cannot ignore the views expressed by some of those on the frontline about their own experience.

2.15 The UK government intends to set up a public inquiry in due course, which is likely to take a much broader and more in depth look at the overall pandemic response. The Welsh Government has stated its view that the Welsh response should be reviewed as part of that inquiry.

22 At the start of the pandemic, we significantly adjusted our work programmes, recognising the impact on our own capacity and to ensure we could contribute to public services' response while not adding to the pressures public services were facing.

23 Auditor General for Wales, Providing Free School Meals During Lockdown, November 2020

24 Auditor General for Wales: Doing it Differently, Doing it Right?, January 2021; Test, Trace, Protect in Wales, March 2021; Procuring and Supplying PPE for the COVID-19 Pandemic, April 2021; Rollout of the COVID-19 vaccination programme in Wales, June 2021

Public services need to manage the ongoing response to the pandemic and start to recover while adapting to new demands

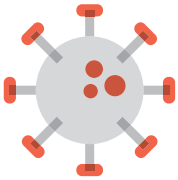
03

3.1 The previous decade threw up many challenges for public services and there will be little respite in the near future. This part of the report looks at some of the key issues for public services in the coming years and important aspects of service transformation where we will be focusing our attention (**Exhibit 10**). This section is not intended to be comprehensive in setting out all the areas public services need to address, and other review bodies will have their own perspective on the key issues.

Exhibit 10: some key opportunities and challenges for public services

A changing world

- Climate change: achieving a fair and just transition
- Equalities: responding to demands for a fairer and more equal society
- Constitution: managing the opportunities and risks of new relationships within the UK



The ongoing pandemic

- Direct costs of response
- Economic hit knocks-on to public finances
- Legacy costs of long-term impacts

Transforming service delivery

- Systems and culture to support new approaches to service delivery
- Purposeful collaboration
- Long-term planning and prevention
- Harnessing technology where appropriate
- Using data to learn across the whole system

3.2 Several of these areas, particularly in relation to a changing world, are reflected in the Welsh Government's Programme for Government for 2021 to 2026[25]. Our commentary builds on some of the messages in our 2020 report on implementation of the Well-being of Future Generations (Wales) Act 2015[26].

25 Welsh Government, Programme for Government, June 2021

26 Auditor General for Wales, So What's Different? Lessons from the Auditor General's Sustainable Development Examinations, May 2020

The Welsh Government has at least an additional £2.6 billion to support the ongoing pandemic response in 2021-22

3.3 The pandemic is not over, and further public spending will be needed in 2021-22. As at July 2021, the Welsh Government had received a total of £2.1 billion additional funding related to COVID-19 for 2021-22. In addition, it has the £485 million carried forward (**paragraph 2.7**), taking the extra funding in 2021-22 to £2.6 billion on top of an increase in the core non-COVID budget.

3.4 As of July 2021, the Welsh Government's internal plans show it had allocated £1.5 billion, with £884 million to health and public services, £470 million to support the economy, £107 million for transport and £14 million for the third sector and communities. The situation remains fluid and, depending on the path of the pandemic and the UK government response, further funding may be announced in the coming months.

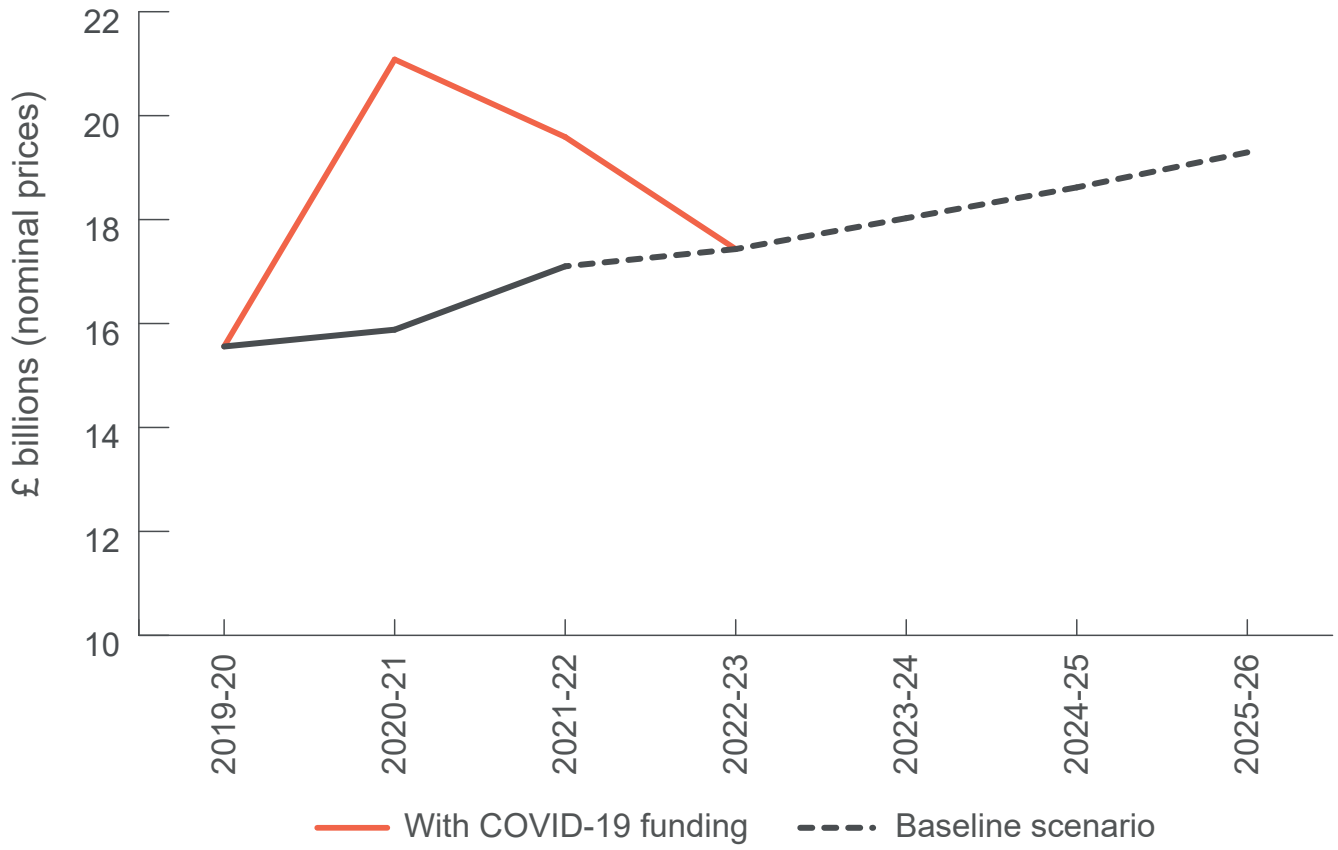
The UK government has promised no return to austerity, but funding is still likely to be tight given the cost pressures facing public services

The economic hit from the pandemic means public finances are likely to be tight for some time

3.5 The funding position beyond 2021-22 is unclear but UK public finances are in a challenging position. Economic activity fell during the pandemic, with companies and individuals paying less tax. Coupled with higher spending, the UK's overall debt and the annual deficit – the gap between income and expenditure – have grown significantly.

3.6 The UK government has said there will not be a return to austerity as it seeks to reduce the level of debt. It revised its spending plans downwards in March 2021 but still intends for overall public spending to grow in real terms. Wales Fiscal Analysis projected the Welsh Government's revenue budget to 2025-26 based on the UK government's March 2021 plans (**Exhibit 11**). It shows a 1.5% a year real terms budget increase between 2021-22 and 2025-26, excluding COVID-specific funding. It is possible these projections will change when the UK government produces a fuller spending review later in 2021.

Exhibit 11: projected funding for Welsh Government day-to-day spending, 2019-20 to 2025-26



Note: The Wales Fiscal Analysis projections in this chart are on a nominal basis, which means they are not adjusted for the impact of inflation. Figures for 2020-21 reflect a fall in non-domestic rate revenues associated with the rates relief, a budget switch to capital spending and the transfer of farm subsidies to the Welsh budget. The 2021-22 figure does not include additional funding, mostly for the COVID-19 response, set out in the Welsh Government's June 2021 Supplementary Budget.

Source: Wales Fiscal Analysis, Welsh Election 2021: Fiscal outlook and challenges for the next Welsh Government, April 2021

Cost pressures from the pandemic and demographic change will mean difficult choices for public funding

3.7 Life for public services remains far from normal and that is likely to remain the case for some time. Once the pandemic is fully over, public services face a huge job of recovery. They will need to catch up on activity that was paused and deal with new problems created by the pandemic. The most obvious challenges are in the NHS where there are backlogs of patients on waiting lists and, unquantified pent-up demand from people who have put off seeking help.

3.8 There are other backlogs, for example the challenge of making up lost learning for pupils and students across the education system. These backlogs all have a significant cost attached: Wales Fiscal Analysis calculated that addressing the backlog in planned care would cost between £152 million and £292 million a year over four years[27]. Applying the Barnett formula to its estimates for England, the Education Policy Institute has estimated that an extra £600 million to 900 million could be needed over three years to support education recovery in Wales[28].

