Audit, Risk & Assurance Committee

Tue 22 March 2022, 10:00 - 13:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

Attached *Chair*

ARA_Agenda_22Mar22_final.pdf (2 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *Chair*

1.3. Minutes from the previous meeting held on 20 January 2022 for approval

Attached *Chair*

ARA_Item_1.3_Minutes_20 January 2022_for Circulation.pdf (9 pages)

1.4. Matters arising from previous meeting

Oral *Chair*

1.5. Committee Action Log

Attached *Chair*

ARA_Item_1.5_Action Log_22 March 2022.pdf (2 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Applications for Single Tender Waiver

Attached *Director of Finance and IT*

ARA_Item_2.1_Application for Single Tender Waiver Mar 22.pdf (3 pages)
ARA_Item_2.1a_Application for Single Tender Waiver Mar 22 - Confidential Appendix.pdf (25 pages)
ARA_Item_2.1b_Analysis of Single Tender Waiver 2017-2022.pdf (5 pages)

2.2. Approach to 2021-22 Annual Accounts

Attached *Director of Finance and IT*

ARA_Item_2.2_Approach to 21-22 Annual Accounts_March2022.pdf (13 pages)

2.3. Counter Fraud Workplan 2022-23

Attached *Director of Finance and IT*

ARA_Item_2.3_March 22 Counter Fraud Work Plan 2022-23.pdf (3 pages)
ARA_Item_2.3a_Powys THB Counter Fraud Work Plan 2022-23.pdf (17 pages)

2.4. Internal Audit Plan 2022/2023

Attached *Head of Internal Audit*

ARA_Item_2.4_PTHB 2022-23 Internal Audit Plan.pdf (29 pages)

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Audit Recommendation Tracking

Attached *Board Secretary*

ARA_Item_3.1_Audit Recommendations_March22_ARA_Final.pdf (11 pages)
ARA_Item_3.1a_Appendix D- Outstanding Internal Audit Recommendations.pdf (64 pages)
ARA_Item_3.1b_Appendix E- Completed Internal Audit Recommendations.pdf (4 pages)
ARA_Item_3.1c_Appendix F - Not Yet Due Internal Audit Recommendations.pdf (20 pages)
ARA_Item_3.1d_Appendix G- Outstanding External Audit Recommendations.pdf (4 pages)
ARA_Item_3.1e_Appendix H- Not Yet Due External Audit Recommendations.pdf (4 pages)
ARA_Item_3.1f_Appendix I- Not Yet Due Local Counter Fraud Recommendations.pdf (4 pages)

3.2. Annual Governance Programme Reporting

Attached *Board Secretary*

ARA_Item_3.2_Annual Governance Programme_2021-22_Q3_.pdf (10 pages)

3.3. PPV Update and Workplan 2022-23

Attached *Director of Finance and IT*

ARA_Item_3.3_PPV Progress Report.pdf (4 pages)
ARA_Item_3.3a_SBAR - PPV progress.pdf (3 pages)
ARA_Item_3.3b_Powys Audit report Apr - Dec 2021 Anonymised.pdf (5 pages)

3.4. Internal Audit Progress Update

Attached *Head of Internal Audit*

ARA_Item_3.4_PTHB A&A Progress Report March 22.pdf (10 pages)

3.5. Internal Audit Reports:

Attached *Head of Internal Audit and Management*

ARA_Item_3.5a_PtHB Waste Management Final Report.pdf (19 pages)
ARA_Item_3.5b_PTHB - Job Evaluation Final Report.pdf (14 pages)
ARA_Item_3.5c_PTHB_Mortality Reviews Final Internal Audit Report.pdf (18 pages)

3.6. External Audit Progress Report

Attached *Audit Wales*

ARA_Item_3.6_External Audit Progress Update.pdf (8 pages)

3.7. Audit Plan 2022

Attached *Audit Wales*

ARA_Item_3.7_Powys tHB 2022 Audit Plan.pdf (14 pages)

3.8. WHSSC Audit Tracker

Attached *Board Secretary*

ARA_Item_3.8_WHSSC AW Tracker Governance Report 31Jan2022.pdf (6 pages)
ARA_Item_3.8a_Appendix 1 - Audit Wales WHSSC Governance Tracker.pdf (24 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

There are no items for inclusion in this section

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: 26 April 2022 at 10am

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 22nd MARCH 2022
10.00AM – 13.00PM
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 20 January 2022	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 20 January 2022	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Applications for Single Tender Waiver	Attached	Director of Finance and IT
2.2	Approach to 2021-22 Annual Accounts	Attached	Director of Finance and IT
2.3	Counter Fraud Workplan 2022-23	Attached	Director of Finance and IT
2.4	Internal Audit Plan 2022/2023	Attached	Head of Internal Audit
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Recommendation Tracking	Attached	Board Secretary
3.2	Annual Governance Programme Reporting	Attached	Board Secretary
3.3	PPV Update and Workplan 2022-23	Attached	Director of Finance and IT
3.4	Internal Audit Progress Update	Attached	Head of Internal Audit
3.5	Internal Audit Reports: <u>Reasonable Assurance:</u> a) Waste Management Final Report b) Job Matching and Evaluation Process Final Report c) Mortality Reviews Final Report	Attached	Head of Internal Audit and Management

3.6	External Audit Progress Update	Attached	Audit Wales
3.7	Audit Plan 2022	Attached	Audit Wales
3.8	WHSSC Audit Tracker	Attached	Board Secretary
4	**ITEMS FOR INFORMATION**		
There are no items for information			
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: • 26 April 2022 at 10:00AM, 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 James Quance, Interim Board Secretary, james.quance2@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 20 JANUARY 2022 VIA MICROSOFT TEAMS MEETING

Present:

Tony Thomas	Independent Member – Finance (Committee Chair)
Mark Taylor	Independent Member – Capital and Estates
Rhobert Lewis	Independent Member - General
Ronnie Alexander	Independent Member - General
Cathie Poynton	Independent Member – Trade Union

In Attendance:

Carol Shillabeer	Chief Executive
Ian Virgil	Internal Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	Internal Audit
Pete Hopgood	Director of Finance and IT
James Quance	Interim Board Secretary
Sarah Pritchard	Head of Financial Services
Alice Rushby	External Audit
Anne Beegan	External Audit
Bethan Hopkins	External Audit
Claire Powell	Powys CHC
Matthew Evans	Swansea Bay Counter Fraud

Committee Support

Stella Parry	Interim Corporate Governance Manager

Apologies

Matthew Dorrance	Independent Member – Local Authority

ARA/21/90	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting, and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/21/91	**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/21/92	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The minutes of the meeting held on 16 November 2021 were RECEIVED and AGREED as being a true and accurate record.
ARA/21/93	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/21/94	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/21/23: It was confirmed that this action had been completed.
ARA/21/95	**APPLICATION FOR SINGLE TENDER WAIVERS (STWs)** The Head of Financial Services presented the previously circulated report and sought the Committee's ratification of STW requests made between 1 November 2021 and 31 December 2021. Four STW requests were considered by the Committee, summarised within the table below:

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
POW2122013	TENDER	Topcon (Great Britain) Medical Ltd	DRI OCT Triton Plus Opthalmic Machine plus accessories	Value for Money and Consistency to previously purchased equipment for programme	23/12/2021	£77,198	N/A	Prospective	A1

POW2122012	TENDER	Oswestry Limited Liability Partnership	Healthcare service delivered on Health Board Premises	No NHS Provision available and clinical need	07/12/2021	£47,700	12 months	Prospective	A2
POW2122011	QUOTE	Brecon Mind	6 month Pilot Twilight out of hours service for Mental Health for South Powys	Continuation of previous pilot not previously funded by PTHB	07/12/2021	£13,699 (6 months only)	6 Months	Prospective	A3
POW2122010	QUOTE	Ponthafren Association	6 month Pilot Twilight out of hours service for Mental Health for North Powys	Continuation of previous pilot not previously funded by PTHB	17/11/2021	£12,000	6 Months	Prospective	A4

Had applications been subject to appropriate rigor and was it felt that the number of STW applications had increased in the previous 12 months?

The Head of Financial Services assured Committee Members that Shared Services Procurement colleagues had and would be involved with all STW applications as part of the process. The Director of Finance and IT suggested that he would bring forward an overview of trend analysis for STWs by month and year. **Action: Director of Finance and IT.**

The Chief Executive confirmed that she had reviewed each application personally as part of the process, which had improved significantly over the last few years following issues with controls around STW several years ago.

The Committee RATIFIED the approval of the STWs as detailed within the report.

ARA/21/96

FINANCIAL CONTROL PROCEDURE (FCP) COVID-19, UPDATE 8

The Director of Finance and IT presented the item and reported that the FCP had been introduced at the start of the Covid-19 pandemic in 2020. Regular reviews of the document had been undertaken to ensure it remained fit for purpose. Version 8 of the document had been updated at the end of December 2021. Full details were provided in the Version Control section of the document, in summary the changes included:

- New cost centres for Recovery & Renewal programme and Long Covid

	• Additional supplementary reports embedded within the monthly Exec Team Report • Ongoing updates linked to the Adult Social Care payment process for 2021/22 and reporting • Update on the management and reporting of savings • Update on the reporting of Covid Capital going forward • Two Way matching process and agreement to continue at an all Wales level The Committee APPROVED Version 8 of the COVID-19 FCP.
ARA/21/97	**AUDIT RECOMMENDATION TRACKING** The Interim Board Secretary presented the item which provided an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services. Committee members welcomed the progress made in relation to audit recommendations in the last few years and the Head of Internal Audit reported that as part of the Internal Audit Plan for 2022/23 a review of recommendations marked as complete would be undertaken to provide assurance in relation the evidence provided to support completion. The Committee DISCUSSED and NOTED the position in relation to the implementation of audit recommendations.
ARA/21/98	**INTERNAL AUDIT PROGRESS REPORT 2021/22** The Head of Internal Audit presented the item which provided an overview of the progress to date against the 2021/22 Internal Audit Plan and a progress update in relation to the development of the 2022/23 Internal Audit Plan. It was highlighted that on 16 November 21, the Committee formally agreed the re-scheduling of the following audits to the end of the 2021/22 plan, with the possibility that they could then be removed / deferred into the 22/23 plan if required due to the pressures faced by the Health Board: • Cancer Services • Looked After Children with Mental Ill Health • Performance Management & Reporting • North Powys Well-being Programme The Head of Internal Audit suggested that it was likely the reports would need to be formally deferred into 2022/23 in recognition of the pressures on the NHS as a result of the ongoing pandemic. The Chief Executive confirmed that a detailed assessment had been undertaken to identify those audits suitable for deferral and sought confirmation that the deferral of the audits would not impact upon the ability of the Head of

	Internal Audit to provide the Internal Audit Opinion for 2021/22. The Head of Internal confirmed that there would be sufficient coverage to provide his opinion for 2022/23 should only four audits be deferred. The Committee DISCUSSED and NOTED the report and it was confirmed that a Draft Internal Audit Plan for 2022/23 would be brought forward to the Committee in March 2022.
ARA/21/99	**INTERNAL AUDIT REPORTS:** **a) Covid Recovery and Rehabilitation Service (Substantial Assurance)** The Head of Internal Audit presented the report which focused on the COVID Recovery and Rehabilitation Service; and sought to provide the Health Board with assurance that the service had been set up effectively and associated systems and processes were managed appropriately. One matter requiring management attention was identified, relating to the Adferiad funding financial breakdown which was out of date. This needed to be addressed to ensure that the allocated funding is effectively utilised for the service. **b) Theatres Utilisation (Reasonable Assurance)** The Head of Internal Audit presented the report which covered theatre efficiency. The review focused on the in-reach services carried out within the Health Board's own theatres. The impact of the Covid-19 Pandemic and the Health Board's recovery and renewal plans were taken into consideration in the assessment of the appropriateness of the arrangements in place. An assessment of the adequacy and effectiveness of internal controls in operation was also undertaken. The matters identified requiring management attention included: • Theatre utilisation was significantly impacted by the fragility of the staff resource due to reliance on in-reach staff from neighbouring Health Boards, for which the service level agreements in place required reviewing and updating. • There is no Clinical Director for Endoscopy and Theatres to oversee clinical issues and so this currently has to be undertaken by the Health Board's Medical Director. • Achievement of access targets, including Referral to Treatment and National Endoscopy Programme Training Site re-accreditation, could potentially be at risk. • Other recommendations / advisory points were provided within the detail of the report. *Had a staffing plan been considered to support planned investment, such as in Llanrindod Wells Hospital Endoscopy?* The Chief Executive reported that an item was due to be considered by the Workforce and Culture Committee in relation to the utilisation of a

different approach for clinical staffing which was under development by the Health Board. It was also suggested that other initiatives would likely support staffing such as the partnership working across South East Wales and the introduction of International Recruitment.

Was there any concern in relation to the patient waiting times in Powys?
The Chief Executive reported that the majority of patients in Powys had waited less than 54 weeks, though outliers had been reported. The Committee was assured that an insourcing scheme was due to commence, which may provide a medium term strategy for recovery within theatres. The Committee recognised the strengths and weaknesses of insourcing.

Health Bodies were required to complete a validated tool, EQ5D5L by the 14 January 2022, how would information in relation this be monitored by the health board?
It was confirmed that the reporting mechanism would report to Executive Committee as part of the monthly Performance Report, which would then be taken forward to the Delivery and Performance Committee. This would also be considered as part of the Directorate Performance Reviews undertaken by the Chief Executive.

c) Dementia Services (Reasonable Assurance)

Jayne Gibbon (Internal Audit) presented the item which focused on the Dementia Home Treatment Teams (DHTT) in both North & South Powys and sought to provide the Health Board with assurance that systems and processes are managed appropriately. The identified matters requiring management attention included:

- Inconsistencies in the structure, skill mix of staff and operational activities undertaken by the teams.
- Policy and procedures not approved.
- Varying degrees of documentation contained within the patients' electronic records.
- Accuracy of submitted performance measures.
- Other recommendations/advisory points were provided within the detail of the report.

Due to the differences in structure between North and South Powys, had there been any reports of differing Patient Experience?
The Chief Executive reported that, due to staffing difficulties, the North Powys Service had been redesigned, whereas the South Powys Service had been added to over a number of years. It was a priority of the Mental Health Service Group to provide equitable services and clear outcomes. The Dementia Services would be considered as part of the Integrated Medium Term Plan (IMTP) from 2022/23 and work on demand and capacity modelling was underway and communication with local communities was due to take place.

	What would be the effect on the services of the introduction of the Regional Investment Fund (RIF) (previously Integrated Care Funding, ICF)? The Chief Executive confirmed that the Regional Partnership Board (RPB) had agreed to use 2022/23 as a transition year; it was suggested that consideration would be given as to how the service would be provided within the Health Board's existing resource in 2022/23 as a reliance on grants was not be the most favourable outcome for the service. The Committee RECEIVED and NOTED the Internal Audit reports.
ARA/21/100	**EXTERNAL AUDIT PROGRESS REPORT 2021/22** Alice Bushby (External Audit) presented the report which provided the Committee with an update on current and planned Audit Wales work. Accounts and performance audit work were considered, and information was also provided on the Auditor General's wider programme of national value-for-money examinations and the work of the Good Practice Exchange (GPX). It was reported that the fieldwork in relation to the Charitable Funds Accounts for 2020/21 was mostly complete. However, there was a valuation outstanding on a property in Ystradgynlais, for which the Health Board had been a part beneficiary that had not previously been reflected in the accounts. *Was there a risk that the Annual Accounts would not be submitted within the Charity Commission's deadline due to the outstanding valuation?* The Director of Finance and IT confirmed this was a potential risk as the deadline for submission was 31 January 2022. External Audit suggested it would be unlikely the accounts would be complete in readiness for the 26 January 2022 meeting of the Board as the case was historic, complex, required a valuation undertaken and would need to be considered by External Audit's Technical Team. The Chief Executive recognised the potential reputational issue for the Health Board and requested further detail outside of the Committee. The Committee DISCUSSED and NOTED the External Audit Progress Report.
ARA/21/101	**EXTERNAL AUDIT ANNUAL REPORT 2021** Anne Beegan (External Audit) presented the item. It was confirmed that this report would be taken forward to the meeting of the Board on 26th January 2022. The Committee DISCUSSED and NOTED the External Audit Annual Report 2021.
ARA/21/102	**EXTERNAL AUDIT STRUCTURED ASSESSMENT** The Head of External Audit and Interim Board Secretary presented the item. A key conclusion from 2021 structured assessment work was "…the Health Board has generally effective Board and committee arrangements,

	although attention is needed to improve the timeliness of agenda papers, local induction training for independent members is required and there are three unfilled associate member posts. In addition, there are imminent gaps within the corporate governance team which are of concern. Plans for response to COVID-19 and transforming services to recover waiting times are in place and supported by good partnership working arrangements and effective scrutiny of delivery. Partnership working and engagement with commissioned providers will be key in delivering good outcomes for Powys residents. Work continues to strengthen risk management arrangements." *What action had been taken to strengthen the Corporate Governance Team?* The Chief Executive reported that since the writing of the report recruitment had taken place into the Corporate Governance Team to ensure robustness in the interim period. The Interim Board Secretary would be considering next steps to ensure the long term stability within the service and would be working alongside other departments to best support Corporate functions for the remainder of the pandemic period. *The Welsh Government Independent Member Induction had received a Limited Assurance rating. Would Independent Members be consulted on for future development of the induction programme?* The Interim Board Secretary suggested a timescale of the end of March 2023 for development work on the local induction programme and welcomed input from Independent Members. It was noted that feedback on the public appointments process had been fed back to External Audit by several Welsh Health Boards, this would be fed back to Welsh Government. The Committee NOTED the Audit Wales Structured Assessment for 2021 and APPROVED the presented Management Response.
ARA/21/103	**COUNTER FRAUD UPDATE** The Head of Local Counter Fraud Services presented the item which provided an update on key areas of work undertaken by the Local Counter Fraud Specialists during 2021/22. The Counter Fraud Team had commenced Local Proactive Exercises (LPEs) in areas identified as national risk or via local fraud risk assessment work. Areas LPEs had been undertaken included: • Controlled Drugs Policy Framework compliance following a number of concerns being raised. • Gifts, Hospitality and Declarations of Interest compliance. • Overpayment of salary resulting in potential offences of theft and/or fraud. Following a NHS Counter Fraud Authority Workshop on LPEs a review would be undertaken to ensure that all LPE work that fits the Authority's

	definition are captured on the case management system. It was also reported that concern had been raised regarding the impact of the pandemic on Counter Fraud Awareness, the Work Plan for 2022/23 would be adjusted to reflect the increased focus on increasing awareness. The Committee welcomed the proactive approach and NOTED the report.
ARA/21/104	**CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS 2020/21** An update in relation to this item was provided under Item 3.4 (ARA/21/100).
ARA/21/105	**COMMITTEE WORK PROGRAMME** The Interim Board Secretary presented the previously circulated report, which provided the Committee with its work programme for 2020-21. The Committee RECEIVED and NOTED the Committee Work Programme 2021/22.
ARA/21/106	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Chief Executive wished to highlight to the Board the pending status of the Charitable Funds Accounts for 2020/21 and the potential impact on the Health Board of a late submission to the Charity Commissioner due to the issues discussed under Item 3.4 (ARA/21/100).
ARA/21/107	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/21/108	**DATE OF NEXT MEETING** 22 March 2022, 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
(March 2022)

Minute	Date	Action	Responsible	Progress	Status
ARA/21/95	20 January 2022	An overview of Single Tender Waiver (STW) activity including trend analysis by month and year would be brought forward to the Committee.	Director of Finance & IT		

ACTIONS COMPLETE

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. Action confirmed as complete 20th January 2022.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 22nd March 2022**
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 January 2022 and 28 February 2022.

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 4 items during the period of 1 January 2022 and 28 February 2022 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 January 2022 meeting which covered the period from 1 November 2021 and 31 December 2021.

A summary of the use of Single Tender Action from 1 January 2022 and 28 February 2022 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
POW/2122/014	Tender	Powys County Council	Gritting Services	Continuation of Arrangements/Value for Money	26/01/2022	£46,000	4 months	Partly Retrospective	A1
POW/2122/017	Tender	Red Cortex	Consultancy	Urgent Interim Arrangement pending Procurement	26/01/2022	£33,260	3 Weeks	Prospective	A2
POW/2122/015	Quote	Sail Databank	Access to research data system	Sole Supplier	23/02/2022	£18,700	3 years	Prospective	A3
POW2122019	Tender	Parkway Clinic	Dental Surgical Interventions for Children and Young Adults	No NHS Provision available and clinical need	23/02/2022	£80,000	2 years	Prospective	A4

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.