3.9 Some, or even all, of the requirements around social distancing, wearing PPE, ensuring adequate ventilation in indoor spaces may be with us for some time, depending on policy choices and public health advice. These restrictions affect the productivity of public services. The shift to online and telephone-based services may offset some of the effect of these restrictions on productivity. But many services, notably surgery and other personal interventions, cannot take place online. As a result, public services need either more capacity or to find ways to reduce demand and activity just to stand still, let alone address backlogs.

3.10 There are potential longer-term implications. The long-term direct health implications of COVID-19 are still being studied. The extent to which these will create new demand and cost pressures on the NHS is unclear. There is evidence of an impact on the mental wellbeing of households, which may increase the need for ongoing health and social care support. There are also other as yet unknown impacts on the public service workforce: there is speculation that some staff may not wish to continue as before or may accelerate retirement plans after the pandemic[29], creating potential capacity and/or pay pressures, for example if gaps need to be filled by expensive agency or locum staff. There may also be costs involved in helping parts of the public service workforce recover from what has been a traumatic experience.

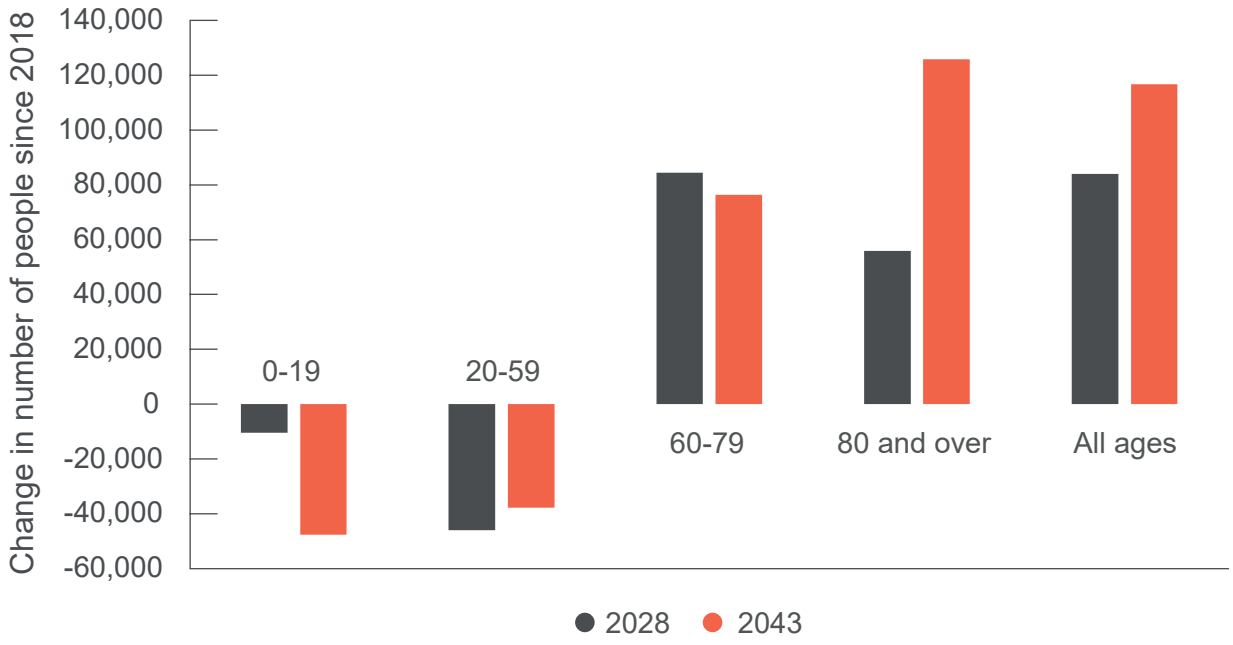
27 Wales Fiscal Analysis, The NHS and the Welsh Budget: Outlook and challenges for the next Welsh Government, April 2021

28 Education Policy Institute, Analysis Paper: Preliminary Research Findings on Education Recovery, April 2021

29 For example, evidence from a British Medical Association survey, which is based on a self-selecting sample, suggests more than a doubling of doctors considering early retirement and many considering reduced hours or a career break. British Medical Association, COVID-19 tracker survey snapshot, April 2021.

3.11 Cost pressures also arise from changes in the population. Currently, Wales' population is expected to increase by around 117,000 by 2043 (**Exhibit 12**). We do not know yet if changes such as increased remote working will be long lasting and potentially affect population trends. For public services, the bigger challenge will be from the change in the age profile because of birth-rates and migration within the UK and beyond. The proportion and number of children and young people is now expected to fall while the number of older people (60-79) and very old people (80 and over) increases. By 2043, it is estimated that 9.1% of the population will be aged 80 and over, compared to 5.4% in 2018. The overall number aged 80 and over is expected to increase by around 126,000 (74%).

Exhibit 12: population projections – change in age groups from 2018 to 2028 and 2043



Source: Office for National Statistics, Principal projection – Wales population in age groups, October 2019

3.12 The aging population is likely to increase demands for health and social care. While fewer children and young people may lead to less demand for some services; there are less obvious cost pressures. For example, in education, the cost of schooling per pupil tends to increase as the number children and young people falls because of the higher costs per head associated with providing small schools.

3.13 Given a likely tight funding settlement and ongoing cost pressures, the Welsh Government faces some difficult immediate choices on funding priorities. Wales Fiscal Analysis reports looking at the NHS (**paragraph 3.8**) and local government[30] suggest that the funding set to come to the government to 2025-26 seems unlikely to cover all the cost and demand pressures faced by these two large sectors. There are also demand and cost pressures in other areas of public service. The Welsh Government and other public services therefore face continued difficult choices about prioritisation.

Other factors including the climate emergency and the push for greater equality will affect public services in the short and long term

Public services face the challenge of achieving a just and fair transition to net zero

3.14 Since our last Picture of Public Services report, the Welsh Government and the majority of local authorities have declared a climate emergency. In March 2019, the Welsh Government's low carbon action plan[31] drew together 100 ongoing and planned actions across government. In March 2021, the Senedd approved a net zero target by 2050 with an ambition to achieve the target earlier[32]. It also approved interim targets for 2030 and 2040 and carbon budgets.

3.15 The Independent Climate Change Committee's 2020 report[33] highlighted the scale of the challenge ahead for the Welsh Government and, by extension, other public bodies. The report showed that, in 2019, Wales' emissions have fallen 31% since 1990. This is less than the fall in the UK as a whole (41%). Achieving the Welsh Government's target of a 63% cut in emissions compared with 1990 by 2030 will require the same fall in the next nine years as has been achieved in the last 30 years.

30 Wales Fiscal Analysis, Local Government and the Welsh Budget: Outlook and challenges for the next Welsh Government, April 2021

31 Welsh Government, Prosperity for All: A Low-Carbon Wales, March 2019. Work to update and revise the plan is currently underway.

32 Under the 2008 Climate Change Act, Wales is required to contribute to the UK 2050 net zero target and the UK's carbon budgets. The Act committed the UK to an 80% reduction in carbon emissions relative to the levels in 1990, to be achieved by 2050. In June 2019, secondary legislation was passed that extended that target to 'at least 100%'. In April 2021, the UK government announced its intention to legislate for a target to reduce emissions by 78% by 2035.

33 The Independent Climate Change Committee is a statutory body established under the Climate Change Act 2008. Its remit covers the UK. It advises the Welsh Government on its targets and strategy. It reports progress against targets annually to the UK and Parliaments of the devolved nations. Climate Change Committee, Progress Report: Reducing emissions in Wales, December 2020.

3.16 As the Committee's report states, achieving net zero will require an integrated approach that puts climate mitigation and adaptation at the heart of public services in every sector. Some public bodies have produced plans for achieving net-zero by 2030. The Welsh Government is producing guidance for public bodies including a Public Sector Route Map to Net Zero and a common methodology for reporting emissions. We will be undertaking an ongoing programme of audit commentary on public sector action to address climate change. This will include a baseline review of action across the public sector during 2021-22.

3.17 Achieving these goals is also dependent on close working and coordination with the UK government: within the Committee's recommended pathway, around 60% of all the abatement in Wales in 2050 is in areas where key policies are mostly reserved to the UK government. Emissions in Wales fell by 20% in just two years (2016-2018) when the last coal-fired power station closed. However, this kind of major energy policy change is reserved to the UK government[34]. The report concluded that public bodies need to make progress in devolved areas such as agriculture, land-use, forestry, buildings and surface transport.

3.18 The most vulnerable are more likely to be directly affected by climate change. However, as both our 2019 report on fuel poverty[35] and the Decarbonisation of Homes in Wales Advisory Group[36] found, there are some difficult trade-offs between social justice and carbon reduction goals. In our 2020 report on the Well-being of Future Generations Act, we drew attention to the challenge facing the Welsh Government and other public bodies to ensure a fair transition to a low carbon economy and protecting the most disadvantaged from the effects of climate change and biodiversity loss.

34 Large scale energy generation policy (over 350 megawatts) is reserved to the UK government.

35 Auditor General for Wales, Fuel Poverty, October 2019

36 Decarbonising Homes in Wales Advisory Group, Better Homes, Better Wales, Better World: Decarbonising existing homes in Wales, July 2019

Reducing inequality will require long-term action and investment

3.19 In 2018, the Equality and Human Rights Commission highlighted ways in which equality had improved in Wales, including a falling number of young people not in education, employment or training, increased employment and improved mental health services[37]. It also documented more evident divisions in society and rising poverty particularly affecting disabled people, and some ethnic minority groups, in Wales compared to others. It called for a 'spotlight on race inequality' in Wales.