Appendix A1

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

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW2122014

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

Request to Waive Standing Financial Instructions: POW/2122/006

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

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

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

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

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

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

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

Section 1

<table>
<tr><td>Request to Waive
Please tick as appropriate</td><td>Single Quotation</td><td>Single Tender</td></tr>
<tr><td>*Supplier:</td><td colspan="2">Powys County Council, Highways Transport & Recycling, County Hall, Llandrindod Wells, LD1 5LG</td></tr>
<tr><td colspan="3">The granting of this application for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate:

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

NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the application process is not delayed</td></tr>
<tr><td>*Please provide detail of Goods/Services/Works required:</td><td colspan="2">Extract from Specification:

Predominantly, we are looking for surface treatment of our main roads, car parks and footpaths along with potential snow clearance of our sites. As these are mainly Hospital premises, we will require unrestricted access for our Blue Light routes for ambulances and emergency vehicles 24/7.</td></tr>
</table>

	We require the service to be provided at the sites listed in the attached file ('PTHB Winter Gritting Sites') across the county of Powys in Mid Wales - we have included the approximate areas (m2) and postcodes of each site. The requirements are as follows: • *To attend the listed PTHB sites, providing a winter gritting service when ice is deemed a risk due to the road surface temperature in the local area* • *To have systems in place to trigger gritting action, and continually monitor temperatures and action accordingly as required* • *Have provisions in place to plough and keep Blue Light routes clear of snow, along with our footpaths and car parks, etc.* • *To ensure staff and equipment are available at all times to provide constant access to our Hospital and our Mass Vaccination sites* • *To provide the treatments in a timely manner at each site (which may need to be concurrent across the county), i.e. before normal working hours (before 8am), as the temperature may drop during the evening, and in extreme weather during the day. There may be occasions where several treatment visits are required in a 24hr period to ensure continued access to our sites* • *Contractor provides appropriate grit or salt for the surface and spread at the correct speed and volume as to not damage surface* • *Contactor vehicles and equipment are maintained as a minimum to legal standards* • *Contractor receives daily forecasts for road surface temperature (RST), and weather data from a reputable source* • *Contractor can operate out of hours service, 24 hours a day including bank holidays, and can provide a 24-hour contact number* • *Contractor has procedures for out of hours working and lone working such as tracking vehicles* • *Contractor can provide a log, whether through vehicle tracking or other recording systems, to demonstrate what was gritted, and when, for audit purposes* *Please note these sites are Health Care or Hospital premises and it is therefore imperative the service is provided without failure. Please also note that these sites are spread across a rural County and there is substantial travelling distance between some of the sites as illustrated in the attached map images.*		
If Services, is this for Consultancy/Individual?	~~**Yes/**~~ **No**	**If 'yes', has an IR35 assessment been completed**	~~**Yes/ No or**~~ **not applicable**
Does this requirement have an implication under GDPR?	~~**Yes/**~~ **No**	**If 'yes', has the IG Department been consulted**	~~**Yes/ No or**~~ **not applicable**
Proposed agreement period including start and end dates and any extension provision required.	December 2021 – April 2022		

NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.			
***Unit Cost/Annual Cost:**	£46,000 excluding VAT (Note: previous year costs with PCC measured per event was £50,838.76 excl. VAT. This year has seen significant fuel cost increases in addition to cost of living.)		
***Total Cost** *(inc delivery & VAT):*			
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	£46,000 excluding VAT – this constitutes a complete winter season fee which includes both gritting and snow clearance and is not limited by 'number of events'. Consumable cost included for multiple sites.		
***New or Replacement Equipment/Service:** *(Please state)*	Not applicable.		
***Life Expectancy of equipment**	Not applicable.		
***Is this a Recurring Procurement?**	**Yes / ~~No~~**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	Revenue	***Please provide Financial Code:**	35850
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*	Revenue charges only.		
Have any revenue consequences (particularly staffing or maintenance implications), been agreed?	**Yes / No If yes give details**	Not applicable.	
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.	The arrangement for a fixed price is by request of the Council, to avoid administration burden of monitoring and invoicing on a 'per event' basis. There is a financial risk for both parties in this arrangement, but as the Council have the Welsh Government Highways contract for Powys, the fleet of gritting vehicles based in Powys are mobilised when the cold weather trigger levels are met and the inclusion of the hospital and healthcare estate is a relatively minor 'diversion from route'. Extra mass vaccination sites, which are critical services, have been added to the contract this year and have impacted costs. The service delivery from a locally based Supplier who is already servicing the county, will deliver significant environmental and decarbonisation benefits, when compared with services which may be managed from outside the county.		
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)**	The rural nature of Powys and the diverse location of sites spread across the county make this a challenging service to provide, often with little notice of inclement conditions and requiring local monitoring to trigger the gritting event. NWSSP Procurement were consulted in respect of the marketplace for suitable Suppliers and Framework opportunities. ESPO Framework for Grounds Maintenance including winter maintenance has been flagged as an option. The Suppliers who have registered competitive rates and have indicated in the contract that they are prepared to provide a service in the 'Region' (Wales) have been contacted.		

	Quote in **2020** as follows from a Supplier; "*I have looked into the feasibility of Greenfinger undertaking this work at length and don't believe it is something we would be willing to get involved in at this stage. This is mainly due to the difficult geographical spread of the sites and the weather navigating these during the winter evenings. From experience I would recommend using a specialist Gritting provider who has access to a more localised infrastructure already in place?*" Further contacts with the Framework were made in **2021**, with email response from J S Lee Ltd*: 'Thank you for the information, which we have studied. Due to the vast area we would not be able to cover all of the sites with confidence and you need a good service. We could look at the sites around Llandrindod Wells back towards Brecon as we have a base in Llandrindod if this is any help.'* Ice Watch, based in Suffolk, have been the only company to provide a cost per visit in 2021, at £1,197.00. This compares with the Powys County Council, Transport Manager bid for 2021: *The costs for gritting these sites would remain the same as last year which was £369.20 on each occasion.* This evidences the capability to deliver a service which demonstrates 'value' has a proven track record for deliverability for this critical service.
***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	When advice was sought by PTHB in 2020/2021, the ESPO Framework was recommended by NWSSP-SES Procurement for winter gritting. The Framework is broken down by Region across the UK with Powys coming under the 'Wales' section. The Framework includes tendered M2 rates for gritting per occasion. The areas of each PTHB site where gritting is required (access roads/driveways and car park areas where appropriate) have been documented with a total area of £30,409M2 identified. This enabled a range of costs from Suppliers, from £243.27 to £15,204.50 per occasion to be calculated (using rates embedded in the Framework document) based on the required area to be treated in Powys. The 'per occasion' price from Powys County Council was £369.20. Only 2 Framework Suppliers had better indicative contract rates quoted and both of these, Mitie Landscape Services Ltd and UK Landscapes Ltd, did not respond to requests to confirm they would be prepared to undertake services for PTHB. However, the band of costs in the Framework indicated a typical average cost for 34,409M2 to be in the order of £1,500 per occasion with the comparable cost from PCC being in the lower, most competitive, quartile. In 2021, the ESPO Framework Suppliers were again consulted. Only one costs was returned from Ice Watch and this was for £1,197.00 per occasion. This compares with a cost per visit from PCC of £369.20 per occasion, demonstrating value for money from the STW recommended Supplier – Powys County Council. The ESPO Framework has been set up on a UK wide basis with 'Wales' being one of the 'regions' and offering only one rate per

	occasion to apply universally. Theoretically, this is a tendered service and the Suppliers could be obliged to undertake the service at the quoted rate anywhere in Wales. NWSSP Procurement recommend a mini-tender is conducted as, in some instances, the tendered rates can be 'bettered' by up to 10% in a competitive setting, however, rates should not be increased above the level indicated in the Framework agreement. In practice, the rates can be competitive where the Suppliers already have a presence and the gritting work is incidental to an existing service, or in the more built-up areas of Wales where other customers for the service are prevalent. However, in the rural areas of Powys where 'the service' covers 25% of the footprint of Wales, the Framework Suppliers are recognising that they would struggle to provide a commercially viable service and are not responding to requests for bids in some instances.		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	~~**Yes/ No**~~	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).	Not Applicable		
***Consequence & Impact if not approved:**	The gritting and snow clearance of the hospital and key clinic sites across the estate is critical to the provision of safe access for staff, contractors, visitors and Patients. Failure to make suitable provision can lead to accidents and incidents, which are foreseeable, and could be mitigated by appropriate action with the engagement of a suitable Supplier for gritting services. Powys County Council service, by nature of its current work gritting the road network in the county, provides the least carbon footprint.		
***Is this an Essential or Non-Essential requirement?**	Essential		
If Yes, please give details (How many years etc)	This is a routine seasonal requirement.		
***Name:**	Geraint Davies		
***Title:**	Head of Estates		
***Ward/Department:**	Estates		
***Contact No:**	01874 712531 / 07443 230105		
***Budget Holder:**	Wayne Tannahill		
***Requisition Created?**	**Yes/ No**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			

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***Signature of requestor (please also print name & position):**	Geraint Davies, Head of Estates	***Signature of budgetary approver (please also print name & position):**	Wayne Tannahill, Associate Director of Estates & Property
Date of Request:	30/12/2021	**Date of Approval :**	30/12/2021
Statement of Support by Approver:	This is an essential seasonal service. Despite testing the marketplace, following advice from NWSSP Procurement, only one bid was returned. This bid was significantly in excess of the cost provided by Powys County Council, Highways Department, who have successfully delivered a resilient service historically in a challenging rural setting. Last year's charge from PCC was £50.8K compared with a proposed cost of £46K this winter period whilst noting the cost increases associated with fuel, etc. There are clear environment and decarbonisation benefits related to using a local provider who already has vehicles 'on the road' in the county when the PTHB service is required. It is recommended that a full review of the service and 'value' is undertaken in 2022 before the next Winter period and, if appropriate, a longer term arrangement be considered in lieu of annual reviews.		

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

Section 2

Declaration of Interest

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

Please confirm the following statements are correct:

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

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

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

Signature:

Signature: ***W. Tannahill***
Print Name: Wayne Tannahill
Position: Associate Director of Estates and Property
Date: 30/12/2021

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Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	Signature	Date
Executive Director/Director	JR Marchant	19th January 2022
Comments:	Essential service and time sensitive. Long standing provider in place with our partner agency PCC. They hold WG highways clearance contract so additionality of doing PTHB sites is not a burden and the response is the same as highways. Market test via ESPO proved to be limited response or more expensive. Price set by PCC is lower than last year inspite of additional fuel costs Approve this STW for service continuity, cost and also carbon management with same fleet doing hospitals and highways.	

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

For Procurement Department Completion Only

Section 4

Procurement Advice (*Delete or cross through as appropriate*)	• Yes, the SQA or STA is an appropriate course • ~~No, an alternative option can be pursued~~ • No Option		
Procurement Advice or Rejection Comments: (*including any conditions/future actions*):	Procurement services deem the following waiver as acceptable and the most appropriate course of action. PTHB approached various contractor to ascertain whether they had the capability to carry out the required work, due to the geographical size of Powys and the locality of its hospitals various supplier s declined to bid with only one positive response to the enquiry, within their response they provided a cost per occasion which came in four times the cost of the price with which PCC had provided. In addition, by using the local council the Health Board would look to minimise its carbon output by using a local service which is already gritting within the Powys geographical area.		
Endorsed	Yes		
Head of Procurement Signature:	SOwens DHOP	**Date:**	26/01/2022

**** Chief Executive Approval****

Section 5

Request Supported?	Yes/No (Yes circled)		
Supporting or Rejection Comments: (*including any conditions/future actions*):	Supported following procurement advice.		
Signed:	[signature]	**Date:**	26/01/2022
Please Print Name &Position:	Carol Shillabeer CEO.		

Appendix A2

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW/2122/017

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

Request to Waive Standing Financial Instructions: POW/2122/017

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

Approval to waive the requirement to seek competitive tenders (purchases between £25,000 & £138,760 inc.VAT) & Quotations (purchases between £5,000 and £24,999). In relation to waiver requests over the OJEU threshold, a VEAT notice will also need to be published via Sell2Wales.

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

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

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

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

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

Section 1

Request to Waive *Please tick as appropriate*	**Single Quotation**	**Single Tender**
***Supplier:**	Red Cortex	
The granting of this application for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate: • **the service/good/works is follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);** • **there is a compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;** • **there is genuinely only one provider;** • **there is a need to retain a particular contractor for real business continuity issues (not just preferences).** *NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the application process is not delayed*		
***Please provide detail of Goods/Services/Works required:** Patterson.Liz 03/18/2022 14:33:10	Network Redesign inc LAN, WAN WIFI x 2 Weeks Cloud Migration Review X 2 days Endpoint Management x 3 Weeks Cyber Controls x 1 week	

If Services, is this for Consultancy/Individual?	**Consultancy**	**If 'yes', has an IR35 assessment been completed**	N/A
Does this requirement have an implication under GDPR?	**No**	**If 'yes', has the IG Department been consulted**	**not applicable**
Proposed agreement period including start and end dates and any extension provision required. *NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.*	Start date Monday 24th Jan 2022 Finish Date Monday 14th February 2022		
***Unit Cost/Annual Cost:**			
***Total Cost** *(inc delivery & VAT):*	£33,260		
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	£33,260		
***New or Replacement Equipment/Service:** *(Please state)*	N/A		
***Life Expectancy of equipment**	N/A		
***Is this a Recurring Procurement?**	**No**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	**Digital Investment Programme Funding (DPIF)**	***Please provide Financial Code:**	B240
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*	N/A		
Have any revenue consequences (particularly staffing or maintenance implications), been agreed?	**Not required**		
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.			
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)**	**Urgency to spend Digital Investment Programme Funds which were agreed late from Welsh Government (Dec 2021) and must be completed by March 31st 2022, Mini Competition against approved framework underway for follow on work but due to timescales there is a risk of non-delivery of follow on work packages if this initial work is not undertaken so need to commence urgently. If this supplier is not awarded further work via the mini competition exercise all work and design undertaken will be provided to another supplier, it is industry best practice and aligned with the All Wales Infrastructure Programme recommendations** **There is a review taking place within PTHB against the infrastructure presently which identifies short, med, long**		

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	term plans for improvements and upgrades. There is ongoing work as part of the national O365 programme which this also aligns to.		
***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	**The rate is standard consultancy and comparable with other suppliers as demonstrated by previous open competition work this firm has undertaken to date**		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	**No**	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).			
***Consequence & Impact if not approved:**	**Risk of non delivery of DPIF funds and critical ICT infrastructure developments to facilitate ongoing fit for purpose ICT offering for Powys THB**		
***Is this an Essential or Non-Essential requirement?**	**Essential**		
If Yes, please give details (How many years etc)			
***Name:**	Vicki Cooper		
***Title:**	Assistant Director of Digital Transformation		
***Ward/Department:**	Finance and ICT		
***Contact No:**	01874 442040		
***Budget Holder:**	Vicki Cooper		
***Requisition Created?**	**Yes/ No**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			
***Signature of requestor (please also print name & position):**		***Signature of budgetary approver (please also print name & position):**	
Date of Request:	21/01/2022	**Date of Approval :**	
Statement of Support by Approver:			

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

Section 2

Declaration of Interest

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

Please confirm the following statements are correct:

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

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

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

Signature:

Signature: 
Print Name: **Vicki Cooper**
Position: **Assistant Director of Digital Transformation**
Date: **21/01/2022**

Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	Signature	Date
Executive Director/Director	Pete McPeed	**21/01/2022**
Comments:		

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

Please now forward to Procurement Department

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

Section 4

Procurement Advice *(Delete or cross through as appropriate)*	• ~~Yes, the SQA or STA is an appropriate course~~ • ~~No, an alternative option can be pursued~~ • **No Option**		
Procurement Advice or Rejection Comments: *(including any conditions/future actions):*	Procurement confirms that a mini competition for follow-on work is currently underway, but the department could not afford the 2-week advertisement window (as per framework requirements). Without a competitive exercise procurement cannot influence this spend, therefore we have no option but to support this waiver.		
Endorsed	**Yes/No**		
Head of Procurement Signature:	SOwens DHOP	**Date:**	24/01/2022

**** Chief Executive Approval****

Section 5

Request Supported?	**Yes/No**		
Supporting or Rejection Comments: *(including any conditions/future actions):*	I have noted the comments from procurer this is recognised as less than ideal. A more balanced approach however is being suggested which I will support on this occasion.		
Signed:		**Date:**	26/01/2022
Please Print Name &Position:	Caro l Shillabeer CED.		

Patterson, Liz 03/[illegible]2022 [illegible]:33:10

Appendix A3

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW/2122/015

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

Request to Waive Standing Financial Instructions: POW/2122/015

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

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

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

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

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

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

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

Section 1

Request to Waive *Please tick as appropriate*	**Single Quotation**	**Single Tender**
***Supplier:**	SAIL Databank	
The granting of this application for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate: • **the service/good/works is follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);** • **there is a compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;** • **there is genuinely only one provider;** • **there is a need to retain a particular contractor for real business continuity issues (not just preferences).** *NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the application process is not delayed*		
***Please provide detail of Goods/Services/Works required:** Patterson,Liz 03/18/2022 14:33:10	SAIL stands for Secure Anonymised Information Linkage. The SAIL Databank is a world-class flagship for the robust secure storage and use of anonymised person-based data for research to improve health, well-being and services. Its databank of anonymised data about the population of Wales is internationally recognised. Backed and endorsed by the Government, the SAIL Databank receives core funding from the Welsh Government's Health and Care Research Wales.	

	Through the SAIL database, we will be able to access anonymised extracts of datasets drawing upon billions of de-identified person-based population, health and social care data records. SAIL will enable our researchers carry out their work without knowing the identities of the individuals represented in the datasets. SAIL have most comprehensive coverage and are only database capable of providing the specific information needed.		
If Services, is this for Consultancy/Individual?	**No**	**If 'yes', has an IR35 assessment been completed**	**not applicable**
Does this requirement have an implication under GDPR?	No - Data within the SAIL Databank is legally anonymised in accordance with the UK ICO's Code of Practice on Anonymisation. SAIL data does not constitute personal data under the provisions of the General Data Protection Regulation 2016 or the Data Protection Act 2018	**If 'yes', has the IG Department been consulted**	
Proposed agreement period including start and end dates and any extension provision required. *NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.*	1st February 2022 – 31st January 2025		
***Unit Cost/Annual Cost:**	£18,700 The cost is for 3 years payable in one invoice and provides access for up to 5 users.		
***Total Cost** *(inc delivery & VAT):*	£18,700		
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	£18,700		
***New or Replacement Equipment/Service:** *(Please state)*	Service		
***Life Expectancy of equipment**	N/A		
***Is this a Recurring Procurement?**	**No**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	RIIC Hub Revenue	***Please provide Financial Code:**	B201
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*			
Have any revenue consequences (particularly staffing or	**No** **If yes give details**	No revenue consequences	

maintenance implications), been agreed?		
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.	Nil	
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)**	Swansea University operates secure anonymised data linkage via the 'SAIL' Databank. There are no other providers of this service. Billions of anonymised, person-based records are held in the SAIL Databank and, subject to safeguards and approvals, these can be linked together to address important research questions. This advanced data linkage research platform is the UK's first single resource for population, health and social care data intended solely for research. The SAIL Databank is home to the broadest and most accessible source of anonymised population data in the world and offers a secure environment to conduct research analysis. The security and protection of the data held within is ensured through its tightly controlled, robust, proportionate Privacy by Design methodology that is regulated by a team of specialists and overseen by an independent Information Governance Review Panel. The SAIL Databank does not receive or handle identifiable data. The commonly-recognised identifying details are removed before datasets come to the SAIL Databank, and so the SAIL Databank cannot reconstruct the identifiable datasets. Procurement advice has been sought in relation to this.	
***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	While most patients on Anti Psychotics (AP) used to remain under psychiatric care, it is evident that increasing numbers (rough estimates for U.K. suggest 30%) who are deemed 'stable' are discharged to GP care only. However, GPs are reluctant to change medications and little is understood about the long term outcomes for this cohort. The project proposes to use SAIL data to: 1. Establish the Welsh prevalence of patients taking AP who are discharged from secondary care outpatients to primary care follow up, and look at demographic factors and comorbidity prevalence in this group compared to patients under psychiatry follow up. 2. Conduct a retrospective cohort study (3 arm) to look at mortality and morbidity outcomes for (1) AP patients who remain under psychiatry care (2) AP patients who are managed in primary care only (3) a matched control group not on AP. The initial research project will be to consider bringing in a cohort of individuals that fit the case definition of discharge from secondary to primary care.	