3.20 The COVID-19 pandemic has highlighted and deepened these existing inequalities. Young people, women and Bangladeshi workers are more likely to work in sectors shut-down. Disabled people have had the highest death rates from COVID and many experienced prolonged isolation. Progress towards equality in some areas has been reversed: for example, the gap in attainment of the highest grades between pupils eligible for free school meals and others and between those with additional learning needs and others has been stable or reducing in recent years but generally widened in 2019/20 at GCSE, AS and A level.

3.21 Black, Asian and Minority Ethnic people have been particularly affected by the pandemic with higher death rates. As concern increased, the First Minister commissioned work to look at the impact of the pandemic on Black, Asian and Minority Ethnic people. Professor Emmanuel Ogbonna's report[38] made 37 recommendations to tackle race inequality, focusing on the impact of long-standing racism and disadvantage and a lack of representation. The 'Black Lives Matter' movement has increased pressure for action. The Welsh Government has recently committed in its Programme for Government to funding and implementing the commitments in its draft race equality plan[39].

3.22 The Welsh Government commenced the 'Socio-economic Duty' in March 2021 requiring relevant public bodies to give due regard to the need to reduce inequalities that exist as a result of socio-economic disadvantage when taking strategic decisions. The Duty sits alongside other requirements in the Equality Act 2010 and the Well-being of Future Generations (Wales) Act 2015 to consider the impact of their decision-making on equality and community cohesion.

37 Equality and Human Rights Commission, Is Wales Fairer?, October 2018

38 Welsh Government, First Minister's BAME COVID-19 advisory group report of the socioeconomic subgroup, June 2020

39 Welsh Government, An Anti-Racist Wales: The Race Equality Action Plan for Wales, March 2021

3.23 At the start of the pandemic, the speed of decision-making meant that the Welsh Government did not conduct some equality impact assessments on key decisions[40]. Others were not published for scrutiny. In some cases, these omissions have been rectified but, as a first step to addressing the unequal impact of the pandemic, public bodies will need to collect better, disaggregated data to understand the impact of previous as well as future decisions on disadvantaged people and communities.

A new post-Brexit constitutional relationship poses a range of challenges as well as opportunities

3.24 Since 1999, the Welsh Government has taken on more powers, including over taxation, for the first time in over 800 years, in 2016. Following Brexit, the Welsh Government has taken on over 4,000 new functions from the EU while the UK government has taken on powers in areas such as immigration and border control. In the coming years, negotiations over the boundaries of these responsibilities will affect the Welsh Government and public bodies.

3.25 In the past, Wales benefitted from substantial EU funding – around £375 million per year during the 2014-2020 structural and investment funding period. The Conservative Party's 2019 UK government manifesto said that future funding would at least match the size of EU funds for each nation. This could lead to parts of Wales receiving more than comparable areas in England[41].

3.26 At present, the Welsh Government manages EU funds within parameters set by the EU. In October 2020, the House of Commons Welsh Affairs Committee acknowledged that the Shared Prosperity Fund – which replaces EU funding – could be an opportunity to develop a funding system that better reflects Wales' needs than previous EU funding streams. However, the Welsh Government's role in decision-making was unclear at the time[42].

3.27 Since the Committee reported, the UK government has announced that the Shared Prosperity Fund will be managed by the UK Treasury using powers under the Internal Market Act 2020 to spend directly on devolved areas of policy. The UK government is using the same powers for the Levelling Up Fund. It invited bids for the first round from local councils and other public bodies in January 2021: at least 5% of the fund is set aside for Wales.

40 Welsh Parliament, Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020

41 Alex Davenport Samuel North David Phillips – Institute for Fiscal Studies, Sharing prosperity? Options and issues for the UK Shared Prosperity Fund, July 2020

42 House of Commons Welsh Affairs Committee, Wales and the Shared Prosperity Fund: Priorities for the replacement of EU structural funding, 20 October 2020

3.28 There is already a complex crowded partnership landscape in Wales (**paragraph 3.33**). Getting value for money from this new way of working, in which UK government works directly with Welsh public bodies, will need care to align with existing local provision and Welsh Government policies. The UK government said it will seek advice from the devolved governments in shortlisting bids for the Levelling Up Fund. The role of devolved governments in the Shared Prosperity Fund's governance is not yet clear.

The recovery from COVID-19 provides an opportunity to learn lessons and progress long-standing ambitions for transforming public services

3.29 The Welsh Government has long-standing ambitions to transform the way public services provide services to the people of Wales. As set out in various strategies and legislation, notably the Well-being of Future Generations (Wales) Act 2015, public services should be citizen-centred, using the principles of co-production to involve service users and communities in the design and delivery of services. They should be collaborative and seek to prevent problems before they escalate. As part of this, public services should be shifting their focus from outputs and activity – how much are they doing and how quickly – to outcomes and the things that matter to communities and individuals.

3.30 Our work suggests public services are moving towards these new ways of working but that there are some long-standing barriers still to overcome. Below are some of the key aspects of service transformation we will be focusing our attention on in the coming years.

Systems and culture to support new approaches to service delivery

3.31 Changing the way public services operate involves changing some of the thinking, management processes and governance arrangements that underpin the status quo. Underlying systems of governance and accountability can help or hinder progress towards new ways of working. They incentivise behaviours by setting out what people and organisations will be held to account for. In the past, governance and accountability have often been focussed on targets for delivery of timely outputs and activity. Different arrangements will be required to encourage a stronger focus on outcomes and wellbeing and to encourage greater experimentation with new approaches.

3.32 In response to the pandemic, many performance management and accountability arrangements have been suspended or modified. There is an opportunity to learn lessons from what happened when these arrangements were relaxed. In future, we will expect to see greater thought being given to how the approach taken to governance and accountability will support the ambitions for service delivery, including the sorts of behaviours and relationships these arrangements incentivise.

Purposeful collaboration

3.33 Collaboration between public services is essential to delivering resilient services that improve the wellbeing of the people of Wales. We have on several occasions raised concerns that the partnership landscape is overly complex and incoherent, with varying geographical coverage, and unclear and overlapping remits. Servicing partnerships occupies a significant amount of the time and energy of senior public servants. Similar concerns have also been expressed by the Future Generations Commissioner[43] and the Public Accounts Committee[44].

3.34 One of the key lessons from the pandemic has been how collaboration has involved getting the right people together working across organisational and professional boundaries towards a common purpose. With a sense of urgency and strong, common goals, public services have demonstrated how pragmatic and flexible partnership arrangements can work to great effect.

3.35 Looking ahead, we will be expecting public services to demonstrate that their partnership working and collaboration are purposeful and leading to tangible benefits for the significant investment of time and effort involved.

Long-term financial and service planning that supports a rigorous and realistic approach to prevention

3.36 Delivering the ambitions of the Well-being of Future Generations Act requires a shift in focus and resources from short-term needs to prevention. There is an inherent tension between the desire for long-term prevention programmes and short and medium-term financial planning cycles. It can be difficult to shift resources needed to manage short-term problems in the anticipation of uncertain benefits at some distant point in the future. This is particularly the case where there are immediate pressures such as gaps between demand and supply with people experiencing delays to services and harm as a result.

43 Future Generations Commissioner for Wales, Future Generations Report 2020, May 2020
44 Public Accounts Committee, Delivering for Future Generations: the story so far, March 2021

3.37 Our report on the findings from our sustainable development examinations (**paragraph 3.2**) highlighted that short-term budget setting remained a barrier to progress. We will be looking for all public services to demonstrate progress towards longer-term financial planning. However, there is a particular responsibility on the Welsh Government to provide longer-term clarity about its priorities and plans for funding.

Harnessing digital technology to make services more accessible

3.38 Our work has highlighted the potential benefits but slow roll out of digital services in the NHS and social care[45]. However, the response to the pandemic has shown that public services can move swiftly to roll out and adopt new digital technology. From the outset, the public sector has used digital technology in new ways, including supporting staff working from home; online teaching for pupils and students; online committee and board meetings; digital needs assessments and virtual clinics and consultations (including telephone consultations).

3.39 The Welsh Government's vision for 'digital change' across Wales includes designing services around user needs to deliver simple, secure and convenient services[46]. We will be expecting public services to demonstrate that they are pursuing opportunities to make services more effective and efficient by using new technologies, where it makes sense to do so. In particular, we will expect public services to be able to demonstrate that digital services are accessible, of a high quality and meet the needs and expectations of users in line with aspirations for holistic citizen-centred services. We will also expect public bodies to learn lessons from the use of digital services introduced during the pandemic, including lessons around their effectiveness and user experiences.

Using data and information to learn and improve across the whole public service system

3.40 Before the pandemic, public services had been grappling with how best to use data to understand how well they were doing. In particular, public services were trying to focus more on measuring outcomes and the wellbeing of the population. Measuring outcomes is hard in and of itself. Understanding what has caused those outcomes when there has been a complex mix of interventions from different bodies in different environments is even harder.

45 Auditor General for Wales: Informatics systems in NHS Wales, January 2018; Welsh Community Care Information System, October 2021

46 Welsh Government, Digital Strategy for Wales, March 2021

3.41 In our 2018 report on local government's use of data[47], we highlighted the challenge of local government sharing information with partners. With collaboration key to delivering better services and better outcomes, public bodies need to get better at sharing information with partners.

3.42 In the coming years, we will expect public bodies to strengthen their ability to understand and demonstrate how they are using their resources to impact on individual and population wellbeing. In particular, we will be looking for them to do more to understand how whole systems are working to achieve outcomes, including the role of the Welsh Government and other funders in setting the rules, and how services can collectively work better for service users and communities.

47 Auditor General for Wales, The maturity of local government in use of data, December 2018

Appendices

1 Audit approach and methods

1 Audit approach and methods

1 The report is based on a synthesis of our published work as well as research by other organisations. Our work includes:

- the annual audit of accounts of the main devolved public bodies in Wales;
- local work looking at governance, management and delivery of services by NHS bodies and local government bodies;
- national reviews, looking at specific services and programmes as well as efforts to improve the wellbeing of particular groups of the population;
- reviews of public bodies' application of the sustainable development principle in line with the requirements of the Well-being of Future Generations (Wales) Act 2015; and
- data tools, which pull together information on particular sectors or areas of interest.

2 Underpinning this report is a series of sector-specific summaries, setting out some key facts and analysis, which we will publish during September and October 2021. We have not done a separate summary for the Welsh Government, as much of the analysis and key issues are covered in this report. We have also not sought to summarise the position across the many Welsh Government sponsored bodies and subsidiary companies. Where relevant, we refer in this report to some of the common issues and pressures they face.

3 Below are some of the key sources of data presented in this report.

- **Welsh Government funding:** for data to 2015-16, we have used the figures we used in our 2015 Picture of Public Services Report. The basis of data for 2015-16 to 2019-20 is the annual HM Treasury Public Expenditure Statistical Analyses dataset to which we have added data on revenues raised (or expected) from devolved taxation.
- **Health revenue:** This data is set out in our NHS Wales Finances Data Tool. It is based on the Welsh Government's final supplementary budget in each year and covers all health-related revenue budget lines from within the Department of Health and Social Services.
- **'Core' local government funding:** this comes from the Local Government Revenue Settlement dataset on StatsWales.
- **Local government spending on services:** this comes from the Local Government Outturn dataset on StatsWales and is based on 'gross revenue' expenditure on services.
- **Comparative UK spending analysis:** this primarily comes from the data that underpins our Public Spending data tool. We have carried out some further analysis using the underlying HM Treasury Country and Regional Analysis dataset, for example to look at social care expenditure.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in Welsh and English.

E-mail: info@audit.wales

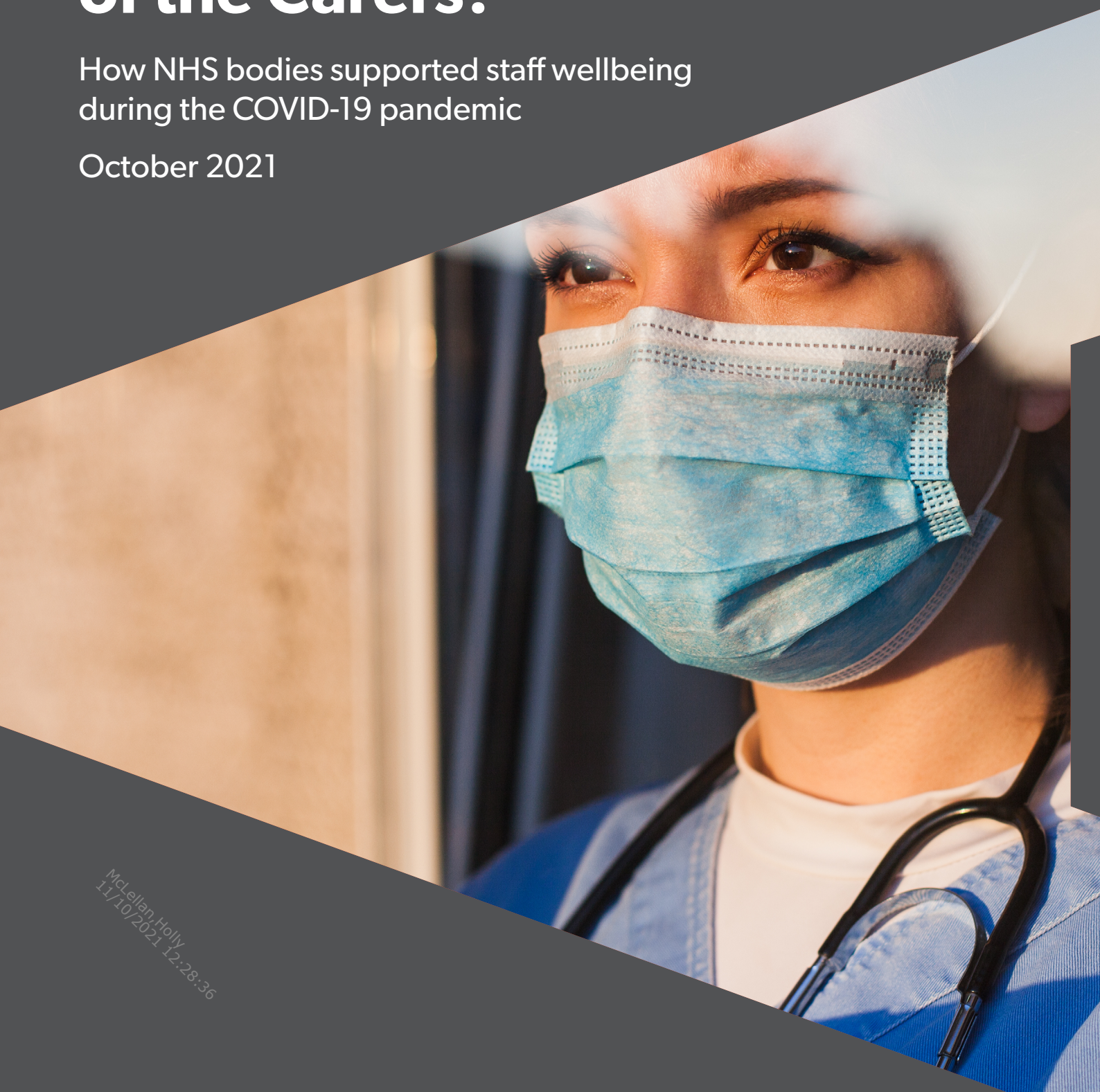
Website: www.audit.wales

Archwilio Cymru
Audit Wales

Taking Care of the Carers?

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

October 2021



This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities with their own legal functions. Audit Wales is not a legal entity. Consequently, in this Report, we make specific reference to the Auditor General or Wales Audit Office in sections where legal precision is needed.

If you require this publication in an alternative format and/or language, or have any questions about its content, please contact us using the details below. We welcome correspondence in Welsh and English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Audit Wales
24 Cathedral Road
Cardiff
CF11 9LJ

Telephone 02920 320 500
Email info@audit.wales
Website www.audit.wales
Twitter @WalesAudit

Mae'r ddogfen hon hefyd ar gael yn Gymraeg

Contents

Background

1 This report describes how NHS bodies have supported the wellbeing of their staff during the COVID-19 pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

2 It is the second of two publications which draw on the findings of our local structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning. The first report Doing it differently, doing it right? - describes how NHS bodies revised their arrangements to enable them to govern in a lean, agile, and rigorous manner during the pandemic.

Key messages

3 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges caused by the crisis.

4 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. However, the unprecedent scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus.

5 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the COVID-19 pandemic. At the outset of the crisis, each NHS body moved quickly to enhance their existing employee assistance arrangements and to put additional measures in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. Key actions taken by NHS bodies to protect staff and support their wellbeing included:

- enhancing infection prevention and control measures;
- reconfiguring healthcare settings;
- facilitating access to COVID-19 tests and, more recently, COVID-19 vaccinations;
- creating dedicated rest spaces;
- increasing mental health and psychological wellbeing provision;
- strengthening staff communication and engagement; and
- enabling remote working.

6 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk from COVID-19. Each NHS body promoted the Risk Assessment Tool in a number of ways. However, Risk Assessment Tool completion rates via the Electronic Staff Record (ESR) have varied considerably between individual NHS bodies. All NHS bodies utilised measures from their wider suite of wellbeing arrangements to meet the individual needs of staff at higher risk from COVID-19 as identified by the Risk Assessment Tool.

7 The boards and committees of most NHS bodies maintained good oversight and ensured effective scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, arrangements for reporting Risk Assessment Tool completion rates and providing assurance on the quality of completed risk assessments could have been strengthened in most NHS bodies.

8 Whilst the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short-term, the longer-term impacts cannot and should not be ignored or underestimated. Surveys and work undertaken by a range of professional bodies highlight the increased stress, exhaustion and burnout experienced by staff, and point to the growing risk to staff of developing longer term physical and psychological problems without ongoing support.

9 A continued focus on providing accessible wellbeing support and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff.

10 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

The resilience and dedication shown by NHS staff at all levels in the face of the unprecedented challenges and pressures presented by the pandemic has been truly remarkable. It is inevitable, however, that this will have taken a considerable toll on the wellbeing of NHS staff, who now also face the challenges of dealing with the pent-up demand in the system caused by COVID-19. It is assuring to see that NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and have implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year. Taking care of those who care for others is probably more important now than it has ever been before.