	This would be for validation purposes. They would need to be registered with GP practices that supply data to SAIL. **Welsh Longitudinal General Practice** (WLGP): to identify patients prescribed antipsychotic medication, and also to identify comorbidities such as obesity, diabetes. Please note that this dataset includes data from ~80% of GP practices in Wales. **Outpatients** (OPDW): to identify appointments with psychiatric specialities (diagnosis information not available in this dataset) ONS Annual District Deaths Extract (ADDE): to identify deaths among the study cohort **Patient Episode Dataset for Wales** (PEDW): to identify comorbidities in the cohort, based on ICD-10 and OPCS4 coding **Welsh Demographic Service** (WDSD): for demographic features including week of birth, sex, WIMD quintile and rurality flag (LSOA not required). Data will be required for all Wales.		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	No	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).			
***Consequence & Impact if not approved:**	Research would not be able to take place		
***Is this an Essential or Non-Essential requirement?**	This is an essential requirement		
If Yes, please give details (How many years etc)	Access will be required for 3 years		
***Name:**	Amanda Edwards		
***Title:**	Assistant Director Innovation & Improvement		
***Ward/Department:**	Medical Directorate		
***Contact No:**	07805852236		
***Budget Holder:**	Amanda Edwards		
***Requisition Created?**	**Not yet**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			
***Signature of requestor (please also print name & position):**	Amanda Edwards	***Signature of budgetary approver (please also print name & position):**	Amanda Edwards

	Assistant Director Innovation & Improvement		Assistant Director Innovation & Improvement
Date of Request:	11.1.2022	**Date of Approval :**	11.1.2022
Statement of Support by Approver:	University of Liverpool population health sciences team have received notice from NIHR that the grant (worth £2.8million) for which Dr Alan Woodall (PTHB) is one of the named Co-Investigators to look at artificial intelligence and machine learning for polypharmacy optimisation (one of the 3 arms is antipsychotic management) has been funded. Access to this database is required to enable this research to progress. I fully support the requirement to access the SAIL database.		

Patterson,Liz
03/18/2022 14:33:10

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

Section 2

Declaration of Interest

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

Please confirm the following statements are correct:

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

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

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

Signature:

Signature: 
Print Name: Amanda Edwards
Position: Assistant Director Innovation & Improvement
Date: 11.1.2022

Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	Signature	Date
Executive Director/Director **Dr Kate Wright** **Executive Medical Director**	KLWright	**12 January 2022**
Comments:		

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

Please now forward to Procurement Department

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

Section 4

Procurement Advice *(Delete or cross through as appropriate)*	• **Yes, the SQA or STA is an appropriate course**		
Procurement Advice or Rejection Comments: *(including any conditions/future actions):*	Sole supplier for the requirement no other suppliers can provide this service.		
Endorsed	**Yes**		
Head of Procurement Signature:	SOwens DHOP	**Date:**	10/02/2022

**** Chief Executive Approval****

Section 5

Request Supported?	**Yes** / **No**		
Supporting or Rejection Comments: *(including any conditions/future actions):*	Procurement advice noted.		
Signed:		**Date:**	23/02/2022
Please Print Name &Position:	Carol Shillabeer - CEO.		

Appendix A4

SINGLE QUOTATION/TENDER REQUEST FORM

REFERENCE NUMBER: POW/2122/019

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

Request to Waive Standing Financial Instructions:POW/2122/015

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

Approval to waive the requirement to seek competitive tenders (purchases between £25,000 & £138,760 inc.VAT) & Quotations (purchases between £5,000 and £24,999). In relation to waiver requests over the OJEU threshold, a VEAT notice will also need to be published via Sell2Wales.

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

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

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

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

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

Section 1

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

If Services, is this for Consultancy/Individual?	**No**	**If 'yes', has an IR35 assessment been completed**	**Yes/ No or not applicable** N/A
Does this requirement have an implication under GDPR?	Yes as per medical records	**If 'yes', has the IG Department been consulted**	**Yes/ No or not applicable**
Proposed agreement period including start and end dates and any extension provision required. *NB: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department.*	February 2022 to February 2024		
***Unit Cost/Annual Cost:**	40K		
***Total Cost** *(inc delivery & VAT):*	80K		
***Whole Life Costs:** *(Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	N/A		
***New or Replacement Equipment/Service:** *(Please state)*	N/A		
***Life Expectancy of equipment**	N/A		
***Is this a Recurring Procurement?**	**Yes**		
***Source of Funding:** *(Revenue/Capital/Charity etc.)*	Revenue	***Please provide Financial Code:**	S120
Breakdown of estimated capital and on-going revenue charges per annum. *NB: Please ensure your Finance Team are consulted before*			
Have any revenue consequences (particularly staffing or maintenance implications), been agreed?	**Yes / No If yes give details**		
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.			
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)** Patterson,Liz 03/18/2022 14:33:10	**Currently no local NHS hospital has capacity to provide dental paediatric GA services. Parkway private hospital has capacity to see child dental patients in a timely manner. NHS providers have a backlog of their own health board patients. Powys THB is unable to carry out paediatric GA services due to current guidance that stops such services being provided outside a DGH.**		

***Explicit Reasons as to How Value for Money will be achieved when services are provided by a Single Supplier.** *Sufficient detail should be provided in this section or the request will be returned.*	**Costs are comparable to NHS theatre costs, Patients are screened/triaged within community dental service to see if alternative techniques can be done prior to the referral being made**		
***Have any Trials / Evaluations been undertaken within the Health Board?** NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken	**No**	If Yes, please state the evaluation reference number:	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation (please state).			
***Consequence & Impact if not approved:**	**Children who are uncooperative for treatment under local anaesthesia will have pain and infection**		
***Is this an Essential or Non-Essential requirement?**	**Essential**		
If Yes, please give details (How many years etc)	2 years		
***Name:**	Warren Tolley		
***Title:**	Associate Dental Director		
***Ward/Department:**	Dental		
***Contact No:**	01686617363		
***Budget Holder:**	Warren Tolley		
***Requisition Created?**	**Yes/ No**	**If Yes, please state requisition number:**	
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.			
***Signature of requestor (please also print name & position):**	Warren Tolley Associate Dental Director	***Signature of budgetary approver (please also print name & position):**	Warren Tolley Associate Dental Director
Date of Request:	02/02/2022	**Date of Approval :**	

Statement of Support by Approver:	

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

Section 2

Declaration of Interest

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

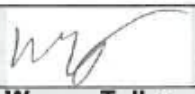
Please confirm the following statements are correct:

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

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

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

Signature:

Signature:	
Print Name:	**Warren Tolley**
Position:	**Associate Dental Director**
Date:	**03/02/2022**

Authorisation – EXECUTIVE DIRECTOR

Section 3

Designation	Signature	Date
Executive Director/Director	Pete Hopgood.	03/02/22
Comments:	Approved as per explanation and rationale as stated.	

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

Please now forward to Procurement Department

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

Section 4

Procurement Advice (*Delete or cross through as appropriate*)	• **Yes, the SQA or STA is an appropriate course** • ~~**No, an alternative option can be pursued**~~ • **No Option**		
Procurement Advice or Rejection Comments: (*including any conditions/future actions*):	No Alternative option available, service is a continuation of waiver ref POW/1819/014, POW/1920/014 & POW/2021/011.		
Endorsed	**Yes/No**		
Head of Procurement Signature:		**Date:**	

**** Chief Executive Approval****

Section 5

Request Supported?	**Yes/No** (Yes circled)		
Supporting or Rejection Comments: (*including any conditions/future actions*):	Procurement advice noted.		
Signed:	[signature]	**Date:**	23/02/2022
Please Print Name &Position:	Carol Shillabeer CEO		

Notes:

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1ii

Audit, Risk and Assurance Committee	**Date of Meeting: 22 March 2022**
Subject :	**ANALYSIS OF SINGLE TENDER WAIVERS 2017 TO 2022**
Approved and Presented by:	Interim Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:
The Audit Risk and Assurance Committee request to NOTE the analysis of Single Tender Waiver requests made between 1 Apr 2017 and 28 Feb 2022.
RECOMMENDATION(S):
It is recommended that the Audit Risk and Assurance Committee NOTES the report.

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

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

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:

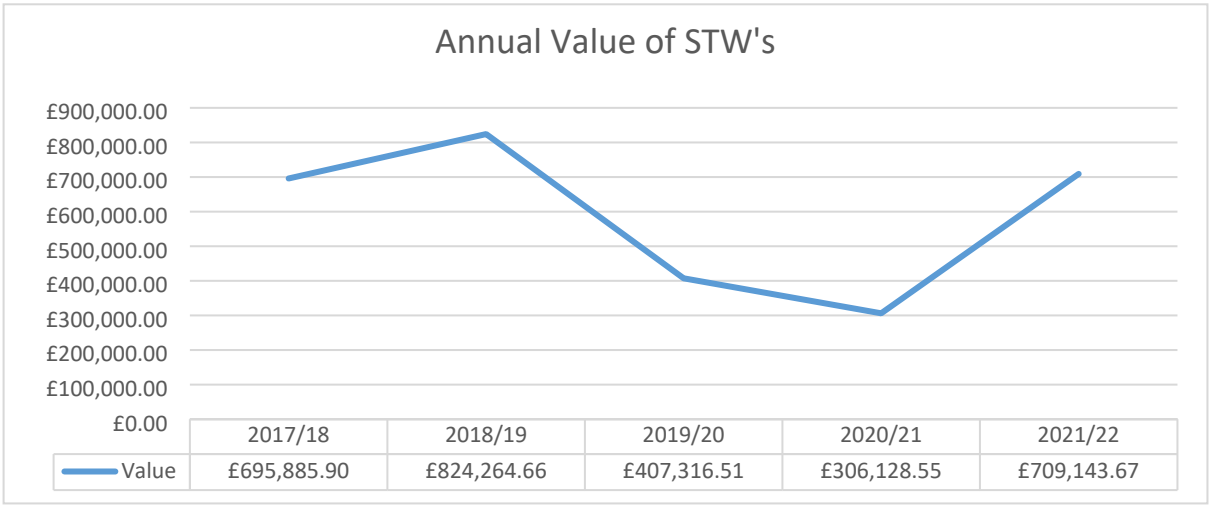
At the January 2022 Audit Risk and Assurance Committee it was requested that a summary of STWs over a period of time is presented to the next meeting, to identify trends and themes where there is a greater use of STWs in a particular area

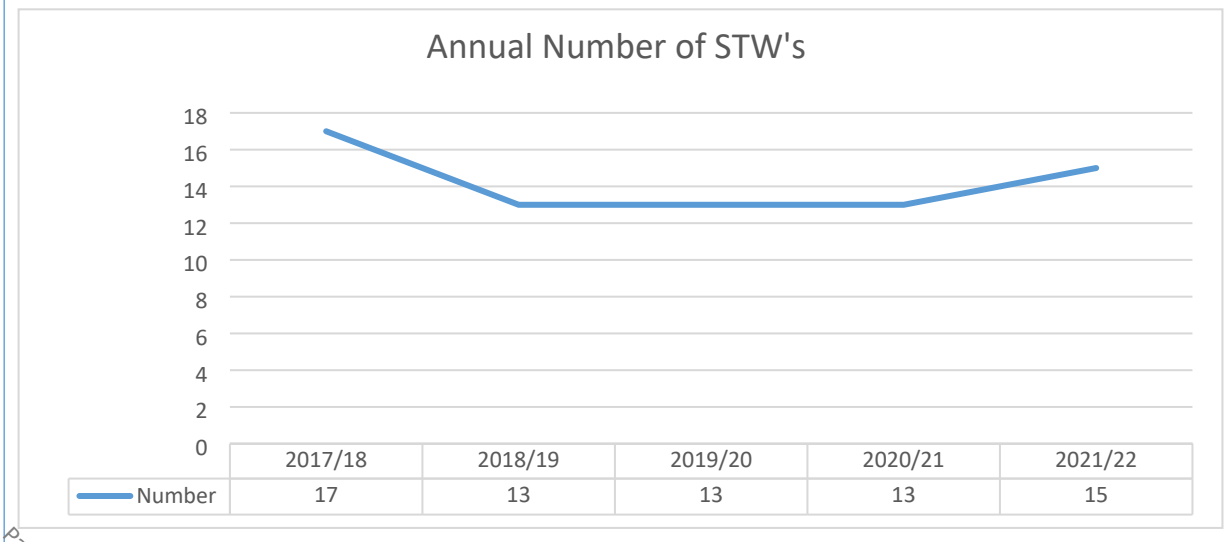
An analysis of approved Single Tender documents covering the period 1st April 2017 to 28th February 2022 has been undertaken by the Head of Financial Services. It should be noted that the 2021/22 financial year metrics only includes 11 months data.

The findings of this analysis are as follows:

Annual Value and Numbers of STW's

The trend can be seen that after a slight increase in annual value during 2018/19 the amounts per year were decreasing in year until a further increase in 2021/22. The numbers per year are also seeing a slight increase in 2021/22 but this is mainly due to Health Care Provision related STW's for longer periods and larger values.



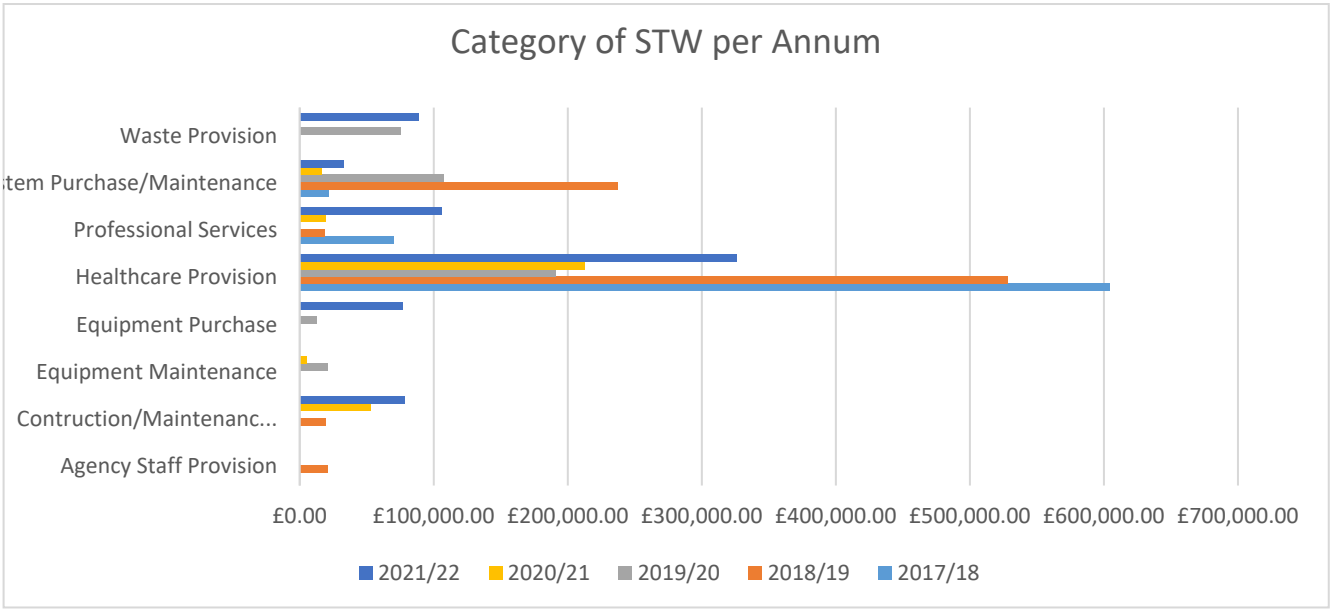


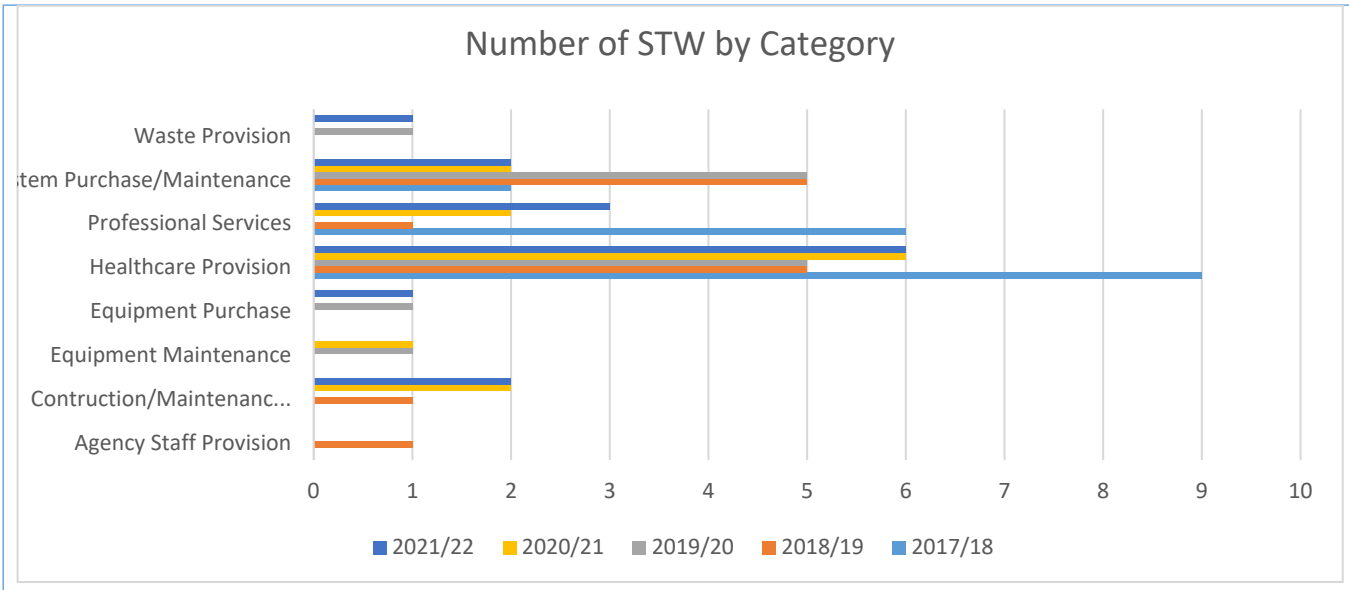
Category of Single Tender Waiver

It can be seen by the chart below that the majority of Single Tender Waiver usage relates to Healthcare provision but this has reduced since the initial period analysed. The main reason for Healthcare Provision usage is due to the inability to secure NHS Capacity to undertake necessary services or treatments for the population of Powys.

System purchase/Maintenance is the next highest category of usage and this is mainly due to sole suppliers of systems in use within the Health Board and the resulting requirement for maintenance contracts that only that supplier can carry out. This trend is showing a downward movement.

The number of waivers by category chart is showing that on an annual basis the comparison of numbers per category is fairly constant with a few minimal fluctuations in individual years





Numbers of Single Tender Waivers by Directorate

Detail of Usage per Directorate is as follows with the majority being undertaken by the Directorate of Primary and Community Care and Mental Health with a fairly constant number year on year and the Directorate of Planning and Performance (includes Estates and Commissioning) which has been declining in numbers each year.

Financial Year Approved	Community Health Councils	Directorate of Environment	Directorate of Finance & ICT	Directorate of Medical Services	Directorate of Nursing and Therapies	Directorate of Planning and Performance	Directorate of Primary Care, Community Services and Mental Health	Directorate of Public Health	Directorate of Workforce and Facilities	Grand Total
2017/18			1		3	4	7		2	17
2018/19						2	9		2	13
2019/20						3	8	1	1	13
2020/21	1				1	2	9			13
2021/22		1	1	1		1	9		2	15
Grand Total	**1**	**1**	**2**	**1**	**4**	**12**	**42**	**1**	**7**	**71**

NEXT STEPS:

None required as a result of this paper

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

Audit, Risk and Assurance Committee	**Date of Meeting: 22 MARCH 2022**
Subject :	**ANNUAL ACCOUNTS 2021-22** **Timetable and Approach to 2021-22 Annual Accounts**
Approved and Presented by:	Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an outline of the approach and principles to be adopted for completion of the 2021-22 Annual Accounts together with the planned approach to key financial areas.

RECOMMENDATION(S):

The Audit Committee is asked to:-

- to note the content of this report;
- to note the planned approach to accounting areas including use of estimates where needed as outlined within the paper.