Adrian Crompton
Auditor General for Wales

Recommendations

11 Recommendations arising from this work are detailed in **Exhibits 1** and **2**.

Exhibit 1: recommendations for NHS bodies

Recommendations

Retaining a strong focus on staff wellbeing

R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.

Considering workforce issues in recovery plans

R2 NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.

Recommendations

Evaluating the effectiveness and impact of the staff wellbeing offer

R3 NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.

Enhancing collaborative approaches to supporting staff wellbeing

R4 NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.

Recommendations

Providing continued assurance to boards and committees

R5 NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.

Building on local and national staff engagement arrangements

R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.

Exhibit 2: recommendations for the Welsh Government

Recommendations

Evaluating the national staff wellbeing offer

R7 The Welsh Government should undertake an evaluation of the national staff wellbeing services and programmes it commissioned during the pandemic in order to assess their impact and cost-effectiveness. In doing so, the Welsh Government should consider which other national services and programmes should be commissioned (either separately or jointly with NHS bodies) to ensure staff continue to be supported throughout the recovery period and beyond.

Evaluating the All-Wales COVID-19 Workforce Risk Assessment Tool

R8 The Welsh Government should undertake a full evaluation of the All-Wales COVID-19 Workforce Risk Assessment Tool to identify the key lessons that can be learnt in terms of its development, roll-out, and effectiveness. In doing so, the Welsh Government should engage with staff at higher risk from COVID-19 to understand their experiences of using the Risk Assessment Tool, particularly in terms of the extent to which it helped them understand their level of risk and to facilitate a conversation with their managers about the steps that should be taken to support and safeguard them during the pandemic.

Introduction

12 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs – the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

13 Our structured assessment work[1] in 2020 was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures presented by the COVID-19 crisis.

14 This report is the second of two publications which draw on the findings of our structured assessment work, and more recent evidence gathering to highlight key themes, identify future opportunities, and share learning both within the NHS and across the public sector in Wales more widely.

15 In our first report – Doing it differently, doing it right? – we discussed the importance of maintaining good governance during a crisis and describe how revised arrangements enabled NHS bodies to govern in a lean, agile, and rigorous manner during the pandemic. We also highlighted the key opportunities for embedding learning and new ways of working in a post-pandemic world.

16 In this report, we discuss the importance of supporting staff wellbeing and describe how NHS bodies have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19. We consider the key lessons that can be drawn from the experiences of NHS bodies of supporting staff wellbeing during the COVID-19 crisis and conclude by highlighting the key challenges and opportunities for the future.

17 Whilst this report draws on the findings of our structured assessment work, it has also been informed by additional evidence gathered from each NHS body as well as information received from the Welsh Government, the British Medical Association (BMA), and the Royal College of Nursing (RCN) in Wales. Furthermore, as this report draws largely on the findings of our structured assessment work, we haven't engaged directly with NHS staff. Instead, we have referenced the findings from surveys undertaken by BMA Wales and others to provide insights into staff experiences during the pandemic.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2004, to be satisfied they have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

Importance of supporting staff wellbeing

18 The workforce is an essential component of the Welsh healthcare system. The NHS in Wales employs around 88,000 full-time equivalent staff (**Exhibit 3**) and staff costs accounted for 50% of total NHS spending in 2020-21[2].

Exhibit 3: NHS staff by staff group (March 2021)[3]

Staff Group	FTE
Medical and dental staff	7,294
Nursing, midwifery, and health visiting staff	36,027
Administration and estates staff	21,380
Scientific, therapeutic, and technical staff	14,947
Health care assistants and other support staff	5,806
Ambulance staff	2,709
Other non-medical staff	96

Source: StatsWales

2 Total NHS spending in 2020-21 was £9.6 billion, of which £4.8 billion was spent on staff costs. (Source: Audit Wales)

3 General Medical and Dental Practitioners are excluded as they are independent NHS contractors.

19 All NHS bodies in Wales have a statutory duty of care to protect the health and safety of their staff and provide a safe and supportive environment in which to work. However, supporting staff wellbeing is also important for several other reasons:

- **patient outcomes** – there is a strong link between negative staff wellbeing and poor patient outcomes. Research shows that negative staff wellbeing and moderate to high levels of burnout are associated with poor patient safety outcomes[4]. The Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust also highlighted the association between poor staff wellbeing and lower quality of care[5]. Supporting positive wellbeing at work, therefore, enables NHS bodies to maintain higher levels of patient safety, provide better quality of care, and ensure higher patient satisfaction.
- **organisational outcomes** – there are considerable financial costs associated with poor staff wellbeing. According to Health Education England, the cost of poor mental health in the NHS workforce equates to £1,794 - £2,174 per employee per year[6]. Furthermore, the costs associated with staff absenteeism are significant. The Boorman Review calculated the direct cost of reported absence in the NHS across the UK was around £1.7 billion a year and the indirect cost of employing temporary staff to provide cover was estimated to be £1.45 billion a year[7]. Supporting positive wellbeing at work, therefore, enables NHS bodies to reduce the number of working days lost as a result of poor staff wellbeing and achieve greater cost savings.
- **employee outcomes** – a poor experience at work is associated with negative wellbeing which, in turn, leads to lower staff engagement and motivation, greater workplace stress, higher staff turnover, and poorer patient outcomes. Research shows that staff wellbeing is impacted negatively by a workforce that is overstretched due to absences and vacancies and supplemented by temporary staff[8,9]. Wellbeing is also negatively affected when staff feel undervalued and unsupported in their roles, feel overwhelmed by their workloads, and feel as though they have little control over their work lives[10]. Supporting positive wellbeing at work, therefore, enables NHS bodies to enhance staff engagement and motivation, minimise workplace stress, and retain more of their employees.

4 Hall et al (2016) Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review
5 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
6 Health Education England (2019) NHS Staff and Learners' Mental Wellbeing Commission
7 NHS Health and Wellbeing Review (2009) Interim Report
8 Rafferty et al (2007) Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records
9 Picker (2018) The risks to care quality and staff wellbeing of an NHS system under pressure
10 West and Coia (2018) Caring for doctors, Caring for patients

How health bodies supported staff wellbeing during the pandemic

20 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. The results of the 2018 NHS Staff Survey show that 64% of respondents stated they had come to work despite not feeling well enough to perform their duties (compared to 57% in 2016), and 34% stated they had been injured or felt unwell as a result of work-related stress (compared to 28% in 2016). Furthermore, the sickness absence 12-month moving average for the 12 months ending March 2020 was the highest since data started to be collected in 2008.

21 However, the unprecedented scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus at both a national and local level in order to:

- protect the health of staff by reducing the prevalence of COVID-19 in healthcare settings and minimising their exposure to the virus;
- reduce the risk of staff transmitting the virus to colleagues, patients, family members, and other members of the wider community;
- safeguard vulnerable groups of staff at higher risk from the virus, such as older people, people with underlying health conditions, pregnant women, and people from certain ethnic minority groups;
- support staff to adapt to new ways of working and adjust to different work settings;
- help staff to cope with the challenges, pressures, uncertainties, and stresses associated with the pandemic;
- ensure NHS bodies maintain sufficient staffing levels to sustain essential services and care safely for patients affected by the virus; and
- enable NHS bodies to restart, recover and rebuild services safely, effectively, and efficiently.

22 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the crisis in line with their operational plans and Welsh Government guidance[11].

11 WHC/2020/019: Expectations for NHS Health Boards and Trusts to ensure the health and wellbeing of the workforce during the Covid-19 pandemic

23 At the outset of the pandemic, each NHS body moved quickly to plan and deliver local packages of support as part of a wider multi-layered wellbeing offer to staff. The multi-layered offer, which grew and evolved over time, gave staff free access to a range of pan-Wales services and resources, including:

- **SilverCloud** – a digital mental health platform designed to help NHS staff manage feelings of stress, anxiety, and depression.
- **Health for Health Professionals Wales** – a free, confidential service that provides NHS staff, students, and volunteers in Wales with access to various levels of mental health support including self-help, guided self-help, peer support, and virtual face-to-face therapies with accredited specialists.
- **Samaritans Support Line** – a confidential bilingual wellbeing support line for health and social care workers and volunteers in Wales.
- **online wellbeing resources for NHS staff** – Health Education and Improvement Wales (HEIW) worked with key colleagues on the Health and Wellbeing Sub-Group of the national COVID-19 Workforce Cell to curate and make resources and access to specific specialist services available through its Covid-19 Playlist – NHS Wales Staff Wellbeing Covid-19 Resource. The Playlist also signposted staff to the wellbeing resources of their respective Health Boards and Trusts. The Health and Wellbeing Sub-Group has now transitioned into the National Health and Wellbeing Network which receives leadership and programme management support from HEIW.

24 In this section, we briefly describe the measures put in place by NHS bodies in Wales to support staff wellbeing at a local level, including their arrangements for safeguarding staff at higher risk from COVID-19.

Supporting physical and mental wellbeing

25 We found that all NHS bodies enhanced their existing employee assistance programmes and services (such as Occupational Health) and put additional arrangements in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. For example:

- **enhancing infection prevention and control measures** – all NHS bodies, particularly the Health Boards and relevant Trusts, introduced enhanced infection prevention and control measures such as providing more hand hygiene facilities, supplying personal protective equipment (PPE) in line with national guidance[12], and increasing the frequency of cleaning and decontaminating surfaces, areas, and equipment.

12 The Auditor General for Wales has reported on the provision of PPE in a separate report titled Procuring and Supplying PPE for the COVID-19 Pandemic (April 2021).

- **reconfiguring healthcare settings** – all of the Health Boards and relevant Trusts reconfigured as much of their healthcare settings as possible to segregate COVID-19 and non-COVID-19 care pathways and minimise patient, staff, and visitor movements between areas. However, the design of older buildings made this more challenging in some NHS bodies.
- **facilitating access to COVID-19 tests and COVID-19 vaccinations** – all of the Health Boards and relevant Trusts put arrangements in place to enable frontline staff to access tests for COVID-19 and, more recently, COVID-19 vaccinations in line with JCVI (Joint Committee on Vaccination and Immunisation) guidance[13]. Although some NHS bodies encountered a few challenges facilitating access to COVID-19 testing at the outset of the pandemic due to limited lab capacity, the situation improved gradually over time as lab capacity increased and new rapid-testing technology became more widely available. In terms of vaccinations, overall uptake amongst healthcare workers is extremely high. As of 17 July 2021, 96.3% had received their first dose and 93.2% had received their second dose[14].
- **creating dedicated rest spaces** – most of the Health Boards and relevant Trusts established designated spaces for front-line staff to rest, recuperate, and focus on their welfare. These spaces, which were predominantly based on acute sites, were referred to as 'wellbeing rooms' or 'recharge rooms' in most areas.
- **increasing mental health and psychological wellbeing provision** – all NHS bodies increased the range, availability, and accessibility of their mental health and psychological wellbeing offer to staff. Examples include:
  - providing information and resources to promote self-care, enhance personal resilience, and support staff to adjust to new ways of working;
  - delivering therapeutic programmes, such as mindfulness and arts in health;
  - facilitating access to counselling and talking services to provide support for staff with mental health concerns such as anxiety, stress, and low mood; and
  - investing in specialised provision for members of staff experiencing the adverse effects of trauma and bereavement.

13 The Auditor General for Wales has reported on the provision of COVID-19 testing and the roll-out of COVID-19 vaccinations in two separate reports titled Test, Trace, Protect in Wales: An Overview of Progress to Date (March 2021) and Rollout of the COVID-19 vaccination programme in Wales (June 2021).

14 Source: Public Health Wales Rapid COVID-19 Surveillance

- **strengthening staff communication and engagement** – all NHS bodies strengthened their internal communication arrangements and used a broad range of channels and platforms to convey information and updates to their staff on a regular basis. In addition, all NHS bodies strengthened their staff engagement arrangements during the pandemic. As well as maintaining ongoing engagement with established employment partnerships and staff networks and groups, all NHS bodies surveyed their staff on a regular basis to better understand their needs and experiences as well as to capture their views on various matters, including the effectiveness of the local wellbeing provision.
- **enabling remote working** – all NHS bodies put arrangements in place to support remote working as part of their wider efforts to ensure and maintain physical distancing, for those staff for whom home working was appropriate. Although some NHS bodies encountered a few challenges rolling-out the necessary technology and software required to support remote working at the outset of the pandemic, these were overcome relatively quickly.
- **providing other forms of support** – a range of other support measures were implemented by NHS bodies, such as:
  - rolling out risk assessment tools, such as Stress Risk Assessment Tools and the All-Wales COVID-19 Workforce Risk Assessment Tool (this is discussed in more detail in the next section);
  - providing additional information and support to leaders and managers to enable them to engage, motivate, and support their teams effectively during the pandemic;
  - providing temporary accommodation for front-line staff living with individuals at higher risk from COVID-19; and
  - enhancing Chaplaincy services to ensure staff have access to pastoral support.

Detailed examples of health and wellbeing initiatives introduced by each NHS body during the pandemic are provided in the briefing produced by Welsh NHS Confederation titled Supporting Welsh NHS staff wellbeing throughout COVID-19.

26 The BMA has surveyed its members extensively during the pandemic. Whilst the results are not representative of the NHS workforce as a whole, they do provide useful insights into the experiences of medical staff during the crisis:

- BMA members responding to the surveys felt better protected from coronavirus in their place of work as the pandemic progressed. The proportion of members stating they felt fully protected was 27% (113 of 417) and 37% (100 of 274) in December 2020 and April 2021 respectively. The proportion of members stating they didn't feel protected at all was 11% (47 of 417) and 6% (16 of 274) in December 2020 and April 2021 respectively.
- A considerable number of BMA members responding to the surveys accessed wellbeing support services (provided by either their employer or a third party) during the pandemic – 43% (117 of 407) in May 2020, 38% (120 of 314) in July, and 38% (95 of 253) in August 2020. However, when asked if they knew how to access wellbeing/occupational health support if they required them, 45% (126 of 279) stated in April 2021 they either didn't know how to access these services or weren't aware what services exist.

27 Whilst it has been positive to see so many initiatives being developed and rolled-out during the pandemic, there is evidence to suggest that some staff experienced difficulties navigating their way around the plethora of initiatives to identify the ones that would best meet their needs. In light of this, the Welsh Government recently announced it would be launching a prototype Workforce Wellbeing Conversation Framework Tool to support NHS staff to pro-actively talk openly and honestly with their managers about their ongoing wellbeing needs and to sign-post them to the support available where appropriate[15]. Whilst this is a positive development, NHS bodies should also continue to engage with their staff to better understand their experiences of seeking and accessing support and adapt and improve their arrangements as necessary.

Safeguarding staff at higher risk from COVID-19

28 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus[16].

15 Written Statement - Minister for Health and Social Services (21 July 2021)

16 The Risk Assessment Tool, which was launched in May 2020, was developed by a multi-disciplinary sub-group reporting to an Expert Advisory Group established by Welsh Government. All NHS bodies were using other risk assessments tools prior to the roll-out of the national tool.

29 The Risk Assessment Tool is based on a large and growing body of data and research which shows that an individual is at higher risk from COVID-19 if they have a combination of the following risk factors:

- they are over the age of 50 (the risk is further increased for those aged over 60 and 70 years old);
- they were born male at birth;
- they are from certain ethnic minority groups;
- they have certain underlying health conditions (the risk very high for the clinically extremely vulnerable);
- they are overweight; and
- their family history makes them more susceptible to COVID-19.

30 The risk assessment process is completed in a number of stages with the aim of encouraging a supportive and honest conversation between a member of staff and their line-manager/employer around the measures that should be put in place to ensure they are adequately safeguarded and supported. The process is summarised in **Exhibit 4**.

31 We found that NHS bodies promoted the Risk Assessment Tool in a number of ways and put a range of measures in place to encourage and support their staff to complete it. The following arrangements and approaches were considered particularly important by NHS bodies:

- **senior management support** – strong and visible support for the Risk Assessment Tool by senior managers was considered important in terms of reassuring staff that the organisation was committed to the risk assessment process and supporting staff at higher risk from COVID-19.
- **utilising workforce data** – analysing and utilising workforce data was considered important in terms of identifying staff potentially at higher risk from COVID-19, planning appropriate packages of support, and facilitating targeted messaging around the importance of completing the risk assessment process. However, several NHS bodies told us they had concerns about the robustness of Electronic Staff Record (ESR) data.
- **support for line-managers** – ongoing information, advice, and support for line-managers, particularly from HR Officers/Business Partners, was considered important not only to help them fully understand their role in the risk assessment process but also to enable them to support their direct reports in a compassionate and supportive manner.

Exhibit 4: COVID-19 workforce risk assessment process

Step 1 – Checking risk	Member of staff completes the Risk Assessment Tool to check which risks apply to them.
Step 2 – Understanding the score	Member of staff calculates their score in order to understand the likely level of risk to them personally (low, high, or very high).
Step 3 – Identifying the right action	Member of staff discusses their score and other relevant factors with their line-manager (especially if they are in the high or very high-risk category) in order to identify the actions they can take personally and/or the support their employer can provide to ensure they are adequately protected.
Step 4 –Taking the right action	Agreed actions are implemented by the member of staff and/or their employer and reviewed on an ongoing basis to ensure they remain relevant and appropriate.

Source: All Wales COVID-19 Workforce Risk Assessment Tool Guidance for Managers and Staff (February 2021)

- **occupational health input** – information, advice, and support from occupational health practitioners was considered important for both line-managers and staff alike. Occupational health input was considered particularly important for members of staff with underlying health conditions who were not required to shield or who were returning to work after a period of shielding to ensure their needs were assessed and addressed appropriately.
- **joint working with staff networks and employment partnerships** – ongoing communication and joint working with established networks, employment partnerships, and individual Trades Unions was considered important for several reasons. Firstly, they were able to use their insights to advise NHS bodies on local approaches to rolling-out the Risk Assessment Tool and supporting staff wellbeing. Secondly, they played an important role in encouraging their members to complete the Risk Assessment Tool. Thirdly, they supported individual members of staff to complete the Risk Assessment Tool and, in some cases, provided advocacy and mediation for and on behalf of their members.

- **identifying staff champions** – identifying and utilising staff champions was considered important to provide encouragement, support, and reassurance to particular groups of staff at higher risk. Indeed, staff champions proved to be particularly important in NHS bodies that did not have the relevant staff networks in place. In these bodies, staff champions were used to reach-out and support individuals and groups of staff that were unaware they were potentially at higher risk as they didn't or couldn't access the relevant information and/or they were sceptical and/or anxious about engaging with the risk assessment process.