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:

The Health Board has a statutory duty to complete and submit Annual Audited Accounts to Welsh Government. This paper is to inform the ARA Committee of the work completed to date and the further steps required plus the key methodology to be adopted in completing the Annual Accounts process.

DETAILED BACKGROUND AND ASSESSMENT:

The purpose of this paper is to update the Committee on the plans in place to close the Annual Accounts for the year ending 31st March 2022.

This paper outlines the timetable and key dates for delivery of the Annual Accounts.

This paper also highlights key financial assumptions and methodologies to be adopted and the impact of this on the Annual Accounts.

NEXT STEPS:

- Adherence to the timetable and approach as defined within the paper.

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

1. INTRODUCTION

1.1. The purpose of this paper is to provide the Audit Committee on the plans in place to close the Annual Accounts for the year ending 31st March 2022.

1.2. As well as the timetable and key dates for delivery of the Annual Accounts this paper will also highlight key financial areas and the approach adopted in Powys on the assessment of these and the impact of this on the Annual Accounts.

2. BACKGROUND

2.1. A very detailed and comprehensive closedown timetable with supporting guidance notes has been developed and made available to all staff within the Directorate via email.

2.2. Once the final version of the Manual for Accounts is received, which is expected this month, this will be saved on a shared drive within Directorate for staff reference where required.

2.3. The key dates and milestones from the main Annual Accounts Closure Timetable are summarised in the table below:

Annual Accounts Task	Deadline
Issue NHS Debtor Balance Statements to other NHS Wales bodies	5th April 2022
Sign off date for Agreement of NHS Wales Debtors & Creditors	8th April 2022
Issue Income transactions to NHS Wales bodies	12th April 2022
Sign off date for agreement of NHS Wales Income & Expenditure	21st April 2022
Finalise Health Board Outturn Position	7th April 2022
Close Health Board old year financial ledger	7th April 2022
Submit LMS to Welsh Government	22nd April 2022
Preparation of draft Accounts for Senior Finance Team review	20th April 2022
Submission of Draft Accounts to Welsh Government	29th April 2022 (NOON)

Annual Accounts Task	Deadline
Submission of Draft Accountability Report and Performance Overview (including Remuneration Report) to Welsh Government	6th May 2022
Submission of Audited Accounts	15th June 2022 (Noon)

3. GOVERNANCE AND RISK ISSUES

3.1. The Audit Committee meeting already scheduled for Tuesday 17th May 2022, will receive the draft Annual Accounts, Accountability and Performance Report and the Remuneration Report.

3.2. A special meeting of the Audit Committee has been arranged for Monday 13th June 2022, to review the full audited statements and reports, with a Board meeting to formally adopt them on Tuesday 14th June 2022. The deadline for submission to Welsh Government is noon on Wednesday,15th June 2022.

3.3. In closing the accounts, the following key issues are drawn to the attention of the Committee and Audit Wales with regards to the technical accounting treatment that will be employed by Powys Teaching Health Board in closing the draft annual accounts.

A. CAPITAL ISSUES

i. De-recognition

The approach developed by the All Wales Technical Accounting Group (TAG) Capital Sub Group for use since 2009/10, where PTHB will require revaluations from the District Valuer where schemes completing in-year have works and fees costs exceeding £0.5m. Subject to completion of some schemes leading up to year-end there are 3 schemes that we anticipate will require revaluation this year.

ii. Verification of Assets

Due to the inability for travel and remote working requirement of the Audit Team the PTHB finance team have agreed an approach where photographic evidence will be provided in lieu of physical visits being undertaken by the Audit Team.

iii. IFRS 16

IFRS 16 Leases supersedes IAS 17 Leases and is effective in the public sector from 1 April 2022.

IFRS 16 provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value.

IFRS 16 was due to be implemented on 1st April 2021 however the THB received notification in December 2020 from Welsh Government that the Financial Reporting Advisory Board (FRAB) and HM Treasury revised the mandatory effective date for IFRS 16 in central government of 1st April 2022 considering the continuing unprecedented resource pressures caused by the COVID-19 pandemic

The 2021/22 annual accounts will carry a disclosure note to provide high level information on the estimated impact going forward to the Financial Statements.

PRIMARY CARE ACCRUALS

The format of the working papers for Primary Care Accruals will be the same as that used in previous years and will provide clear linkages and audit trails from the Annual Accounts back to the General Ledger.

The Health Board has reviewed the accounting methodologies used across the primary care accrual areas last year. This review has taken into consideration actual outturn values against accrual values and whether there have been any amendments to primary care contracts in year to determine whether any changes are required for 2021/22. The outcome of this work has concluded the following: -

i. GMS Enhanced Services

Given the timescales allowed for practices to claim Enhanced Services, some of the claims may not be received until the following year, therefore the HB is required to estimate the final out-turn. In previous years the HB would review the latest claims from each practice for each enhanced service and estimate the final out-turn, by taking account of current or prior year trends (where seasonality impacts) on the given service.

Due to the Covid pandemic payments for most ES in 2020/21 were based on those made in the 12 months 2018/19 Q4 - 2019/20 Q3 ('Covid block payments'). This arrangement continued for all Wales up to Q2 of 2021/22. From Q3 payments were based on actual activity. In Powys the local agreement is that practices will again receive 100% of the Covid block payments for Q3 and Q4 of 2021/22 provided they achieve 75% of the activity baseline used to derive the Covid block payments. It is deemed by the Primary Care Team highly likely that these payments will be made in full so the accrual for the relevant schemes will be based on 100% of the Covid block payments uplifted for inflation. Therefore no estimation has been required for 21/22 for most of the standard Enhanced Services. Vaccination services will need to be accrued based on estimation of unclaimed payments.

ii. GMS QAIF (Quality Assurance and Improvement Framework)

Under the QAIF scheme, GP Practices achieve a certain level of points and these are multiplied by £x value per point (varies depending on practice weighted list size) to establish the payments due. QAIF years run from 1st October to 30 September, so the final achievement value for M7-12 of a given year is not known until the following December. Estimates are therefore required.

Points to note for this year's formula:

- The QAIF rewards contractors for the provision of quality care and helps to embed quality improvement into general practice. Contractor participation in QAIF is voluntary.

- The QAIF consists of three domains: **Quality Assurance (QA), Quality Improvement (QI**) and the new domain of **Access.**

- The points available for QAIF are:

    - QA-225, QI – 285 and Access - 125

    - A total of 635 points are therefore available to be paid at an individual practice rate, dependent on registered patient list size.

    - Of 16 practices in Powys, 9 achieved maximum points for the period October 2020 to September 2021. The remaining 7 practices achieved an average of 98.85% of the maximum. The accrual will be based on 100% achievement.

iii. Pharmacy Contract

In Powys in 20/21 the accrual for February and March 2021 was based on straight line projection from the 10 months of actual payments made (payments ÷ 10 x 12). This resulted in an over-accrual of £90k (13%).
No changes are proposed for the approach to calculating the accruals for 2021/22. Estimates will predominantly be straight line together with any adjustments for additionality identified as part of the year end review.

iv. Primary Care Prescribing

Information on Prescribing costs is available two months in arears, and therefore requires a level of estimation for year-end accruals. Historically the Health Board has used the Prescribing Audit Report from NHS Wales Shared Services Partnership to support the estimation of year end accruals.

In the advent of the COVID pandemic prescribing activity and costs have proved highly volatile. The Health Board has undertaken further work to research how other NHS organisations estimate and understand their prescribing patterns and trend, which has included the work of the NHS Business Service Authority in England, as well as Dispensing days analysis undertaken by other Health Boards in Wales. This has been undertaken alongside information to provide greater insight on issues relating to high cost areas such as CAT M, NCSO and DOACs.

The Health Board will review these forecasting methodologies at the time of accounts closure together with any additional supplementary information available and together with its Chief Pharmacist will take a view of an appropriate accrual.

C. RETROSPECTIVE CONTINUING HEALTH CARE CLAIMS (OMBUDSMAN PROVISION)

i. Background

At the start of 2011/12, the PTHB Ombudsman Nursing team was disbanded and all cases received prior to 15th August 2010 (Phase 1), were transferred to the All Wales Retrospective Continuing Health Care Team hosted by Powys Teaching Health Board (Powys HB), to be managed using a standardised All Wales approach.

During 2014, the Welsh Government launched an advertising campaign to draw the public's attention to the cut-off date for retrospective continuing NHS health care claims relating to the period 1st April 2003 to 31st July 2013 (Phase 3). Claimants needed to register their intent to claim by 31st July 2014, and no later than 31st December 2014 (later extended by Welsh Government to 31st January 2015), to provide evidence of their right to make the claim and proof of fees paid to the care home or domiciliary agency. The intent to claim and the supporting documentation had to be submitted to the All Wales Retrospective Review Team within Powys HB.

Financial responsibility for all post 2003 claims, regardless of when they were received, rests with the Health Board and pre 2003 cases with Welsh Government.

During 2019/20, the All Wales Retrospective CHC team were disbanded and any remaining phase 2 and phase 3 claims which had not been settled reverted to the management of the Powys Teaching Health Board.

Further annual publicity campaigns have resulted in the ability to claim for periods post July 2013. For phase 4 and subsequent phases, the average success rate will be continued to be used to make a reliable estimate for probable claims based on the average weekly rate. All phase 4,5 & 6 cases have now been settled. As at 31st March 2022 a provision will be provided for the phase 7 claims, currently recording 3 cases.

D. REPORTING ISSUES

i) Single Lead Employer

NHS Wales Shared Services Partnership (NWSSP) holds the contract for GP Specialty Trainees, Pre-Registration Pharmacists and Dental Foundation Trainees on behalf of NHS Wales. These staff are paid via the Velindre NHS Trust payroll system (as the host body for NWSSP) and Velindre NHS Trust invoice the appropriate Health Board who are hosting the trainees via a monthly Single Lead Employer Arrangement.

This scheme is not applicable for Powys THB for 2021/22 as Powys THB does not currently have any current members of staff allocated under these schemes.

ii) Pension 6.3%

The recent revaluation of public sector pension schemes resulted in a 6.3% increase in the employer contribution rate for the NHS Pensions Scheme (14.38% to 20.68%).

A transitional approach was agreed with the Business Services Authority, whereby an employer rate of 20.68% will apply from 1 April 2019, however in 2019-20 the Business Services Authority will only collect 14.38% from NHS Wales' bodies. Central payments

have been made by Welsh Government for the outstanding 6.3% on behalf of NHS Wales bodies.

It is important that notional transactions are recorded in NHS Accounts to record the true costs of the pension contributions the bodies have incurred therefore adjustments are made in the accounts for the 6.3% and a specific note is completed under Note 34 Other Information to explain the relevant accounting entries to the reader of the accounts. The amount to be included will be provided to the Health Board by Welsh Government.

iii) Scheme Pays

In December 2019, Welsh Government confirmed that clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold would be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31st July 2021). The NHS employer would then make a contractually binding commitment to pay them a corresponding amount on retirement.

For the 2019/20 accounts no disclosure with regard to this policy was required as the information to determine whether a provision or contingent liability was required was not available. For the 2020/21 accounts a narrative contingent liability note was disclosed detailing the scheme as insufficient information was available to support a provision. For the 2021/22 accounts it is still uncertain as to whether a provision or contingent liability will be required for the future costs of this commitment by NHS bodies. Welsh Government is working with the NHS Pensions Agency to identify the estimated costs for each health body and there may be a requirement for each health body to disclose a provision in the 2021/22 accounts together with identification of the number of staff who have taken up this option. In the event that a provision is required there will no impact to the reported position of the health board as Welsh Government have advised that the provision will be offset within the financial statement by a debtor to Welsh Government similar to the process for the Welsh Risk Pool.

Of concern, however, is the view of the Auditor General for Wales that any provision included within health board accounts for the cost of Scheme Pays will constitute irregular expenditure and lead to a qualification of the health board's accounts, with the qualification being in respect of the regularity opinion.

E. MOVEMENT IN OTHER KEY PROVISIONS

I. Early Retirement Pension Provision / Permanent Injury

There has been a further change in the Discount Factors to be applied in line with the draft Manual for Accounts issued by Welsh Government in December 2021. This directs health boards to use -1.30% this year (-0.95% 2020/21). This will result in a financial cost estimate of £0.017M this year.

PTHB also account for the early retirement/permanent injury provision in respect of former members of staff of Health Authorities which were reorganised into Health Boards in April 2003. This provision although material within the THB accounts is fully funded by Welsh Government and therefore any financial impact on movement of this

provision year on year is reimbursed to the Health Board via an allocation by Welsh Government so has no impact on the reported position of the Teaching Health Board. The THB has proposed to discharge the early retirement provision via a one-off payment during the year and should this option be exercised; it will eliminate the provision from within the THB Financial Statements with the exception of one remaining case that retired due to permanent injury as this category of retirement cannot be discharged via a one-off payment. All payments in this respect will be reimbursed to the THB from Welsh Government.

II. Defence Fee Provision for Probability 3 (possible) Successful Legal Claims

As is the case for previous years, to comply with the requirements of IAS 37: Accounting for Provisions, Welsh Government has issued guidance regarding the accounting treatment of defence fees for legal claims where the chance of success is deemed as possible (6-49% chance of success).

For the defence legal costs provision of claims within the possible category, the obligating event is a claim being received in respect of Clinical Negligence or Personal Injury.

It is probable, when considering the possible claims as a cohort, that this obligating event may lead to a future transfer of economic benefit in that the organisation may incur some costs in investigating the alleged claim, and therefore a provision is required for the possible claims as a cohort and for which a reliable estimate can be made based on local information held for similar cases. The estimate cannot be made reliably on a claim-by-claim basis; rather the analysis of historical information covering a three-year period should be used.

The table below shows the prescribed accounting treatment to be applied for all claims based on their probability of success:

Probability of Success of Claim	Accounting Treatment
Certain 95-100% Success	***Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports***
Probable 50- 95% Success.	***Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports***
Possible 6-49% Success	***Defence Fee Provision Required – Provision to be based on the Welsh Health Legal Services quantum reports -*** Organisations with numerous claims should base the provision on three year's historical cost data. Note there may be different % values for clinical negligence and personal injury cases, and the % values will be calculated using the methodology agreed.

Probability of Success of Claim	Accounting Treatment
Remote 0- 5% success	***No provision or contingent liability required***

In 2020/21 the Health Board provided on the basis outlined in the table above with the percentages used to provide for probability 3 cases being 28% for Clinical Negligence cases and 56% for Personal Injury cases. This percentage will be used again for 2021/22. Based on the 3rd quarter quantum reports from Welsh Health Legal Services this has resulted in an increase in the provision of £0.105m. This figure may be subject to change as more recent quantum is received.

PTHB also account for claims against the previous Health Authorities which were reorganised into Health Boards in April 2003. These claims are fully managed by the Welsh Risk Pool on behalf of the THB. This provision although material within the THB accounts is fully funded by Welsh Risk Pool and therefore any financial impact on movement of this provision year on year is reimbursed to the Health Board via the Welsh Risk Pool so has no impact on the reported position of the Teaching Health Board.

III. Accounting for Redress Provisions

At the end of the 2018/19 financial year responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool. At the same time, Welsh Risk Pool changed the accounting requirement for redress cases from a cash basis to an accruals basis therefore requiring provisions to be included in the 2018/19 accounts for redress cases for the first time. This accounting treatment is again in place for 2021/22 with provisions for redress cases being included in the accounts based on estimated claim costs provided locally by the Concerns Team. As all payments made in respect of redress cases except for the claimant's legal costs (capped at £1,920) are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

IV. GP Indemnity Scheme

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GP's and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. To date the health board has received three claims under this scheme and therefore a small provision of £0.036M is anticipated for this scheme in the 2021/22 year end accounts. As all payments made in respect of such cases are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

F. COVID

i) Revenue Covid

Covid-19 expenditure has been monitored and reported to WG throughout 2021/22 on three returns:

- Table B3 – covers all Covid Costs including local response costs, recovery costs, Test Trace & Protect (TTP) and Mass Vaccinations

- Test Trace & Protect (TTP) includes both Health and Local Authority Costs for the delivery of this programme
- Mass Vaccinations – this includes the costs of the delivery of the Mass Vaccination programme for Covid-19. The vaccine costs have not incurred by the Health Board and so are not included in this return which focuses on costs for running the Health Board Vaccination Centres and the GMS Enhanced Service,

ii) Annual Leave

Historically the Health Board have required all staff to utilise annual leave in full and so no annual leave provision has been included within the Annual Accounts. However, 2020/21 was an unprecedented year and it was recognised that staff across all disciplines may not have had the opportunity to take their full annual leave entitlement. Therefore, a provision was included within the 2020/21 Annual Accounts.

To establish some consistency across NHS Wales the Technical Accounting Group (TAG) has set out some general principles in 2020/21 that have continued into 2021/22.

Validation of data has taken place during February utilising all local data sources, working with budget holders. This exercise has concluded a provision of £0.858m will be required for 21/22. As per the national principles the THB will allow for up to 10 days to be carried forward with more being permissable in exceptional circumstances only.

There is currently an option of annual leave buyback for those staff who will carry forward annual leave.

iii) FCP / Internal Audit Report

Following publication of guidance from WG on Financial Governance during the pandemic at the end of March 2020 the Health Board developed an internal Covid FCP, approved by Audit Committee. This has been updated throughout the Financial Year to reflect any changes and is published via Powys THB Intranet Staff.

iv) Increase Expenditure linked to Covid

Covid forecast full year expenditure, including TTP and Mass Vaccinations at the end of Month 11 was estimated to be in region of £37.5M and this compares to a figure of £26M at the same point in 20/21. The overall expenditure for Powys will have increased significantly in 2021/22 due to the mass vaccination programme, enhanced cleaning standards and recovery and renewals programme. For the notes of the Annual Accounts the spend will impact on numerous areas of expenditure. There will be material increased expenditure in all 3 of the expenditure notes (3.1, 3.2 and 3.3).

v) Commissioning Contracts (note NCA no change)

At the start of 2020/21 it was recognised that the previous LTA arrangements would not be adequate during the pandemic. So historically:

- English Contracts – through the year an agreed cash value is paid to each provider monthly. However, as the contract is in the main on a cost per case agreement using the English Tariffs rates work is required to estimate the impact of actual performance in the Annual Accounts using the most up to date information available. However final settlement of this creditor / debtor will not be resolved until early

summer once the full MDS data has been received and reviewed in detail by the Health Board.

- Welsh Contracts - paid in year at an agreed value based on historic activity and financial values uplifted by an All Wales %. At the end of the year contract performance is agreed using a marginal rate and finalised prior to the end of the financial year as part of the intra NHS Balance Agreement process.

For 2021/22 as in 2020/21 a new approach to contracting was agreed. The basis of new arrangements between NHS Wales and NHS England has been led by WG and the basis of the new arrangements within NHS Wales has been led and agreed by Directors of Finance. So, at its basic level all contracts were agreed as block, whereby an agreed sum would be paid each month to providers regardless of the activity undertaken. This ensure (1) the cash flowed to all providers and (2) Powys patients were treated regardless of the reason for their admission.

4. REMOTE WORKING

Due to the current COVID restrictions in operation it has already been agreed that the Audit Team will be working remotely for the period of the audit. The THB finance department continue to work closely with the Audit Wales Team to make arrangements for information flow and communication methods to facilitate this and it is not anticipated that this approach will be detrimental to the delivery of the Audit.

5. RECOMMENDATIONS

5.1. The Audit Committee is being asked to note and approve the approach to the 21/22 annual accounts:

a) The timetable, key dates and milestones for the submission of the Annual Accounts for 2021/22;
b) Approve the arrangements in place for the review and adoption of the Annual Accounts noting the approach on the following;
c) the approach for accounting for capital issues;
d) the approach for accounting for primary care accruals;
e) the approach for accounting for retrospective continuing health care claims;
f) To note the anticipated movements in other key provisions;
g) To note the impact of Covid on the financial position.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.3

Audit Risk and Assurance Committee	**Date of Meeting: 22 March 2022**
Subject:	**Counter Fraud Work Plan 2022/23**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	Executive Committee, 9 March 2022

PURPOSE:
The purpose of this report is to present the Counter Fraud Work Plan 2022/23 to the Audit, Risk and Assurance Committee for approval.
RECOMMENDATION(S):
It is recommended that the Audit Risk & Assurance Committee receive the report for ratification.