32 Over 62,000 risk assessments were completed via ESR and the Learning@Wales platform across the NHS in Wales between June 2020 and April 2021[17]. Staff had to complete paper versions of the Risk Assessment Tool prior to its roll-out via ESR in June 2020. In October 2020, the Welsh Government asked NHS bodies to request all staff to complete the Risk Assessment Tool via ESR. Completion rates via ESR in individual NHS bodies are shown in **Exhibit 5**.

33 As **Exhibit 5** shows, there is considerable variation in completion rates via ESR. There are several reasons for this:

- completing the Risk Assessment Tool via ESR has not been mandated by all NHS bodies such as Cardiff & Vale and Swansea Bay University Health Boards;
- staff in some NHS bodies that completed the paper-based Risk Assessment Tool when it was first rolled-out in May were not asked to repeat the assessment when it became available in ESR in June 2020;
- some staff are unable to access their ESR as they either work in roles that do not require the use of a computer or they do not have general access to a computer at their place of work;
- most NHS bodies have placed a greater focus on encouraging staff at higher risk to complete the Risk Assessment Tool rather than the workforce as a whole; and
- evidence from the member surveys undertaken by the BMA suggests that some staff were unaware of any risk assessment at their place of work or had been told explicitly they did not need to be assessed[18].

17 58,552 risk assessments have been completed via ESR and 3,770 have been completed via Learning@Wales between 15 June 2020 and 8 April 2021. Individuals that have completed the Risk Assessment Tool more than once via the ESR are counted more than once in the data. (Source: NHS Wales Shared Services Partnership)

18 The BMA asked its members: 'Have you been risk assessed in your place of work to test if you might be at increased risk from contact with Coronavirus patients in your current role?' The proportion that stated they were not aware of any risk assessment in their place of work was 33% (70 of 211) and 35% (61 of 175) in July and August 2020 respectively. The proportion that stated they had been told explicitly they did not need to be assessed was 7% (15 of 211) and 6% (11 of 175) in July and August 2020 respectively.

Exhibit 5: completion rates as recorded in ESR by NHS body

NHS Body	Number of recorded assessments	% of staff with a completed assessment
Aneurin Bevan University Health Board	3,071	24%
Betsi Cadwaladr University Health Board	19,195	52%
Cardiff & Vale University Health Board	857	5%
Cwm Taf Morgannwg University Health Board	15,487	58%
Health Education and Improvement Wales	134	29%
Hywel Dda University Health Board	6,965	48%
Powys Teaching Health Board	1,789	48%
Public Health Wales	1,019	73%
Swansea Bay University Health Board	174	2%
Velindre NHS Trust	6,716	81%
Welsh Ambulance Services Trust	3,145	67%

Source: NHS Wales Shared Services Partnership (15 June 2020 - 8 April 2021)

34 Whilst low completion rates via ESR does not necessarily equate to low use of the tool, it is difficult to know how many staff across the NHS in Wales have actually completed the Risk Assessment Tool due to the variable data collection and monitoring arrangements introduced by NHS bodies when it was launched.

35 We found that all NHS bodies adopted the 'hierarchy of control' approach to protect and support staff at higher risk from COVID-19. Under this approach, NHS bodies identified and utilised the most suitable measures from their wider suite of wellbeing arrangements to meet the individual needs of members of staff as identified through the Risk Assessment Tool.

These measures included:

- **engineering and administrative controls** – all NHS bodies put a range of engineering and administrative controls in place to safeguard staff at higher risk who were unable to work from home because of their role, and to support staff at higher risk returning to the workplace after a period of shielding. These included creating 'COVID-19 secure settings' (areas that posed a lower level of risk) by segregating COVID-19 and non-COVID-19 care pathways; staggering shift start and end times to reduce congestion; recalling staff on a rotational basis to limit the number of people in the workplace; and offering a phased return to the workplace.
- **personal protective equipment (PPE)** – PPE was provided in line with agreed guidelines to reduce or remove any residual risk to staff not eliminated by other measures. As stated in the Auditor General's report titled Procuring and Supplying PPE for the COVID-19 Pandemic, Shared Services, in collaboration with other public services, overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. However, the report also acknowledges that some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher grade of PPE than required by guidance.
- **substitution measures** – working from home was not considered a viable option for all members of staff at higher risk. For some members of staff, such as those living with an abusive partner, working from home could potentially have had a greater negative impact on their overall health and wellbeing. As a result, NHS bodies put arrangements in place to enable and support staff in these situations to work in 'COVID-19 secure settings'. For members of staff unable to perform their normal duties from home due to the nature of the work, NHS bodies put arrangements in place to enable them to work in 'COVID-19 secure settings' or to be redeployed to other suitable roles which they could undertake either from home or in 'COVID-19 secure settings' with additional support, such as retraining.
- **elimination measures** – all NHS bodies put arrangements in place to enable and support the majority of staff at higher risk to work from home, particularly during official periods of shielding. Most staff at higher risk were also supported to continue working from home when shielding periods ended if this was considered appropriate and safe to do so, and if the arrangement worked effectively for both the employer and employee.

36 All NHS bodies also encouraged and supported staff at higher risk to access mental health and psychological wellbeing services to help them adjust to new ways of working and/or manage any anxieties or worries they experienced. Detailed guidance was also provided to line-managers on how to provide effective support to staff at higher risk during the pandemic. As NHS bodies move towards the recovery period, they should continue to engage with staff at higher risk to evaluate the impact of the support and interventions they are providing and amend or improve their arrangements as necessary.

37 We found that there are a number of advantages and disadvantages to the Risk Assessment Tool, as follows:

Advantages of the Risk Assessment Tool

- the tool has ensured consistency, reduced variability, and facilitated the sharing of learning across the NHS;
- the format of the tool is simple, easy to use, and enables staff to focus on the main factors which may place them at greater risk;
- the tool helps managers appreciate the importance of addressing risks to staff in a timely and sensitive manner as well as the importance of being a compassionate and supportive manager;
- the process, if done correctly, provides reassurance to staff and gives assurance to managers and leaders that staff risks are being managed appropriately;
- the tool has galvanised organisations into adopting holistic approaches to managing staff risks; and
- the tool has generated a greater awareness and understanding of the needs of certain groups of staff, particularly those underrepresented within existing organisational structures.

Disadvantages of the Risk Assessment Tool

- the tool has made some staff feel ‘targeted’ or ‘singled out’ for special treatment;
- there have been some concerns about the use of the acronym BAME (Black, Asian, and Minority Ethnic) in the tool because it places a greater emphasis on certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other and White ethnic minority groups);
- there have been some concerns that the tool’s scoring matrix does not give sufficient weighting to certain risk factors, such as ethnicity and Type 1 diabetes;
- the tool and process have been seen and treated as a ‘tick box exercise’ by a small number of managers and members of staff; that is, the tool was completed to maintain compliance, but no real action was taken in response to the score;

- the tool does not pick-up the whole picture in one place for all staff, particularly those required to complete other risk assessments (eg stress risk assessment); and
- the ongoing development and evolution of the tool has led to a sense of 'risk assessment fatigue' amongst some members of staff.

Maintaining oversight of staff wellbeing arrangements

38 At an operational level, we found that all NHS bodies had staff wellbeing planning cells/groups in place as part of their emergency command and control structures with responsibility for planning and overseeing the delivery of local staff wellbeing provision. These planning cells/groups were tasked with working with other relevant cells/groups, such as those with responsibility for PPE and staff communication and engagement, to ensure a co-ordinated approach to supporting staff wellbeing.

39 These planning cells/groups were also responsible for monitoring COVID-19 workforce related risks and indicators and escalating key concerns and issues to the relevant group(s) within the emergency command structure as appropriate. Whilst the majority of these planning cells/groups monitored similar indicators, such as absence rates due to illness or shielding, we found that only a small number were actively monitoring risk assessment completion rates. Furthermore, we found that only NHS body had arrangements in place at an operational level to assess and monitor the quality of completed risk assessments.

40 At a corporate level, we saw evidence in most NHS bodies of good flows of information to boards and committees to provide assurance and enable effective oversight and scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, we found there was scope across most NHS bodies to strengthen the arrangements for reporting risk assessment completion rates and providing greater assurances to boards and committees around the quality of completed risk assessments.

41 We found that the crisis generated a greater awareness at board-level in all NHS bodies around the importance of supporting staff wellbeing and, in particular, the importance of understanding and addressing the needs of particular groups of staff. In some NHS bodies, this led to the creation of new staff networks and advisory groups for specific groups of staff which have traditionally been underrepresented within existing corporate structures. However, one Health Board has taken this further by establishing an Advisory Group for staff from ethnic minority groups as a formal sub-group of the board to ensure a stronger voice and involvement within the organisation for black, Asian, and minority ethnic staff. Although the Advisory Group reports formally via the Health Board's Chair, the Advisory Group's Chair and Vice-Chair are invited to attend all board meetings.

Key challenges and opportunities for the future

42 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges presented by the crisis, including:

- working longer hours and managing greater workloads;
- operating in rapidly changing, demanding, and intensive environments;
- managing fears, concerns, and anxieties about the risks to their own health as well as the risks to the health of their loved ones;
- seeing patients, colleagues and/or family and friends falling seriously ill or even dying with COVID-19;
- contracting COVID-19, and, for some, managing the longer-term effects of the virus (long-COVID);
- adjusting to new ways of working and, in some cases, adjusting to different roles;
- dealing with the resulting impact of shielding or working from home in terms of feeling isolated and alone and/or feeling guilty about not being able to support colleagues on the front-line; and
- adapting to wider social restrictions and managing their associated impacts, such as delivering home schooling, and providing enhanced care for elderly or vulnerable relatives.