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

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	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	✓

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				

Marriage and civil partnership	✓				
Welsh Language	✓				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

Item 2.3

Counter Fraud Work Plan 2022/23

Matthew Evans
Head of Counter Fraud Services

22 March 2022

Introduction

NHS Wales will introduce Government Functional Standards on Counter Fraud to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22. The Quality Assessment will remain the same with oversight from NHS Counter Fraud Authority. A full in-depth self-assessment against the new standards will be undertaken as part of the usual end of year process.

Full compliance with the new standards is not to be enforced until 2023/24 to allow Organisations to adjust. A mapping process between new and former standards was undertaken by NHS CFA and utilised to develop the 2021/22 Counter Fraud Work Plan. The Work Plan for 2022/23 is aimed at consolidating work undertaken in the previous period to embed new techniques and approaches brought in via the new standards.

The progress against the 2021/22 Counter Fraud Work Plan has been reviewed and is appended to this report for information.

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture in line with GovS 013 component 11. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	Throughout the Year
2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	Throughout the Year
3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	Q2 and Q4
4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	Throughout the Year
5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	Throughout the Year
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	As Appropriate
7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	Q2 and Q4

COUNTER FRAUD WORK PLAN 2022/23

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	Q2
9	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Throughout the Year
	TOTAL DAYS ALLOCATED	**70**

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
10	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	As Appropriate
11	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Q4
12	Further develop the fraud risk profile developed from risk assessment work to effectively evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2 and GovS 013 component 5.	Throughout the Year
13	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	Q1
14	Review and update information sharing protocols currently in place. Review and refresh protocols with key partners of Internal Audit and Workforce & Organisational Development	Q4
15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Throughout the Year
16	Record and respond to ad-hoc requests for assistance received.	Throughout the Year
17	Action Fraud Prevention Instructions issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate

COUNTER FRAUD WORK PLAN 2022/23

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
18	Issue of fraud alerts to all appropriate staff.	As Appropriate
19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Throughout the Year
20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Throughout the Year
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	As Required
22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line with GovS 013 component 10.	Throughout the Year
23	Membership of Local Intelligence Network and attendance at meetings.	As Required
	TOTAL DAYS ALLOCATED	**103**

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
24	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	As Required
25	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	As Required
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	As Required
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	As Required
28	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	As Required
29	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	Q1
	TOTAL DAYS ALLOCATED	**100**

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
29	Attendance at all Fraud Forum meetings held by CFS Wales.	As Required
30	Nominate a Fraud Champion for the Health Board in line with GovS 013 component 1.	Q1
31	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	Q4
32	Completion and agreement of the annual report with Director of Finance	Q1
33	Regular meetings/liaison with Director and/or Assistant Director of Finance	Throughout the Year
34	Preparation for and attendance at Audit Committee meetings.	As Required
35	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Q4 and As Required
36	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	As Required
37	Implementation of the revised case management CLUE3, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	Q1 and Throughout the Year
38	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	Throughout the Year
39	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	Q2
	TOTAL DAYS ALLOCATED	**35**

SUMMARY TOTALS		
	STRATEGIC AREA OF ACTIVITY	**RESOURCE ALLOCATED (in days)**
A	**INFORM AND INVOLVE**	70
B	**PREVENT AND DETER**	103
C	**HOLD TO ACCOUNT**	100
D	**STRATEGIC GOVERNANCE**	35
	TOTAL	**308**

COUNTER FRAUD WORK PLAN 2022/23

Appendix – Review of Progress Against Counter Fraud Work Plan 2021/22

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	A programme of awareness presentations has been developed and implemented. The Counter Fraud Team utilise ESR for booking and recording of training presentations in line with Health Board procedure.
2	Undertake a suitable exercise to identify the level of fraud awareness within the organisation and analyse and act upon the results.	A draft survey has been prepared and will be issued for responses in March 2022. The survey will target general staff and Primary Care contractors as well as tailored surveys aimed at Finance and Workforce & OD staff.
3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	The intranet site was refreshed earlier this year. This is an ongoing exercise to ensure the information remains current and the intranet page is utilised as the central resource for new updates to staff.
4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	The Counter Fraud Team have not engaged in site visits to raise awareness in this financial year. Covid risks and pressures at sites was paramount to this decision. Summer 2022/23 is planned for a site tour with Covid rates and pressures anticipated to be at lowest.
5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	Messaging around availability of Counter Fraud e-Learning has been included in issued newsletters.

COUNTER FRAUD WORK PLAN 2022/23

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	Payslip messaging has been utilised in March 2022 to highlight the requirement to declare secondary employment in line with Policy requirements.
7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other "beware" notices and relevant messages.	A Newsletter was issued in September 2021 as an Autumn edition. A spring newsletter has been drafted and will be issued in March 2022. A special edition newsletter was also issued in November 2021 to support the International Fraud Awareness Week event.
8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	The LCFS engaged with the Communications Team and took advice on communication methods available within the Health Board.
9	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	A draft survey has been prepared and will be issued for responses in March 2022. The survey will target general staff as well as tailored surveys aimed at Primary Care, Finance and Workforce & OD staff.

COUNTER FRAUD WORK PLAN 2022/23

PREVENT AND DETER		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
10	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	Policy and procedures have been reviewed as part of risk assessment process.
11	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Risk assessment has been undertaken throughout the year.
12	Develop a fraud risk profile developed from risk assessment work to effectively evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2 and GovS 013 component 5.	Fraud risk profile has been developed around core NHS fraud risks identified by NHSCFA.
13	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	A scoping exercise being undertaken to measure effectiveness of arrangements. Awareness of staff responsibilities is included in staff surveys.
14	Review and update information sharing protocols currently in place. Explore opportunities for new protocols where appropriate.	Information sharing protocols reviewed. Planned refresh of IA – LCFS, WOD – LCFS protocols to be included in 2022/23 workplan.

COUNTER FRAUD WORK PLAN 2022/23

PREVENT AND DETER		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Liaison with Internal Audit colleagues is undertaken with areas of joint interest.
16	Record and respond to ad-hoc requests for assistance received.	Regular request for assistance is receive by the LCFS. These are recorded and updated as necessary.
17	Action Fraud Prevention Instructions issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	All fraud prevention notices are risk assessed or shared with appropriate contacts.
18	Issue of fraud alerts to all appropriate staff.	Fraud alerts are disseminated as appropriate.
19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Meetings with PPV colleagues have been undertaken in year and identified potential concerns discussed and interrogated.
20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	The Health Board is progressing work around completion of National Fraud Initiative data matches.
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	The Health Board has participated in a national NHSCFA led exercise around Non-PO vs PO spend and Covid procurement.
22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line with GovS 013 component 10.	Proactive fraud detection work has been undertaken in areas of identified fraud risk relating to overpayments of salary, medicines management, Gifts & Hospitality and Declaration of Interests and Temporary Covid Workers.

COUNTER FRAUD WORK PLAN 2022/23

PREVENT AND DETER		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
23	Membership of Local Intelligence Network and attendance at meetings.	The Local Counter Fraud Specialist is a member of the Local Intelligence Network and regularly attends meetings.

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
24	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	Investigations have been undertaken. Consideration is given to all cases and appropriate actions including investigation, fraud risk management or raising awareness.
25	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	The new case management system Clue3 is being fully utilised by the Counter Fraud Team.
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	A good working relationship is maintained between Local Counter Fraud and National Teams. Assistance is provided were required reciprocally.
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	The range of sanctions available is considered in every case investigated by the Counter Fraud Team.
28	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	Financial redress/recovery is pursued in all appropriate cases. Recoveries are recorded on the case management system and reported as part of operational statistic returns.
29	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	A review of professional competencies and capabilities has identified that Open Source Intelligence refresh training would be beneficial to the Team. Plans are being explored to organise training on an all Wales basis for Counter Fraud Specialists across NHS Wales.

COUNTER FRAUD WORK PLAN 2022/23

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
29	Attendance at all Fraud Forum meetings held by CFS Wales.	The Counter Fraud Team have attended all forum meetings held by CFS Wales.
30	Nominate a Fraud Champion for the Health Board in line with GovS 013 component 1.	The Health Board's Board Secretary was planned to be nominated as the Health Board's Fraud Champion.
31	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	A Counter Fraud Work Plan for 2022/23 will be presented to the Director of Finance and Audit Committee in March 2022.
32	Completion and agreement of the annual report with Director of Finance	A Counter Fraud Annual Report was presented in Q1 2021/22.
33	Regular meetings/liaison with Director and/or Assistant Director of Finance	The Director of Finance and LCFS have engaged in meetings and discussions around Counter Fraud work.
34	Preparation for and attendance at Audit Committee meetings.	Counter Fraud is regularly on the agenda of Audit Committee meetings.
35	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	The LCFS has prepared in readiness for release or the quality assurance process for 2022/23.
36	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Mandatory and Statutory training has been maintained. NHS Counter Fraud Authority delivered a training workshop on
37	Implementation of the new case management CLUE3. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	The new case management system is fully utilised by the Counter Fraud Team.

COUNTER FRAUD WORK PLAN 2022/23

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**CURRENT PROGRESS**
38	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	The Health Board participated in NHS Counter Fraud Authority exercises and provided responses. Operational Statistics reports have been provided on quarterly basis to CFS Wales and Welsh Government.
39	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	The Counter Fraud Policy and Response Plan was reviewed and found to be compliant with the relevant standards; no further amendments were required at that time.
40	Develop a system of outcome based metrics around reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions to enable targets to be set on an annual basis. Develop ability to evidence performance against set metrics in line with GovS 013 component 6.	Guidance obtained from the Quality Assurance Team at NHS Counter Fraud Authority around the operation of GovS 013 component 6 is that performance metrics are relative to the Organisation itself. Existing metrics of operational statistics can be utilised for this purpose. Further developments of the Clue case management system will lead to natural progression of these metrics with recording opportunities built into the system.

Annual Internal Audit Plan: Draft Internal Audit Charter

March 2022

Powys Teaching Health Board

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk & Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19 and the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the

organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk & Assurances Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit, Risk & Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executives and Independent members to discuss current areas of risk and

related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team, the Independent Members and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk & Assurance Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from

the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit, Risk & Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk & Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the health board will need to pay an additional £57,614 (£55,223 in 21/22) to cover this additional audit work.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk & Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. For 2022/23, this additional charge is £21,400 (£26,821 in 21/22).

Therefore, the Health Board will be charged an additional amount of £79,014 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2022/23.

6. Action required

The Audit, Risk & Assurance Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Board Secretary	Q4
Board Assurance Framework / Risk Management	1	N/A	Focus on development of effective assurance processes alongside risk identification / escalation. Dependent on outcome of 21/22 audit and progress made by Health Board.	Board Secretary	Q4
Staff Rostering	2	CRR 006	Review the controls and processes in place for the planning and management of staff rosters. Focus on Nurse rostering but also consider another area as a comparator - Works & Estates.	Director of Workforce & OD	Q3
Temporary Staffing Department	3	CRR 006	Review how the department is set up and operating / effectiveness of service provided. Review controls in place around requesting / authorising / paying of bank and agency staff. Look at use of off contract agency.	Director of Workforce & OD	Q1

			Assess compliance with Health Board Bank & Agency Policy.		
Workforce Futures Framework (Defferred from 21/22)	4	CRR 006	Provide assurance that the framework has embedded and is providing clear direction of the future work required to achieve the outcomes intended.	Director of Workforce & OD	TBC
Looked After Children with Mental Ill Health (Deferred from 21/22)	5	CRR 004/5	Assurance on the effectiveness of access to services and how they are commissioned. Include interface and communications between CAMHS and looked after children services.	Director of Nursing & Midwifery / Director PC&MH	Q2
Directorate Quality & Safety Governance Arrangements	6	CRR 001	Review the arrangements in place within the Directorates for Quality and Safety Governance.	Director of Nursing & Midwifery / Director PC&MH	Q3
Savings Plans / Efficiency Framework	7	CRR 002	Provide assurance around the development, monitoring and achievement of the Health Board's savings plans linked to recovery and the associated Efficiency Framework.	Director of Finance, Information & IT	Q4
Charitable Funds	8	CRR 002	Review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.	Director of Finance, Information & IT	Q2 / Q3

IT Asset & Infrastructure Management	9	CRR 005	Review of the processes in place for managing the Health Boards IT assets and infrastructure. Detailed scope to be confirmed.	Director of Finance, Information & IT	Q1 / Q2
Cyber Security	10	N/A	Establish if the mechanisms in place for ensuring cyber-security are appropriately designed, and procedures and controls have been effectively implemented.	Director of Finance, Information & IT	TBC
Cancer Services (Deferred from 21/22 plan)	11	CRR 007/13	The review will assess the effectiveness of the structure in place to provide an assurance that cancer patients are receiving the best possible service. Focus of review to include clarity of Pathways / early diagnosis / systematic tracking of Cancer Patients.	Medical Director / Director of Planning & Performance	Q1 / Q2
SLAs for In-reach Medical Staff	12	CRR 006	Provide assurance over actions taken to review and update SLA arrangements for in-reach medical staff across all Health Board services.	Medical Director	Q4
Welsh Language Standards / Equalities	13	CRR 012	Review processes in place within the Health Board to ensure compliance with the requirements of the Welsh Language Standards Act and wider Equalities regulations.	Director of Therapies & Health Science	Q1
Professional Governance Structure	14	CRR 006	Review implementation of structure to provide assurance on professional oversight.	Director of Therapies &	Q4

				Health Science	
Performance Management & Reporting (Deferred from 21/22)	15	CRR 007	A review of the effectiveness of the health board's performance management and reporting arrangements. To ensure the achievement of an integrated approach through the Improving Performance Framework.	Director of Planning & Performance	Q2 /Q3
North Powys Wellbeing Programme (Deferred from 21/22 plan)	16	CRR 001/8	An assessment of the health board's arrangements to take the programme forward. To include focus on the management of demand and capacity modelling and service mapping.	Director of Planning & Performance	Q1
Planned Care / Recovery of backlog Services	17	CRR 003/7	Provide assurance across key areas - Community Services / planned care / recovery of backlog services	Director of Planning & Performance	TBC
Review of a service area within the PC&MH Directorate	18	N/A	Review of an identified service area including coverage of Q&S Governance / risk / Governance / operational controls. (Area to be agreed with Director PC&MH)	Director PC&MH	Q1
Covid-19 Incident Management Arrangements	19	CRR 014	Review of residual arrangements for managing and reporting future Covid 19 incidents. Compliance with communicable diseases reporting requirements.	Director of Public Health	Q2

Operational Service Review – Security Services	20	N/A	Review of the structure and effectiveness of security services within the Health Board.	Director of Environment	Q1
Machynlleth Project	21	CRR 005	To assess the THB's processes, procedures and operational management of the £14.92m Machynlleth reconfiguration project to create a primary and community care hub. The focus of the 2022/23 review may include an assessment of the following: • Follow up to previous agreed management actions • Ongoing project governance and management arrangements; • Interim valuation and payments processes; • Change Management arrangements; • Site Management • Commissioning arrangements; • Equipment procurement processes; and • Other – i.e. any other issues identified at the project affecting project delivery.	Director of Environment	TBC
Decarbonisation	22	CRR 005	To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy, and to	Director of Environment	Q2

			provide assurance on capital allocations provided by Welsh Government to address decarbonisation issues across the estate during 2021/22.		
Follow – up Action Tracker	23	CRR 005	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Board Secretary	Q4

Please note: The national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Powys Teaching Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Powys Teaching Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Powys Teaching Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk & Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk & Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk & Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk & Assurance Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk & Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk & Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk & Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk & Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk & Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive

and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit, Risk & Assurance Committee or management, this may include areas of concern identified in the corporate risk register;

- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk & Assurance Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national

transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk & Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk & Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk & Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit, Risk & Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk & Assurance Committee requirements; and
- The Audit, Risk & Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for

improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit, Risk & Assurance Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit, Risk & Assurance Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit, Risk & Assurance Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.

- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit, Risk & Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit, Risk & Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk & Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk & Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk & Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2022

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AGENDA ITEM: 3.1

AUDIT, RISK AND ASSURANCE COMMITTEE	DATE OF MEETING: 22 March 2022
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 9 March 2022

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to NOTE and DISCUSS 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 and 2021/22 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	1		3
Priority 2	5	1	7	Medium	5	2		20
Priority 3	0	0	8	Low	8	0		16
Not Yet Prioritised	0	0	1					1
TOTAL	5	1	16		15	3		40

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	2021/22	TOTAL OUTSTANDING
	Number	Number	Number	Number	Number
Priority 1	0	0	1	0	0
Priority 2	2	0		0	2
Priority 3	1	0		0	1
Not Yet Prioritised	0	0		0	1
TOTAL	3	0	1	0	4

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 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 I – Local Counter Fraud Audit Recommendations NOT YET DUE for implementation

NEXT STEPS:

Progress against outstanding audit recommendations will continue to be monitored by the Executive Committee and Audit, Risk and Assurance Committee.

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	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**	**1**	**0**	**5**	**0**	

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	1	2	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	1								✓
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	2	0	0	1	0	0	1	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**	**55**	**30**	**4**	**10**	**2**	**0**	**7**	**8**	**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	3	2										✓
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	4										✓
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	8				0	0	5	×
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	2	0				0	0	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**	**19**	**11**	**2**	**5**	**8**	**1**	**0**	**0**	**0**	**2**	**6**	

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	×
212202	Control of Contractors	Limited	4	2	1	2	2	1	2	0	0	0	0	0	×
212203	Medical Equipment and Devices	Reasonable	3	3	1	0	0	0	0	1	0	3	2	1	×
212204	Midwifery – Safeguarding Supervision	Reasonable	0	2	0	0	1	0	0	0	0	0	1	0	×
212205	COVID Recovery and Rehabilitation Service	Substantial	0	1	0	0	0	0	0	0	0	0	1	0	×
212206	Theatres Utilisation	Reasonable	2	2	1	0	0	0	0	0	1	2	2	0	×
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	1	0	0	0	0	1	3	1	×
TOTAL			**11**	**15**	**5**	**3**	**4**	**1**	**2**	**1**	**1**	**6**	**10**	**3**	

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	6							✓
TOTAL		**20**	**15**	**1**	**0**	**1**	**1**	**3**	**4**	

2021/22 External Audits

	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		
212251	Structured Assessment 2021 (Phase One)	0								✓
212252	Structured Assessment 2021	3	1	0	0	0	0	0	2	×
TOTAL		**3**	**1**	**0**	**0**	**0**	**0**	**0**	**2**	

APPENDIX C

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
171817	Policies Management	Reasonable	Board Secretary		R1
171817	Policies Management	Reasonable	Board Secretary		R2
171817	Policies Management	Reasonable	Board Secretary		R3

171817	Policies Management	Reasonable	Board Secretary		R4
171817	Policies Management	Reasonable	Board Secretary		R5
181909	Occupational Therapy Service	Reasonable	Board Secretary		R5

192006	Records Management	No Assurance	Board Secretary		R3
192006	Records Management	No Assurance	Board Secretary		R4

192006	Records Management	No Assurance	Board Secretary		R5
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R2

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

192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3

192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health Services	R4
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1

192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R1
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and IT		R2

192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R3
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R4
192023	Estates Assurance Follow Up	Reasonable	Director of Environment	Asbestos Manager	AM2

192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary / Head of Risk & Assurance	R5
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3

192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R1
202102	Estates Assurance – Fire Safety	Limited	Director of Environment	Fire Safety Advisers	R5
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R1

202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R5
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R2
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R3
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R4
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R5
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R6

202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R8
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R9
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R14

202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R1
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2

202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R1
202114	Implementation of digital solutions	Reasonable	Director of Finance, Information and IT	Assistant Director Digital Transformation and Informatics	R2

212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R6
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads	R3
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Planned Care Manager	R5

Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due
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	Overdue
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	Overdue
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	Overdue

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	Overdue
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	Overdue
The Records Management Policy, Health Records Procedure and Safe Haven and Information Policies should be reviewed and updated as necessary so that they comply with General Data Protection Regulations (GDPR). A consistent approach to records management	The policies and procedures will be updated to ensure compliance with GDPR. Occupational Therapy Teams will be reminded of the standards for records management to promote a consistent approach.	Apr-19	Dec-21	Overdue

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
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

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
(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

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

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

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
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

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
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

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	Mar-22	Deadline Revised
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	Jan-22	Overdue
A detailed review of the Asbestos Management Plan should be completed. Patterson,Liz 03/18/2022 14:33:10		Jan-21	Feb-22	Deadline Revised

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	Mar-22	Deadline Revised
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

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
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	Jan-22	Deadline Revised
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

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
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		Overdue
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		Overdue
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		Overdue
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		Overdue
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		Overdue

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		Overdue
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		Overdue
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		Overdue

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		Overdue
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

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
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		Overdue

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.	a. 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. b. 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. c. 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.	Sep-21		Overdue
All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	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.”	Nov-21	Feb-22	Deadline Revised
The Health Board should develop a protocol which describes the administrative processes which are in place regarding theatre utilisation.	Terms of Reference for Theatre Planning Meeting will be formalised and admin processes for list planning added to the SOP.	Jan-22		Overdue

COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendatio		
			Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
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
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
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

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
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
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.