43 The crisis has undoubtedly had a considerable impact on the wellbeing of staff. For example, surveys undertaken by RCN Wales, whilst not representative of the NHS workforce as a whole, highlight the impact of the pandemic on staff wellbeing. The results of the survey undertaken in June 2020, which received 2,011 responses, found:

- 75.9% stated their stress levels had increased since the beginning of the pandemic;
- 58.4% stated that staff morale had worsened since the beginning of the pandemic; and
- 52% stated they either strongly agreed or agreed with the statement ‘I am worried about my mental health’.

44 However, the longer-term impacts cannot and should not be ignored or underestimated. Indeed, the surveys undertaken by the BMA, whilst not representative of the NHS workforce as a whole, point to some of the challenges that remain in relation to staff wellbeing:

- In April 2021, 45% (126 of 279) of members stated they were suffering from depression, anxiety, stress, burnout, emotional distress, or other mental health conditions relating to or made worse by their place of work or study compared with 40% (298 of 735) in April 2020.

- in April 2021, 33% (92 of 279) of members stated their symptoms were worse than before the start of the pandemic compared with 25% (185 of 735) in April 2020.
- in April 2021, 36% (72 of 281) of members stated their current levels of health and wellbeing were slightly worse or much worse compared with that during the first wave between March and May 2020. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 43% (205 of 480) and 48% (224 of 467) respectively.
- on a scale of one to five (where 1 equalled very low/negative, and 5 equalled very high/positive), 32% (74 of 229) of members scored their morale as either a 1 or 2 in April 2021. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 45% (203 of 454) and 47% (195 of 402) respectively.
- in April 2021, 56% (157 of 282) of members stated their current level of fatigue or exhaustion was higher than normal from working or studying during the pandemic. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 60% (286 of 480) and 64% (297 of 467) respectively.

45 Surveys and work undertaken by other professional bodies also highlight the increased stress, exhaustion, and burnout experienced by staff. They also point to the increased risk to staff of developing longer term physical and psychological problems without ongoing support and opportunities for proper rest and recuperation.

46 Trends in sickness absence rates also point to some of the challenges that NHS bodies have faced during the crisis. After a gradual fall during 2015 to 2017, the sickness absence 12-month moving average has been rising and was 6.0% over the last year, mainly due to an increase from the April to June 2020 quarter during the pandemic. For the quarter ending 31 December 2020[19]:

- the sickness absence rate was 6.4%, up 1.3 percentage points compared to the quarter ending 30 September 2020.
- the NHS bodies with the highest sickness rates were Cwm Taf Morgannwg University Health Board at 8.5%, Welsh Ambulance Services NHS Trust at 8.4%, and Swansea Bay University Health Board at 8.3% (compared with 5.6%, 5.9%, and 6.2% respectively for the quarter ending 30 September 2020).

19 Source: StatsWales

- the staff groups with the highest sickness absence rates were the Ambulance staff group at 9.6%, the Healthcare Assistants and Support Workers staff group at 9.2%, and the Nursing, Midwifery and Health Visiting staff group at 8.1% (compared with 6.2%, 7.4%, and 6.5% respectively for the quarter ending 30 September 2020).

47 In the short-term, NHS bodies will face challenges in terms of managing seasonable absences which tend to be higher in the winter months as well as dealing with absences caused by staff requiring to self-isolate by the Test, Trace, Protect Service. However, they will also potentially face future challenges in terms of managing absence rates attributed to the longer-term physical and mental conditions caused by the pandemic unless they maintain and build upon their staff wellbeing arrangements.

48 The COVID-19 pandemic has undoubtedly brought staff wellbeing into sharper focus at both a national and local level. It has also shown that NHS bodies can respond rapidly and effectively to the challenges and pressures presented by a crisis. However, there is no doubt that the NHS workforce in Wales, which was already under pressure prior to the pandemic, is more emotionally and physically exhausted than ever before after the significant and unprecedented efforts of the last 18 months.

49 A continued focus on providing accessible wellbeing support and services and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff. Without such a focus, there is a risk the impact of the pandemic on the physical and mental health of staff will grow which could, in turn, compromise the ability of NHS bodies to deal effectively with the combined challenges of recovering and restarting services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year.

50 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

51 We have prepared a checklist to accompany this report which sets out some of the questions NHS Board Members should be asking to obtain assurance that their respective health bodies have effective, efficient, and robust arrangements in place to support the wellbeing of their staff.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Taking Care of the Carers? A Checklist for NHS Board Members

This checklist sets out some of the questions NHS Board Members should be asking to obtain assurance that their respective health bodies have effective, efficient, and robust arrangements in place to support the wellbeing of their staff. The questions are aligned to the recommendations we have set out in our report – Taking Care of the Carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic

1. 

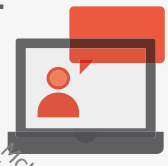
What wellbeing services does the health body currently offer to staff?

The Board should have a clear understanding of the health body's current wellbeing offer to staff. In particular, the Board should seek to understand: (a) what provision has remained largely unchanged during the pandemic, (b) what provision has been enhanced during the pandemic, and (c) what new provision has been introduced during the pandemic. The Board should also seek to understand which services are available to all groups of staff and which services are available to particular groups of staff, such as staff at higher risk from COVID-19.

2. 

How much do they cost?

The Board should have a clear understanding of the costs/resources associated with the health body's current wellbeing offer to staff and how they are funded.

3. 

How accessible is the health body's current staff wellbeing offer?

The Board should have a clear understanding of how the health body's current wellbeing offer is promoted to and accessed by staff. In particular, the Board should seek to gain an understanding of staff experiences of accessing the services they feel they need and/or have been assessed as requiring in order to meet their wellbeing needs. Boards should seek assurance that appropriate action is being taken to address any issues or difficulties experienced by staff.

4. 

How effective is the health body's current staff wellbeing offer?

The Board should have a clear understanding of the effectiveness of the health body's current staff wellbeing offer. In particular, the Board should seek to understand which services are the most effective and the least effective based on staff feedback and/or user evaluations. The Board should also consider any evidence which might be available on the clinical effectiveness of particular approaches and interventions adopted by the health body.

5. 

Which wellbeing services should the health body offer to staff in the short-, medium-, and long-term?

The Board should consider which wellbeing services the health body should offer to staff initially in the short-term to deal with the immediate impact of the pandemic on the physical health and mental wellbeing of staff. Whilst the longer-term impact of the pandemic is difficult to quantity at this stage, Boards should nevertheless start to consider which wellbeing services will be required in the medium to long term.

In refreshing the health body's wellbeing offer to staff, Boards should consider the following questions in line with staff needs, staff feedback/user evaluations, evidence of clinical effectiveness, and value for money:

- which existing services should be scaled back or stopped altogether?
- which existing services should be enhanced or reconfigured?
- which new services should be piloted or introduced?

As part of this exercise, Boards should also seek to distinguish between services aimed at all staff groups and services required by particular groups of staff, such as those at higher risk from COVID-19 and those that have directly worked at the front-line throughout the pandemic.

6. 

How should the health body deliver its wellbeing offer to staff?

Boards should have a clear understanding of the opportunities that exist to collaborate with other health bodies to procure, commission, and/or deliver wellbeing services on a joint basis particularly in specialist areas, such as psychotherapy. Boards should also seek to understand the opportunities that exist to share learning and resources more widely in respect of general approaches to staff wellbeing.

Boards should also have a clear understanding of how services will be funded with a view to providing stability, ensuring sustainability, and achieving value for money.

7. 

How should the health body continue to engage with staff?

Boards should have a clear understanding of how the health body will continue to engage with staff to ensure they have meaningful opportunities to highlight their needs and share their views on a regular basis, particularly during the recovery phase of the pandemic. Boards should also seek to understand what arrangements are in place or will be put in place to engage meaningfully with underrepresented groups of staff, such as ethnic minority staff. Boards should also seek assurance that the health body's staff engagement arrangements compliment, rather than duplicate, other arrangements that might be in place at a national level.

8. 

What assurance does the Board require going forward?

The Board should ensure there are robust arrangements in place to receive assurance on all relevant matters relating to staff wellbeing. The Board should provide clarity on which matters should be scrutinised by the relevant committee with responsibility for workforce matters and which matters should be reserved by the Board and/ or reviewed by the Board on a regular basis (such as monitoring performance against key workforce indicators).

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

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

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

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

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-2022						
		29 April	08 June	12 July	14 Sept	16 Nov	20 Jan	22 March
Governance & Assurance:								
Approach to 2021-22 Annual Accounts	DF&IT							✓
Annual Accountability Report 2020-21	BS	✓	✓					
Annual Accounts 2020-21, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit of COVID-19 Governance Arrangements	BS	✓						
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Charitable Funds Annual Report and Accounts 2020-21	DF&IT					~~✓~~	✓	
Losses and Special Payments Annual Report 2020-21	DF&IT		✓					
Losses and Special Payments Update report	DF&IT			✓		✓	~~✓~~	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS				✓			
Review of Standing Orders	BS					✓		
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					✓			✓

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