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.
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.

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.
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.	

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	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation

2	Partially complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart	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.

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. 28/2/2022 As part of the restructure of the team in CSG betweeen November 2021and January 2022 the service was re mapped	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
3	Partially complete		This work has been paused due to the COVID pandemic and current winter pressures. – However a number of the OD priorities have been included in other plans; such as the wellbeing plan- leadership and team development.		This will be reviewed as part of the reintroduction of BAU

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.		
	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	

3	Partially complete			COVID-19 delays	
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. Furher information is now being reported by acute hospital sites for follow up performance including those overdue. Information will be included in the next D&P Committee Report		Follow-up is discussed in CQPRMs.
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.

2	Partially complete		High level work has been initiated to outline the framework and principles.		
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 moved to another post in Oct 2021, coinciding with the appointment of new staff; a replacement has been appointed however a bedding-in period with an entirely new team. Likely risk that the cross-over period will result in further delays to implementation in the short term. Failure to pre-emptively comply with the standards may also lead to operational inefficiency with staff time taken up by responding to and addressing complaints rather than ensuring compliance in the first place.	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); all are now in post along with the new SIM for Welsh Language and Equality. Additional resource has been allocated for translation costs.

3	Partially complete		Reablement agreement reviewed. The review of the Overarching Agreement Deed of Variation has been delayed due to covid-19		
1	Partially complete		Site Coordinators appointed and significant numbers of Fire Incident Coordinators and Fire Wardens trained for end November 2021 with minimum of btween 20 and 73 per hospital site which ensures suitable coverage. Training includes use of local fire management folders.	Attendance to sessions was and continues to be limited by number limitations on training rooms from C-19 social distancing.	Fire evacuation drills up to date with last 2 planned for January 2022: this is the practical enactment which tests the resilience of the training. Fire Safety Advisors have overseen these exercises.
	Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.		

	Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.		
	No progress				
	No progress				
	No progress				
	No progress				
	No progress				

	No progress				
	No progress				
	No progress				

	Partially complete		Meetings continue to include clinical representation from a frontline, management and Director level across organisations. The focus of Phase 2 has been Maternity and Neonatal with a clinically led workstream established. This approach has been embedded in the programme and will continue. The readiness assessment continues to be updated during the workstream meetings. As reported to the Board on 24th November 2021 it is not yet possible to recommend to the Board the timing of the strategic pathway change as further information is awaited from the Independent Oversight Panel. It will only be possible to complete this action once the timing of the		Worktream in place involving clinicians from ABUHB, CTMUHB and PTHB chaired by the DONM, monitoring existing pathways and assurance.
	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	Individual programme PIDs have set out the stages required.

	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		
	No progress				

	Partially complete		a. Monitoring sheet in place and 5% check implemented on Estates jobs - COMPLETE b. KPI's written into 3-5 year maintenance contacts including any future contracts. COMPLETE c. Report to be taken to 15 Feb 2022 IEG meeting ONGOING		Monitoring being undertaken.
	Partially complete		Meeting held with Governance Leads and Medical Device & Point of Care Testing Manager 06/12/21. Example of Idemnity Form shared with Governance Leads who will be undertaking focused work with services to ensure all areas use the indemnity forms and track medical devices loaned to patients accordingly.	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.
	No progress		Terms of Reference are now in place. Utilisation picked up as part of GIRFT review.Operational theatre report to be revamped in line with GIRFT expectations		

n When will implementation be achieved?	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
Apr-22		44	1	Jan-22	26/02/2019
Apr-22		44	1	Jan-22	26/02/2019
Apr-22		44	1	Jan-22	26/02/2019

Apr-22		45	1	Jan-22	26/02/2019
Apr-22		44	1	Jan-22	26/02/2019
31-Dec-21		33	1	Jan-22	26/02/2019

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01-Apr-22		22	13	Jan-22	15/11/2019
Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		21	#NUM!	Jan-22	14/11/2019

Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		21	#NUM!	Jan-22	14/11/2019
Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		21	1464	Jan-22	

Sep-21		13	4	Jan-22	

Jul-21		21	6	Jan-22	

Apr-21		22	9	Jan-22	
end of Qtr 2		22	16	Jan-22	

Mar-22		10	#NUM!	Jan-22	26/09/2020
		10	#NUM!	Jan-22	26/09/2020

Mar-22		10	#NUM!	Jan-22	26/09/2020
Jan-22		10	0	Jan-22	26/09/2020
Feb-22		12	#NUM!	Jan-22	26/09/2020

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		10	#NUM!	Jan-22	26/09/2020
Implementation will be ongoing		10	#NUM!	Jan-22	26/09/2020

		9	1464	Jan-22	26/09/2020
Jan-22		6	0	Jan-22	
		4	#NUM!	Jan-22	

		4	#NUM!	Jan-22	
		3		Jan-22	
		3		Jan-22	
		3		Jan-22	
		3		Jan-22	
		3		Jan-22	

		3		Jan-22	
		3		Jan-22	
		3		Jan-22	

This cannot be implemented until the Board has agreed the timing of the strategic pathway change. It is not possible to set a revised deadline until the timing of the strategic decision has been reached by Board.		2		Jan-22	
01/03/2022, however there will be implications for other health boards. This is timetabled to coincide with the change to Strategic Commissioning Framework at Board in March 2022.		4		Jan-22	

		4		Jan-22	
		1		Jan-22	

15-Feb-22		4	1464	Jan-22	
Review of compliance to be undertaken at next Medical Devices Group in January 2022.		2	#NUM!	Jan-22	
Mar-22			1464	Jan-22	Jan-22

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	Medical Director	Chief Pharmacist	R4
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R3
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R4
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R5
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R7
212207	Dementia Services- Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Operations Manager, Mental Health Services/ Director of Finance and ICT Services	R3

Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due
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	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	Complete
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	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.	Oct-21		Complete
a. 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.	4.1a 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	Sep-21		Complete
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. 2. A written record should be maintained of the	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	Nov-21		Complete
All contractor-related incidents / accidents should be recorded on Datix, and appropriately coded to facilitate management review / reporting.	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.	Nov-21		Complete
Operational issues regarding the WCCIS system should be formally escalated and feedback should be provided to staff on what steps are being taken to resolve the issues. Management should ensure all appropriate documentation is maintained within the WCCIS and staff should be reminded of the importance of this.	Performance of the WCCIS system will continue to be formally escalated to the Director of Finance (Lead of IT and systems with PTHB) and representation made to lead commissioners and Welsh Government on the performance of the system.	Jan-22		Complete

COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation		
			Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
3	Complete		The Medicines Policy is currently being updated and this will include guidance on generic and brand name prescribing. The use of branded generics will be	The health boards formulary is being systematically reviewed and this will help to ensure appropriate use of branded medicines. In addition to this, our	Generic prescribing is actively encouraged where brand name prescribing is not necessary. The health board does not routinely monitor
	Complete		Worker competencies checked in accordance with HTMs. Induction process being undertaken. Contractor Job Forms are being undertaken.		Worker competencies for high risk activities are checked. Induction process is applied. Contractor Job Form being completed.
	Complete		a. Capital team have now received training on the Estates control of contractors system COMPLETE. b. Documentation is filed - COMPLETE		Capital team have been trained in the use of the Estates process
	Complete		Site Access controls in terms of signing in/out are in place with written records being maintained.		review of the access arrangements being enacted in Q1 as extra level of resilience.
	Complete		Incidents are recorded on Once for Wales / Datix.		
	Complete		WCCIS system has improved performance over the last 2 weeks. All escalation actions have been implemented.		

When will implementation be achieved?	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
Sep-20		45	16	Jan-22	27/03/2019
	yes	3	1464	Jan-22	
	yes	4	1464	Jan-22	
	yes	2	1464	Jan-22	
	yes	2	1464	Jan-22	
		0	1464	Jan-22	Jan-22

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R7
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R10
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R11
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R12
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	R13

202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R2
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R3
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R5
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R2
212201	Access to Systems	Reasonable	Director of Finance, Information and IT	Digital Project Manager	R3
212202	Control of Contractors	Limited	Director of Environment	Associate Director of Estates & Property	R2

212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R1
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R2
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Ward Manager – Graham Davies Ward / Governance Lead / Department Leads / Medical Device & POCT Manager	R4
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Head of Clinical Education / Medical Device & POCT Manager	R5
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R6
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads / Medical Device & POCT Manager	R7

212204	Midwifery – Safeguarding Supervision	Substantial	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding supervision / Assistant Director for	R1
212205	COVID Recovery and Rehabilitation Service	Substantial	Director of Therapies and Health Sciences	Head of Pain & Fatigue Management	R1
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Medical Director	R1
212206	Theatres Utilisation	Reasonable	Planning and Performance	Assistant Director of Community Services Group	R2
212206	Theatres Utilisation	Reasonable	Planning & Performance	Assistant Director Community services	R3
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance.	Assistant Director of Community services	R4

212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Assistant Director of Mental Health Services	R1
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Operations Manager, Mental Health Services	R2
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Business Manager, Mental Health	R4
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Assistant Director of Mental Health Services	R5
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Therapies and Health Science	Business Manager, Mental Health Services	R6

Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due
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	Apr-22		Not yet due
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
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
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
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

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	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	Mar-22		Not yet due
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	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	May-22		Not yet due
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.	Jul-22		Not yet due
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
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
1. Contractors should be periodically reminded of the THB's H&S requirements, via issue of the H&S Contract Rules & Guidance. 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. 3. The benefits of using a standard contractor	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. 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	Dec-21		Not yet due

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. 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. 3. The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	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. 2. There is currently a section within the EDOF stating NWSSP Procurement must be involved. However, management will	Nov-22		Not yet due
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;	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	Dec-21		Not yet due
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. 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.	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." 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	Mar-22		Not yet due
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. 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	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	Mar-22		Not yet due
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	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. Standing agenda item will be added to the	Apr-22		Not yet due
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. 2. Staff and independent contractors across the HB responsible for the management of medical devices	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. 2. The Management of POCT policy will be updated to include an indicative timescale for undertaking self-audits and completing	Dec-22		Not yet due

1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives 1c. Requirements to attend Safeguarding	Dec-21		Not yet due
1.1 Management need to ensure that the budgets are reviewed and the £100k is appropriately utilised in support of long covid services.	1.1 The Long-Term Conditions Indicative Financial Plan will continue to be reviewed as part of the weekly meeting held between the service and the DOTH. This information will be shared with the Finance Business Partner to monitor spend against the budget.	Ongoing		Not yet due
Further work should be undertaken to take forward the consideration regarding appointment of a part time Clinical Director for Endoscopy and Theatres to improve the oversight and discussion of clinical issues. Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board	To explore opportunities for a Clinical Director role for Planned Care (including Endoscopy and Theatres)	Mar-22		Not yet due
Progress on delivering the Theatres and Endoscopy Recovery Plan should be appropriately controlled and monitored to ensure that the 2021/22 Renewal Priorities are achieved.	Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board.	Mar-22		Not yet due
The Service Level Agreements for the in-reach staff should be reviewed and updated as soon as possible.The assumptions and calculations within management information should be reviewed and updated as soon as possible. Agreed Management Action 3	To review service level agreement with in reach providers, this is challenging due to current seasonal pressures focus and all providers re-aligning/transforming services and implanting recovery plans. Management reports will be aligned with updated SLAs as part of 2022/23 service planning.	Mar-22		Not yet due
The actions put in place should continue to be monitored to ensure that they mitigate the risk of failing to achieve access targets including Referral to Treatment and National Endoscopy Programme Joint Advisory Group Training Site re-accreditation.	Plans in place monitored via Delivery & Performance Committee and Diagnostics, Ambulatory Care & Planned Care Board Programme, PTHB Integrated Performance Report.	Ongoing		Not yet due

The operating environment within both teams needs further evaluation, to ensure clients have consistent access to services throughout the Health Board and good practice can be shared and embedded.	The configuration of the North Powys team to match the clinical specialism of the South will require additional funding, as well as any move to the South Team matching the North's 7- Day working practices. Elements of this funding will be considered as part of the Mental Health Service Improvement funding and any additional funding released by Welsh	Sep-22		Not yet due
The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee.Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the operational updating of the WCCIS System.	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 – day basis we will require two flow charts demonstration patient flow and the method of referral.The SOP requires finalisation and until full expansion of the service will require two sections, relating to North and South Powys. This will	Apr-22		Not yet due
Management must ensure that the Performance measures are subject to appropriate independent review prior to submission.Good practice in data collection should be shared between the teams.	This process will be reviewed to ensure that Performance Measures are independently and rigorously tested prior to submission.The MHLD business manager will facilitate the sharing of good practice within data collection, including a common method to capturing and processing information.	Mar-22		Not yet due
A review of the performance measures should be undertaken to ensure they are meaningful, and duplication is avoided.Guidance on how to interpret and evidence the performance measure should be provided. Management should consider standardising the performance measures across both teams to ensure meaningful and comparable information is collected.	The review of performance measures will be undertaken as part of a wider MHLD service group's participation in Welsh Government's move to service user led outcomes and core data sets.Within the National move to service user led outcome and data sets, training for staff and managers on its collation and interpretation will be facilitated on a	Sep-22		Not yet due
Consideration should be given to providing the Mental Health SMT information on the performance of the Dementia Home treatment team.	DHTT performance will be included in the SMT performance reporting on at least a quarterly basis.	Apr-22		Not yet due

COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation		
			Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
	No progress				
	No progress				
	No progress				
	No progress				
	No progress				

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	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		
	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		
	No progress				
	No progress				
	No progress				
	Partially complete		1. COMPLETE - Health and Safety Rules/Guidance booklet and pamphlet circulated to all current Estates and Capital Maintenance Contractors. 2. COMPLETE - KPI's are	COVID has acted to delay focus on the maintenance contract roll out, which has been a significant undertaking involving 30+ contracts.	Safety Booklets had historically been issued but not always recorded - now complete. Contractor performance is monitored currently, however, the KPI standardisation ensures a consisitent approach

	No progress				
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n When will implementation be achieved?	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
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	Yes via meeting minutes & action logs	#NUM!		Jan-22	
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01-Mar-22		1	1464	Jan-22	

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PTHB Ref. No.	Report Title	Director	Ref.	Recommendation
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.
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.
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.
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I1	Implement mandatory counter-fraud training for some or all staff groups.

Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level
Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Overdue	2
The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	Oct-19	Dec-21	Overdue	2
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
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	

Status	If closed and not complete, please provide justification	Progress being made to implement recommendation		
		Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
No progress		To be taken forward in Q2.	Delayed in light of COVID-19	Clinical and Stakeholder engagement is undertaken via other means
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
Partially complete		Report templates and masterclasses for senior managers will be delivered in Q2.	COVID-19 arrangements have taken priority over this work.	
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.

When will implementation be achieved?	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
31-Mar-21		27	10	Jan-22	
30-Apr-22		27	1	Jan-22	
30-Apr-22		31	10	Jan-22	
Formalisation of Mandatory training for staff at higher risk of exposure to fraud will be explored in 2021/22.		10		Jan-22	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation
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.
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.
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.
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.
212252	Structured Assessment 2021	Board Secretary	R1	The Health Board is experiencing a period of significant change within its independent members cohort. Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them. To supplement the national induction programme, the Health Board should develop a local induction training programme as soon as possible to help new independent members ease quickly into their role.
212252	Structured Assessment 2022	Board Secretary	R2	The Health Board does not currently have any associate Board members to assist it in carrying out its functions. Previously the Corporate Director (Children and Adults) from Powys County Council was as associate Board member but has not attended. The Health Board should work with Powys County Council to identify a suitable replacement as soon as possible.

Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level
• 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
• 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	
• 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	
• 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
Review and strengthen the induction arrangements for Independent Members to improve early understanding of corporate business. To include: • Background information on establishment of the health board • Good governance and structure of Committees • Board Assurance Framework • Cycle of meetings and Terms of Reference • Roles and responsibilities • Declarations of Interest and Standards of Behaviour • Strategic Plans • Role of Charity Trustees • Means of accessing further information on the Health Board	Mar-22		Not yet due	
Review and strengthen the induction Interim Board Secretary will engage with Powys County Council's Monitoring Officer to identify a replacement Associate Director.	Mar-22		Not yet due	

Status	If closed and not complete, please provide justification	Progress being made to implement recommendation		
		Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
No progress				
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.
Partially complete				
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
No progress				
No progress				

When will implementation be achieved?	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
		#NUM!		Jan-22	
		#NUM!		Jan-22	
		#NUM!		Jan-22	
Mar-22		#NUM!		Jan-22	
		#NUM!		Jan-22	
Patterson,Liz 03/18/2022 14:33:10		#NUM!		Jan-22	

PTHB Ref. No.	Report Title	Director	Responsible Officer	Ref / Priority
212281	Overpayments	Director of Finance, Information and IT		R1
212281	Overpayments	Director of Finance, Information and IT		R2
212281	Overpayments	Director of Finance, Information and IT		R3

Recommendation	Agreed Deadline	Revised Deadline
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	
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	
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	

Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation		
				Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?
Not yet due		No progress				
Not yet due		No progress				
Not yet due		No progress				

When will implementation be achieved?	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
		#NUM!	1464	Jan-22	
		#NUM!	1464	Jan-22	
		#NUM!	1464	Jan-22	

ANNUAL GOVERNANCE PROGRAMME

MILESTONES

2021/22

Quarter 3 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.
	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 Q4.
	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 Q4. 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.
	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	
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.
	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 of individual roles and the board as a cohesive team	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 undertaken April 2022.

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	
	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 development of the 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 are under review.
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 going forward.
h) Review and implement arrangements for the development, review, approval and publication of	Policy Management Framework to be reviewed, confirming policy approval routes	Executive Director Policy Owners					Due to capacity constraints, this work has been delayed. Policy Review continues, led by
	Policies section of intranet/internet to be refreshed						

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
policies delegated by the Board	Policy toolkit to be rolled out with awareness raising						Policy Owners, with updates published to the Intranet.
	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 required to refine operational risk

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	
							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 ongoing to ensure that

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	
							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 been stood back up during the pandemic. In its absence, the Board continues to receive its Corporate Risk Register at each meeting and
	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						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						

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.3

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 22nd March 2022**
Subject:	**Post Payment Verification Progress Report - 1st April 2021 to 31st December 2021**
Approved and presented by:	Director of Finance/All Wales Post Payment Verification Manager
Prepared by:	Amanda Legge Post Payment Verification Manager
Considered by Executive Committee on:	9 March 2022
Other Committees and meetings considered at:	None

PURPOSE:

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle, and the two previous. It also demonstrates the overall performance of the HB against the national averages. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

The paper is being produced for the Committee to review for information purposes and discussion. PPV provides assurance in all contractor disciplines, except for General Dental Services.

This year, 2021-2022, we continue to face challenges associated with the COVID-19 pandemic. To effectively respond to challenges identified within Primary Care we continue to investigate further avenues to enhance our PPV service. The decision to halt physical visits to our contractor premises was taken to protect our front-line services, to maintain colleagues' safety and to remove any pressure on primary care contractors and their teams during difficult times. A review of opportunities and a recovery plan has been considered during this time, to maintain an excellent level of

PPV, which would continue to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

General Medical Services (GMS): The visit plan runs on a 3-year cycle for GMS and is agreed by Health Board Audit Committees. Following review of the All-Wales visit plan and the inability to perform physical visits, we concentrated on our PPV arrangements within the GMS discipline. These visits can be completed remotely and would not be intrusive or place additional requirements on local front-line service provision. Remote access verification would take place based on a sample of claims submitted from April 2019 - March 2020, due to the sudden decrease of claims from the point of lockdown in March 2020.

It was agreed by General Practitioner Committee Wales and Heads of Primary Care that PPV proceeded with the GMS visits during the 2021-2022 financial year as part of the PPV three-yearly cycle, utilising 2019-2020 claim data from April 2021.

General Ophthalmic Services (GOS): Pre COVID-19, the visit plan for GOS 2020-2021 was agreed by Health Board Audit Committees. However, ophthalmic practices were unable to remain open to the public for certain periods and it is a service where PPV teams did not have the ability to undertake reviews via remote access. We explored PPV remote access options having full support from Optometry Wales and have begun to carry out these visits via Microsoft TEAMS which is proving successful. Future visits will now be included in the 2022-2023 visit plan, and we are hoping to increase the number of contractors as we progress in this new way of working which is being encouraged by Welsh Government. We also continue to undertake the GOS quarterly patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

Pharmacy Services (GPS): Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022, NWSSP is hoping to introduce a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme.

PPV are currently verifying Bonus Payment checks as requested by Welsh Government that were claimed and paid to all Health Service staff in 2021.
The GMS snapshot and statistics tab now separate the routine and the revisit errors and averages.
Revisits are generally higher percentages due to 100% of the claims checked over a longer period.

RECOMMENDATION(S):

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for information/Assurance only.

The report details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.

Approval/Ratification/Decision[1]	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	

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential, or positive impact that may arise from a decision being taken***
Age					
Disability					
Gender reassignment					
Pregnancy and maternity					

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

Race					
Religion/ Belief					
Sex					
Sexual Orientation					
Marriage and civil partnership					
Welsh Language					

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
Clinical					
Financial					
Corporate					
Operational					
Reputational					

Primary Care Services
Post Payment Verification Progress
August 2021

SITUATION

During 2020-2021, Post Payment Verification (PPV) faced significant challenges associated with the COVID19 pandemic. To respond effectively to challenges identified within Primary Care Services (PCS), Welsh Government (WG) agreed on the 19th March that PPV would be stood down and would not be reinstated until October 1st, 2020.

When our service recommenced, we were still unable to visit contractors' premises so we concentrated on General Medical Services (GMS) as these could be carried out remotely. This decision was taken to protect and maintain colleague's safety and to remove any pressure on primary care contractor's and their teams during unprecedented times.

It was also noted that during the COVID19 episode ophthalmic practices were unable to remain open to the public and PPV teams did not have the ability to undertake any visits via remote access arrangements. Taking this into account, we moved resource to enable a national roll out of a previous pilot which enabled PPV teams to contact patients directly, to confirm what ophthalmic services had been provided. Following on from the pilot, it was agreed with Local/National counter fraud colleagues and Optometry Wales that we rolled out this quarterly 'dip testing' programme across Wales.

A review of many other opportunities were considered in this time to reinstate an acceptable level of PPV within our other disciplines, which would continue to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

Collaborative working relationships were vital in these future months to allow us to deploy longer-term PPV solutions as we moved forward with this pandemic and beyond.

BACKGROUND

1. There are 4 PPV sites in Wales each with a Team of staff who concentrated on their own local area due to travelling to sites and geographical knowledge.
2. PPV provide assurance in all contractor disciplines, except for General Dental Services. We have now reviewed how we are able to reinstate a better level of PPV within the General Medical Services (GMS), General Ophthalmic Service (GOS) and General Pharmacy Service (GPS) as we are uncertain to when we are able to attend these premises. We have now explored the option of carrying out remote access on the two other disciplines.
3. The patient letter programme for GOS is completed quarterly.
4. We carried out physical Clinical Waste checks with our GMS and GPS services.

5. Training and assistance for our contractors were carried out in different ways prior to Covid via Physical visits and training events.

ASSESSMENT

1. Due to the inability travel, on reinstatement An All-Wales approach was considered and rolled out concentrating on GMS only. A lot of training and knowledge sharing was completed in this time and continues, which has enabled business continuity throughout difficult times. It has also upskilled staff for an All-Wales process and improved consistency and continuity throughout.
2. We undertake our PPV for GMS by logging into the two practice GP systems, this would be impossible for GOS contactors with too many clinical systems used to enable us to gain access. In understanding this, we then looked at our Microsoft TEAMS functions and the ability to share screens and have control of the system. We are also exploring the remote checking of the Quality and Safety scheme for pharmacy by utilising the data that PCS holds.
3. The patient letter programme has now been running throughout Wales for a 12-month period. We are looking at making enhancements to these checks as discussed with our CounterFraud colleagues.
4. Not being able to physically check Clinical Waste has also been an issue. To address this problem, we have created a Self-Assessment form for GMS contractors to complete every 3 years to ensure that they are meeting their obligations in accordance with clinical waste legislation. This has been piloted by 6 GMS contractors and feedback has been collated.
5. We have looked at many ways to provide training and assistance remotely.

We have continued to provide one on one training when requested via TEAMS.

We have created a video recorded guide which is available to all GMS contractors to aid them and provide them with assistance.

We have a new 360-degree questionnaire which is emailed at the closure of every visit and we are collated all feedback and acting upon it.

We are rolling out roadshow training events via TEAMS in October/November based on individual HB trend data.

We have established a GMS All Wales working group which is run bimonthly and has representatives who attend from every HB across Wales.

We have re-established quarterly meetings with our National and local CounterFraud colleagues.

Quarterly individual HB meetings are now re-established to discuss any issues or concerns with any practices and where we can assist them.

RECOMMENDATION

1. It is proposed that the All-Wales training continues for GMS across all 4 sites in Wales and we align this process with GOS and GPS when we are able to begin remote access visits within these disciplines.
2. The pilot for GOS remote access via TEAMS was tested and proved successful, and we are hoping to roll out this remote access and PPV visits for GOS with support from Optometry Wales by October/November 2021.
   Utilising the data that we hold in PCS we can potentially carry out the Quality and Safety Scheme checks remotely for GPS. We need to have access to the data that we hold or ensure that this can be provided by the relevant departments in a suitable timeframe.
3. The GOS patient letter programme is continuing, and the response rate is slowly increasing. It has been suggested by Counter Fraud that we check the non-responders addresses to make sure they are accurate. This will be piloted on the April-June data where we have had over 40% response rate.
4. Annual PPV Hazardous Waste Audit checks will be carried out electronically within GMS where contractors will provide relevant photographic and written evidence. These forms would be required to be completed within a 3-month timescale and sent back into Action Point and would not be obtrusive or place additional requirements on local front line service provision especially in the difficult times ongoing. It is proposed that the self-assessment arrangements as outlined in this document are introduced from October/November 2021. Acceptance testing of this arrangement will be verified prior to this date to ensure that all potential issues are resolved.
5. Training and support will continue to be provided and enhanced and regular Quarterly Roadshow events will remain throughout the future months until all enhance services have been covered off.

ADDITIONAL

PPV department is currently defining requirements to utilise Robotic Process Automation for the creation of sample for GOS.

PPV will continue when needed and able to provide support with any other services with elements of PPV.

- Welsh Government and Patient Opening hours for GOS.
- The WECs creation of samples for PCAT and ABuHB.
- Welsh Government – Bonus Payment Verification to take place from Jan-March 2022

Powys Teaching Health Board

GMS PPV Progress Report: April 2021 to December 2021

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	4.77%
Wales claim error % Ave	
2019/20 recovery amount	£2,500.92

GMS Snapshot	Visit 1				Visit 2				Vi		
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size
Practice 1	Jan-19	Routine	7.41%	£437.97	Dec-20	REVISIT	56.41%	£13,338.04	May-21	Routine	167
Practice 2	Jan-19	Routine	1.82%	£149.82	Mar-20	REVISIT	15.04%	£4,356.40	Sep-21	Routine	217
Practice 3	Mar-17	REVISIT	5.97%	£244.16	Jul-18	Routine	1.52%	£202.48	Jul-21	Routine	295
Practice 4	Apr-18	Routine	2.31%	£287.08	Oct-19	REVISIT	4.71%	£376.97	Jun-21	Routine	233
	Visit 1				Visit 2				Vi		
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size
Practice 5	Oct-18	Routine	0.00%	£0.00	Nov-20	Routine	1.65%	£191.20	Oct-21	REVISIT	345

Visit 3		
Claim errors	Claim error %	Recovery
16	9.58%	£696.72
5	2.30%	£430.39
6	2.03%	£287.44
13	5.58%	£180.52

Visit 3		
Claim errors	Claim error %	Recovery
20	5.58%	£905.85

We have
Restarte d National
We are
We have
To use technolo gy to
New 360 degree
All PPV
To begin
Currently verifiying contracto
We have
For General Opthalmi c
PPV will

GMS	Health Board			All Wales		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	8	10	5	234	185	188
Amount of claims sampled	5,822	5,044	1,257	171,919	75,768	86,692
Claim errors identified	603	1279	60	21,550	8,490	9969
Average claim error rate	10.36%	25.36%	4.77%	12.53%	11.21%	11.50%
Recovery amount	£9,607.80	£17,842.67	£2,500.92	£466,107.55	£173,946.42	£234,148.67
	Health Board - ROUTINE			All Wales - ROUTINE		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	4	7	4	129	125	122
Amount of claims sampled	1,281	1,377	912	62,694	36,799	27,521
Claim errors identified	127	52	40	3,015	2,251	1597
Average claim error rate	9.91%	3.78%	4.39%	4.80%	6.12%	5.80%
Recovery amount	£3,282.24	£2,326.14	£1,595.07	£85,165.13	£65,956.43	£67,196.24
	Health Board - REVISIT			All Wales - REVISIT		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	4	3	1	105	60	65

Amount of claims sampled	4,541	3,667	345	109,225	38,969	59,171
Claim errors identified	476	1227	20	18,535	6,239	8372
Average claim error rate	10.48%	33.46%	5.80%	16.97%	16.01%	14.15%
Recovery amount	£6,325.56	£15,516.53	£905.85	£380,942.42	£107,989.99	£166,952.43

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
March 2022

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

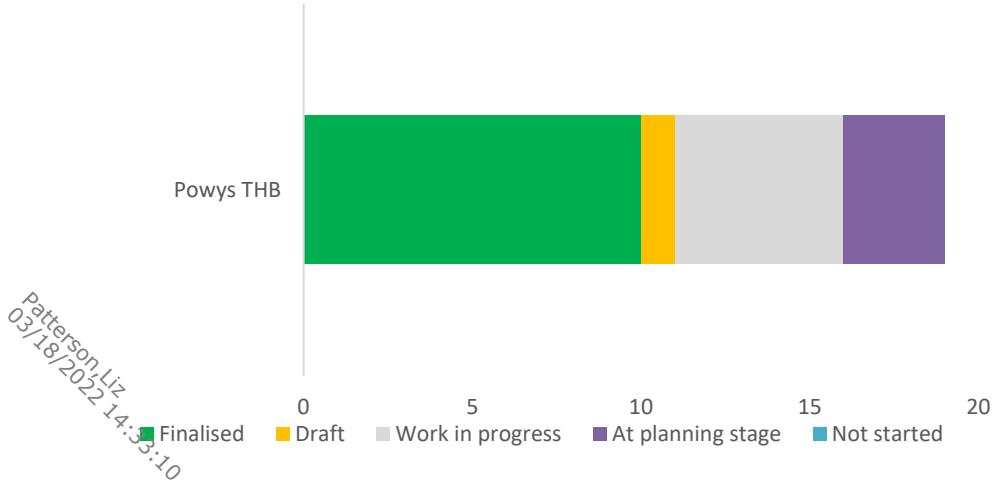
Since the January 22 meeting of the Committee, three reviews have been finalised. Details of these are included in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Waste Management	Reasonable	
Job Matching and Evaluation Process		
Mortality Reviews		

3. Delivery of the 2021/22 Internal Audit Plan

There are a total of 19 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 ten audits have been finalised so far this year with another one at the draft report stage.

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

At the meeting in February 22, the Committee formally agreed the deferral of four audits from the 2021/22 plan, these are recorded within the assignment status schedule under Appendix A. The reason for the deferrals was a result of delays in progressing delivery of the plan due to the pressures being faced by the Health Board and resourcing issues within the Internal Audit team.

The four audits have been considered for inclusion within the 2022/23 plan, as part of the process for developing the plan detailed within section 4 below.

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. Development of the 2022/23 Internal Audit Plan

Meetings were held with the Health Board's Executive Directors during January and February to identify and discuss potential areas for inclusion within the 2022/23 Internal Audit Plan.

An outline 'long list' plan was then developed and discussed with the Interim Board Secretary and Chief Executive prior to being submitted to the Executive Team and Independent Members for review and comment.

The draft 2022/23 plan was subsequently produced and is included separately on the Committee agenda for formal review and approval.

5. Engagement

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

Board / Sub Committees

- Board – 26 January
- Executive Committee – 09 March

Health Board Meetings

- Stuart Bourne, Director of Public Health – 03 February
- James Quance, Interim Board Secretary – 07 February / 04 March
- Carol Shilabeer, Chief Executive – 07 February
- Jamie Marchant, Director of Environment - 07 February
- Kate Wright, Medical Director – 02 March

6. Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Note the outcomes from the finalised 21/22 audits; and
- Note the progress with delivery of 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	08/11	09/11	21/12	04/01	Reasonable	January	Final
Covid Recovery and Rehabilitation Service	~~Q2~~ Q3	04/10	15/12	17/12	07/01	10/01	Substantial	January	Final
Dementia Service – Dementia Home Treatment Teams	Q2	23/08	29/11	09/12	11/01	11/01	Reasonable	January	Final
Waste Management	Q4	15/11	10/12	21/12& 20/01	27/01	27/01	Reasonable	March	Final
Job Matching & Evaluation Process	Q3	03/11	05/01	19/01	08/03	08/03	Reasonable	March	Final
Mortality Reviews	~~Q2~~ Q4	10/01	17/02	02/03	09/03	10/03	Reasonable	March	Final
Machynlleth (Bro Ddyfi Hospital)	Q2	27/09	22/11	23/11			Limited	April	Draft
Occupational Health	Q3							April	Work in Progress
Breath Well Programme	Q3							May	Planning
Financial Savings & Budgetary Control	Q4							April	Work in Progress

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
Concerns Tracking/Monitoring Assurance	Q4							April	Work in Progress
Network and Information Systems (NIS) Directive	Q4							April	Work in Progress
Risk Management & Assurance	Q4							May	Work in Progress
Site Management (Advisory)	Q4							June	Planning
Follow-up Action Tracker	Q4							April	Planning
Reviews Deferred / Removed from the plan									
Cancer Services	Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
Performance Management & Reporting	Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
North Powys Well-being Programme	~~Q3~~ Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							
Looked after children with mental ill health	~~Q3~~ Q4	*Deferred to the 22/23 plan. Agreed at the January 22 Audit Committee.*							

Key Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100% 11 out of 11	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		50% 5 out of 10	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		100% 10 out of 10	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.

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Waste Management
Final Internal Audit Report

January 2022

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:	SSU-PTHB-2122-02
Report status:	Final
Fieldwork commencement:	15 November 2021
Fieldwork completion:	10 December 2021
Draft report issued:	21 December 2021
Draft report meeting:	12 January 2022
Management response received:	27 January 2022
Final report issued:	27 January 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Jamie Marchant, Director of Environment
Distribution:	Andrew Cresswell, Assistant Director, Support Services Andrew Quarrell, Service Improvement Manager Wayne Tannahill, Assistant Director of Estates & Property Steven Bromley, Environment & Sustainability Manager James Quance, Interim 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.

Executive Summary

Purpose

The audit was undertaken to assess the THB's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Reasonable assurance has been issued in this area.

A number of areas of good practice have been evidenced during the audit which reflect the efforts of the Support Services team in the management of waste at the THB – particularly in respect of the operational practice at the sites visited.

The matters requiring management attention include:

- The need to review the content and formality of the Waste Process document, and the associated intranet content;
- The sufficiency of attendances at the Waste & Recycling Group;
- The preparation of a training needs assessment to encompass all staff, and development of improved means for wider training delivery;
- Completion of a formal procurement exercise for general waste and recycling arrangements; and
- Enhanced audit recommendation monitoring arrangements.

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	Policy & Procedures	Reasonable
2	Governance & Management	Reasonable
3	Contractual Arrangements	Reasonable
4	Operational Practice	Substantial
5	Monitoring & Reporting	Reasonable

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

Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Policy & Procedures	1	Design	Medium
2	Waste & Recycling Group attendance	2	Operation	Medium
3	Training	2	Operation	Medium
4	Contractual arrangements	3	Operation	Medium
5	Monitoring of Audit Recommendations	5	Operation	Medium

1. Introduction

1.1 Welsh Health Technical Memorandum (WHTM) 07-01: *'Safe Management of Healthcare Waste'* provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.

1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('Covid-19 waste management standard operating procedure').

1.4 The Welsh Government's waste reduction targets were set out in its 'Towards Zero Waste' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for all waste to be recycled by 2050.

1.5 This audit assessed Powys Teaching Health Board's (the THB) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.

1.6 The audit brief was agreed by the Director of Workforce & Organisational Development (the previous responsible officer). It is recognised that Executive responsibility for waste management changed, mid-audit, to the newly established role of Director of Environment.

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

- Safety of THB staff, patients, visitors and contractors.
- Environmental damage.
- Non-compliance with legislation, risking financial penalties or prosecution.
- Failure to achieve mandated waste reduction targets.
- Reputational damage associated with negative publicity.
- Failure to achieve value for money for the THB.

2. Detailed Audit Findings

Policy & Procedures: To ensure that an appropriate Waste Management Policy and supporting procedures were in place.

2.1 The THB's Waste Process document had been scheduled for review in April 2021, however this had been delayed due to prioritisation of the Covid response. The document was under review at the time of the audit.

2.2 WHTM 07-01 requires, as a minimum, that a healthcare waste policy is signed off at Board level to demonstrate high level commitment. This has been observed at other Health Boards across NHS Wales. However, the THB's document has been approved by the

Environment & Sustainability Group and therefore, is not considered a formal THB policy document (**MA1**).

2.3 The document was considered comprehensive, providing key elements of policy and procedure coverage; however, enhancements were required to ensure full compliance with the WHTM requirements and best practice. (**MA1**).

2.4 It was noted that the document currently under review had been removed from online publication, however an earlier version of the document (expired 2015) still remained online (**MA1**).

2.5 Recognising the above, **reasonable assurance** has been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored and escalated, and training appropriately delivered.

2.6 The Director of Workforce and Organisation Development was identified within the Waste Process document as holding responsibility for waste management within the THB. However, with effect from 1 December 2021, this had transferred to the new Director of Environment.

2.7 Operational management arrangements is via the Waste & Recycling Group, reporting to the Environment & Sustainability Group. It was evident (from a review of the 2021 minutes, and discussions with management), that the effectiveness of the Waste & Recycling Group could be improved by regular membership attendance in accordance with the approved terms of reference (**MA2**).

2.8 Board-level Committee responsibility for waste management was not explicitly defined within the Waste Process document (**MA1**), however reporting of any key issues arising was evidenced to the Performance & Resources Committee.

2.9 Budget and risk management arrangements were operating appropriately. Whilst noting the additional pressures on the management of clinical waste during the Covid pandemic, both budget and risks were managed within existing operational remits, and / or available additional Covid recovery monies.

2.10 Evidence was available that waste management training had been delivered through a variety of means, including:

- targeted advice in response to audit findings;
- circulation of clinical waste guidance; and
- on-the-job training for e.g. porters.

However, a formal training needs assessment had not been undertaken to determine the wider training needs and responsibilities across the THB. At the time of the audit fieldwork, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc. (**MA3**).

2.11 Noting the above, **reasonable assurance** has been determined in this area.

Contractual arrangements: Assurance that waste contracts have been appropriately procured, and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

2.12 The THB's contractual arrangements for clinical waste (at both permanent sites and mass vaccination centres) were centrally procured and managed by NWSSP Procurement Services. Contracts had recently been extended with the existing providers.

2.13 The confidential waste contract had recently been let by direct award via an approved framework, with consideration given to value for money when selecting the preferred contractor.

2.14 Contract awards complied with the THB's Standing Financial Instructions and relevant Procurement Regulations, including Covid-19 exemptions where necessary.

2.15 Clinical waste contract performance (including delivery against KPIs) is monitored at both the All-Wales Clinical Waste Consortium, with an increased focus on performance during the last 18 months, to manage the service through the Covid pandemic. Continuing issues (NHS Wales-wide) with capacity and performance, which fall outside the agreed performance targets, and the potential for financial penalties to be imposed under the contract, were being discussed between the key parties at the time of review.

2.16 The THB plans to join the forthcoming All-Wales contract for general waste and recycling arrangements, which is scheduled to be tendered by NWSSP Procurement Services in 2022. It was confirmed that Single Tender Actions (STAs) had been appropriately approved to support the continuation of existing arrangements for both 2020/21 and 2021/22. However, it was noted that these were the first formal approvals obtained, with arrangements having been in place with Powys County Council for many years and no formal tender process having been undertaken or formal contract arrangements in place.

2.17 Whilst recognising that recent STAs and future procurement arrangements should ensure these arrangements are fully compliant, the historic absence of formal procurement arrangements was a breach of Procurement Regulations (and the THB's Standing Financial Instructions). The cumulative value of the contract (circa £88k per annum in 2021/22 alone) exceeds the threshold for service contracts set by the European Public Contracts Directive (2013/24/EU) (**MA4**).

2.18 Whilst the absence of a formal contract for the general waste and recycling arrangements means formal performance measures have not been determined, management confirmed that no adverse performance issues have been experienced with the existing provider.

2.19 Robust controls were observed in the payment of invoices, to ensure payments were based on accurate charges and made in a timely manner.

2.20 Whilst noting the historic non-compliance with Procurement Regulations and Standing Financial Instructions in respect of the general waste and recycling arrangements, in the last two years management has worked with NWSSP Procurement Services to ensure appropriate governance arrangements via the THB's Single Tender Action Process, recognising the potential move to an All Wales contract in 2022. **Reasonable assurance** has therefore been determined.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the THB's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

2.21 Operational practice was reviewed through site visits at Bronllys (including the vaccination centre), Brecon and Llandrindod Wells Hospitals. The site visits incorporated a review of waste management arrangements in areas including main entrances, wards, office areas, canteens and the external waste compounds.

2.22 Good practice was observed in all areas reviewed, including the following:

- Provision of procedural guidance displayed at key locations, with clearly labelled and suitable bins to facilitate correct segregation of waste at source;
- Appropriate frequency of removal of waste from source to central holding areas, to prevent build-up of waste; and
- Appropriate labelling and packaging of waste in accordance with WHTM 07-01 requirements.

2.23 Whilst the waste compounds observed were tidy and well managed, it has been acknowledged by management that the waste compounds on most of the THB's hospital sites (including those visited) require improvements in accessibility and security. A capital bid has been approved by the Capital Control Group, with design development underway at the date of reporting.

2.24 For a sample reviewed, waste consignment notes had been completed correctly and retained for the required period.

2.25 Clinical waste volumes increased significantly across NHS Wales during the Covid pandemic (including at the THB), due to the inclusion of Personal Protective Equipment (PPE) etc. as infectious clinical waste. NWSSP: SES published updated guidance (*'Covid-19 waste management standard operating procedure,'* June 2021*)* stating that organisations should comply with the requirements of WHTM 07-01 i.e. disposal of non-infectious PPE in the domestic or offensive waste streams where appropriate. During the site visits, the THB was observed to be appropriately applying this guidance.

2.26 During 2019/20, funding was secured from the Charitable Funds Committee to enable the roll-out of a number of recycling stations across the THB (during the Autumn of 2020) to support the achievement of the national 'zero waste' targets; with further investment planned in the forthcoming year. WHTM 07-01 also places emphasis on the importance of waste minimisation at the outset, to avoid the unnecessary procurement of items which will subsequently need to be disposed of. Management confirmed that waste minimisation is currently being considered through the wider decarbonisation agenda at the THB's Decarbonisation Group.

2.27 Noting the above, **substantial assurance** has been determined in this area.

Monitoring & Reporting: That adequate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

2.28 Appropriate arrangements had been determined for the recording and investigation of waste-related incidents. Only one incident had been recorded in the last three years (in March 2021), which had been thoroughly investigated with mitigating controls implemented to prevent recurrence.

2.29 The THB participates in a number of waste-related audits each year, including

- ISO14001 Environmental System external audit;
- Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises); and
- Monthly internal site audits.

2.30 Non-conformance/recommendations arising from the above audit processes are reported to and discussed at the Waste & Recycling Group. However, recently reported pre-acceptance audit recommendations had not been logged on the Group's Action Plan to enable the monitoring of actions taken (**MA5**).

2.31 Robust reporting mechanisms were operating, including:

- Monthly RAG (red/amber/green) dashboards prepared for Gold Command;
- Exception reports have been taken to the Performance & Resources Committee when required; and
- Waste matters are discussed operationally at the Waste & Recycling Group, and reported to the Environment & Sustainability Group where relevant.

2.32 Noting the scope for improved monitoring of audit recommendations, **reasonable assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	**Impact**
Welsh Health Technical Memorandum (WHTM) 7.1: '*Safe Management of Healthcare Waste,*' sets out the importance of a healthcare waste policy: *"To effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for the waste and provides clearly written instructions on how it should be managed"* (6.2); and that the policy should include: *"a clear statement, outlining the aims and rationale of the policy, signed off at board level to demonstrate high-level commitment"* (6.4). The THB's current 'Waste Process' document was published in April 2018 and had been scheduled for review by April 2021. Recognising prioritisation of the Covid response, the document was still under review at the time of the audit. However, the document was not considered a formal THB policy, recognising its approval by the Environment & Sustainability Group, rather than at Board level as required by the WHTM. It was also noted that other NHS Wales Health Boards reviewed had formal waste management policies in place, approved at Board-level Committee. Whilst the document was found to be generally comprehensive and in accordance with the guidance provided by WHTM 07-01 (6.4), it was noted the following areas were not incorporated: • Confirmation of Board-level Committee responsibility for waste management; • Detail of contractual arrangements (including contingencies); • The process of identifying improvement programmes;	Potential risk of: • Absence of Board-level commitment does not provide the THB's approach with the support required; • Incomplete / out of date guidance available to staff, potentially not in accordance with current WHTM 07-01 requirements.

- Sources of further information and guidance;
- Detail regarding the waste hierarchy; and
- Detail regarding staff training arrangements.

Further, the document was not currently available on the intranet; having been removed when the review date passed. It was noted however, that an earlier version of the document (expired 2015) still remained online.

It is recognised, that procedural guidance was clearly displayed on site (as confirmed during the site visits to Bronllys, Brecon and Llandrindod Wells), providing relevant instruction to staff at the point of waste disposal.

Recommendations		Priority
1.1a	The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements.	**Medium**
1.1b	The THB should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements	
1.1c	The new document, once approved, should be published online	
1.1d	Superseded documents should be removed from the intranet.	

Agreed Management Action		Target Date	Responsible Officer
1.1a	Agreed. The core document is already in place and is currently out for consultation with Waste Group members.	May 2022	1.1a-c Service Improvement Manager,
1.1b	Agreed. The updated document will be signed off as a Policy at Executive Committee.	May 2022	

1.1c	Agreed.	May 2022	with support from relevant parties
1.1d	Agreed.	Actioned since fieldwork	

Matter Arising 2: Waste & Recycling Group (Operation)	**Impact**
The Waste & Recycling Group operates as a dedicated forum for waste management; bringing together key parties from Support Services (including site representation), Estates and Infection & Prevention Control. An appropriate terms of reference had been determined, with the Group meeting bi-monthly and reporting to the Environment & Sustainability Group as required. It was noted however, for the period reviewed (March – September 2021), that attendance was generally limited to the same core individuals attending each meeting, with the full range of members identified in the terms of reference not routinely attending. Membership attendance issues have been recorded within the Group minutes, with an acknowledgement that wider representation at the Group would improve effectiveness in discharging its role.	Potential risk of: • Insufficient oversight and scrutiny of key issues.

Recommendations		**Priority**
2.1	The Waste & Recycling Group should continue to seek improved attendances wherever possible. If non-attendances affect performance, this should be escalated as appropriate	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. We will review the current membership and attendances to ensure this supports the group's intended function.	March 2022	Service Improvement Manager

Matter Arising 3: Training (Operation)	**Impact**
WHTM 07.01 (6.33) highlights the importance of waste management training: *"A policy for the safe management of healthcare waste cannot be effective unless it is applied carefully, consistently and universally. This requires that all healthcare staff should be aware of the policy/procedures and that the policy is implemented by trained and competent people;"* and *"A training record will readily enable line managers to identify members of staff who are not receiving the appropriate level of training, and where such training should be focused."* As noted at **MA1**, the THB's Waste Process document does not currently detail training requirements. A formal training needs assessment, encompassing all relevant THB staff groups (e.g. support services, clinical and general staff), was not identified. Such an assessment would determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling). Management advised that training is currently delivered in a variety of ways, including: • Key support staff (e.g. porters) receive on-the-job training via workplace shadowing, to learn best practice in their area of responsibility; • Recognising ongoing restrictions in face-to-face training, clinical waste guidance has been circulated to departmental leads; • Ad-hoc training has been delivered when additional support is requested or issues are identified via audit processes; and • The distribution of posters for display across the sites, to ensure guidance is displayed at the point of disposal.	Potential risk of: • Staff do not receive sufficient training to safely handle waste. • Non-compliance with WHTM 07-01 requirements

However, limitations on training coverage were noted: the routine training of clinical staff was not within the scope of the team's current activities, and waste management was not encompassed in corporate induction or mandatory e-learning.

Management recognise the benefit of wider training provision within the THB, particularly noting the forthcoming updated Welsh Government business waste regulations anticipated in 2023 (which will require a greater degree of waste segregation and recycling), and have suggested there may be efficiencies to be gained by taking an all-Wales approach in conjunction with colleagues from other Health Boards. This could be pursued via the all-Wales Clinical Waste Consortium to agree a joint approach (or as a minimum, seek examples of good practice elsewhere).

Recommendations		Priority
3.1a	A training needs assessment should be prepared, identifying for each relevant staff group the level and frequency of training required and how this is to be delivered.	**Medium**
3.1b	Management should consider the option of developing an online training module, in conjunction with relevant parties.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Agreed. We will liaise with Workforce & Organisational Development to obtain advice on how best to take this forward, noting some training is also delivered by other departments and sits within their training records. A PTHB wide training needs analysis is a significant project which will take several months to complete.	June 2022	Service Improvement Manager
3.1b	Agreed. We will liaise with other NHS Wales parties, and Stericycle to discuss how best this can be taken forward.	June 2022	Service Improvement Manager, in consultation with the All-Wales Consortium.

Matter Arising 4: Contractual Arrangements (Operation)	**Impact**
The THB's general waste and recycling disposal services have been provided by Powys County Council since 2004, with no formal tender process having been undertaken or formal contractual arrangements established. The 2019/20 '*Financial Safeguarding: Support Services-Led Work'* audit report (issued May 2020) identified the need for formalised contract arrangements in a number of areas, and recommended that: "*The Support Services function should ensure that pre-planned maintenance areas* [noting pre-planned maintenance was the focus of the audit] *are covered by formalised contacts arrangements, and that there are formal interim measures in place until these contracts are finalised."* Acknowledging this need for formalised contracts, the general waste and recycling contract was due to be tendered (in conjunction with NWSSP Procurement Services) during 2020, but this was delayed due to prioritisation of the Covid response. The THB has subsequently been invited to join the forthcoming tender for an All-Wales contract (anticipated to commence in circa August 2022). This new contractual arrangement, led by NWSSP Procurement Services, aims to secure services in partnership with the other Trusts and Health Boards in Wales and create more service resilience, greater accountability and better value for money. It was confirmed that Single Tender Actions (STAs) had been appropriately approved to support the continuation of existing arrangements for both 2020/21 and 2021/22, recognising the importance of business continuity, and the continued good performance of the contractor. The contractual situation has also been reported to the Performance and Resources Committee in both June 2020 and June 2021. Whilst STAs have been approved for 2020/21 and 2021/22, the historic absence of formal procurement arrangements was a breach of Procurement Regulations, noting that the cumulative value of the contract (circa £88k per annum in 2021/22) would likely exceed the threshold for service contracts set by the European Public Contracts Directive (2013/24/EU) (currently £189,330).	Potential risk of: • Non-compliance with Procurement Regulations and Standing Financial Instructions.

In the unlikely event therefore that the planned All-Wales arrangement does not proceed, or the THB decides not to participate in the consortium arrangements (potentially considering performance and environmental impact), the THB must ensure it has appropriate tender and contract arrangements in place going forward.			
Recommendations			**Priority**
4.1	The THB should ensure compliance with SO/SFI and National Procurement Regulations at the award of all future waste management contracts i.e. participation in National Framework arrangements and / or, application of formal tender arrangements, completion of formal contract arrangements etc.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	NWSSP Procurement Services confirmed on 17/1/22 that Powys County Council is precluded from joining the ESPO framework process which is currently the chosen All Wales procurement route. As this decision excludes our long-term partner from the tendering process Support Services are preparing an options appraisal paper to enable the Executive Team to consider and decide on next steps prior to any procurement exercise	August 2022	Assistant Director, Support Services, in conjunction with NWSSP Procurement Services.

Matter Arising 5: Monitoring of Audit Recommendations (Operation)	**Impact**
The THB participates in a number of audits each year covering aspects of waste management, including: • Annual external audits as part of the ISO14001 Environmental Management System re-accreditation process; • Annual / five-yearly (depending on waste tonnage produced per site) clinical waste Pre-Acceptance audits as required by WHTM 07-01; and • Monthly internal site audits. Management advised that the implementation and monitoring of recommended improvements is managed via the Waste & Recycling Group, with an Action Plan maintained to track progress. Whilst a review of Group minutes confirmed that audit findings have been discussed, actions arising from the most recent Pre-Acceptance audit (Ystradgynlais, September 2021) had not been added to the Action Plan. Whilst recognising that the majority of issues raised via the Pre-Acceptance audits can be promptly addressed by the responsible departmental lead, to ensure awareness of issues and consistency of actions, these should be centrally logged within the Action Plan.	Potential risk of: • Insufficient progress in actioning recommendations arising from non-conformities identified.

Recommendations		**Priority**
5.1	Waste audit recommendations should be centrally logged and monitored	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed. We will liaise with the Environment & Sustainability Manager to incorporate pre-acceptance audit recommendations into the existing ISO14001 audit tracker, to provide a central log for ease of monitoring. This will help ensure that all points are addressed.	March 2022	Service Improvement Manager

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.

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Job Matching and Evaluation Process
Final Internal Audit Report

March 2022

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

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Auditors:	Murray Gard – Principal Auditor Jayne Gibbon – Audit Manager Ian Virgil – Head of Internal Audit
Executive sign-off:	Julie Rowles – Director Workforce and Organisational Development
Distribution:	Vicky Malcomson - Senior HR Business Partner Jayne Spence – HR Advisor and Job Evaluation Lead Mark McIntyre – Deputy Director of Workforce & OD
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.

Executive Summary

Purpose

The review focused on the Job Matching and Evaluation process; and seeks to provide the Health Board with assurance that systems and processes are managed appropriately.

Overview

We have issued a reasonable assurance rating for this audit reflecting existing practices in place and the requirement for enhancements in a number of key areas.

The identified matters requiring management attention include:

- Wider representation within the Health Board for completing job matching training
- Enhancing arrangements within the job evaluation process; including the membership of job matching panels.

Report Classification

Reasonable Assurance

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 Policies, Procedures and Guidance in place.	Substantial
2	Robust training arrangements are in place.	Reasonable
3	Effective arrangements are in place for the Job Matching and Evaluation process.	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
2	Availability of Trained Job Matchers	2	Operation	Medium
3	Job Evaluation Panel – Wider Health Board Representation	3	Operation	Medium

1. Introduction

1.1 The review of the Job Matching and Evaluation Process was completed in line with Powys Teaching Health Board's (the 'Health Board') 2021/22 Internal Audit Plan.

1.2 Job evaluation is a key part of the pay system that covers NHS staff on the 'NHS Terms and Conditions of Service Handbook' (Agenda for Change). One of the aims of Agenda for Change is to allow NHS bodies to operate more flexibly by redefining and developing roles in partnership with the aim of further modernising the service for the benefit of patients. The introduction of the NHS Job Evaluation Scheme enables all posts to be banded through the job matching and evaluation process to ensure fairness, consistency, and equality for all members of staff.

1.3 The Health Board is required to comply with the NHS Job Evaluation Handbook. The procedures are to be used to match and evaluate new posts and for those where there are significant changes that are likely to affect the previous matched or evaluated job result. The framework should also be used where managers need to develop existing posts, or enhance roles, for example, because of departmental restructuring.

1.4 The Lead Executive for this review was the Director of Workforce and Organisational Development.

1.5 The potential risks considered in this review are as follows:

- A lack of clarity regarding processes, resulting in poor coordination of service provision.
- Staff resources and skills are not sufficient to operate the process viably.
- Job matching and Evaluation processes are not robust which undermines the integrity of the function leading to disputes and challenges over outcomes.

2. Detailed Audit Findings

Objective 1: The Health Board has appropriate Job Matching and Evaluation policies, procedures, and other guidance documents in place.

2.1 The NHS Wales Job Evaluation Handbook is the comprehensive guide for all NHS organisations on job evaluation. It is in its seventh edition and was last updated in September 2018.

2.2 The Health Board has in place a *"Evaluating New Jobs & Re-evaluation of Changed Jobs"* Policy (Reference HR073) that was approved by the Management Executive Team in November 2020 and is available on the intranet. Enhancements are needed to the policy to ensure alignment with the NHS Wales Job Evaluation Handbook (*Matter Arising 1 – Low Priority*).

2.3 Alongside the above, the Health Board has a host of standard documents/guidance material that are useful for the Job Evaluation process. These are available to all staff via the intranet, and include:

- Writing Job Description Guidance.
- Job Evaluation – Managers Process.
- Authorisation Forms.

2.4 We also noted updates surrounding Job Evaluation being supplied to staff via the Health Board's Weekly announcements.

Conclusion:

2.5 It was evident that policies, procedures, and guidance documents were in place and being updated in a timely manner. Accordingly, we have provided substantial assurance against this objective.

Objective 2: The Health Board has sufficient resources in place for Job Matching, Evaluation, analysis, and appropriate training has been provided to all staff in the Job Matching and Evaluation process.

2.6 Management maintains a tracker off all staff that have been trained in Job Matching and Consistency checking; this document also details the last time the member of staff attended a panel session and whether they are a management or staff side representative.

2.7 From our analysis of the numbers, type (management or staff side) and directorate of staff that have undertaken the training; there is a large percentage of trained staff from Workforce and Organisational Development, compared to other directorates/departments within the Health Board. We also noted a high percentage of management representatives compared to staff side and instances where trained individuals had not participated for lengthy periods. (*Matter Arising 2 – Medium Priority*).

2.8 The Health Board has a total of four consistency checkers: two from management and two from staff side. Consistency checking consists of assuring that the scoring awarded to a post is appropriate and they challenge outcomes as appropriate.

2.9 Management also provide training on the job evaluation process for managers as part of the managers induction programme.

Conclusion

2.10 Whilst the Health Board currently has resources in place for the undertaking of Job Matching and Evaluation as well as providing training of staff, going forward a greater focus is required on the type of staff being trained to ensure a wider representation from all areas of the Health Board. Accordingly, we have provided Reasonable Assurance for this Objective.

Objective 3: Appropriate arrangements are in place to ensure that all new posts, re-evaluations and changed posts are subject to appropriate matching and evaluation in accordance with the Health Board's policy and the requirements of the NHS Job Evaluation Handbook.

2.11 Job evaluation activity is undertaken via the national Computer Aided Job Evaluation System (CAJE) which records the panel member names, notes of the panel members make, the scoring awarded. From our sample testing of the system, the above was operating well.

2.12 Alongside recording in the system, local electronic files hold information which ensures a robust trail is maintained; these include:

- Job Description with CAJE reference.
- Job Profile.
- Organisational Chart.
- Authorisation form.
- Communication with management.

From our sample testing of the process the above was well documented.

2.13 Our sample of both new posts and re-evaluated posts noted that all instances had been consistency checked by appropriately trained individuals.

2.14 From our evaluation of the job matching panel membership; we noted that there is an overreliance on Workforce and Organisational Development Staff attending these panels. We also noted instances where the outcomes of the panels had not been communicated to managers in a timely manner (*Matter Arising 3 – Medium Priority*).

Conclusion:

2.15 There is a structured process in place for Job Matching and Evaluating with an effective audit trail being maintained. However, the panel memberships are not representative of the Health Board; with a clear overreliance of Workforce and Organisational Staff attending the panels. Accordingly, we have provided Reasonable Assurance for this Objective.

Appendix A: Management Action Plan

<table>
<tr><th colspan="2">Matter Arising 1: Policy Details (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">
The NHS Wales job evaluation handbook (September 2018 Chapter 11 section 2.1 provides guidance around the make-up of job matching panels being a matter for local agreement.
"Matching should be carried out by a panel comprising both management and staff representative members. It should be representative of the organisation as a whole. Panel members must have been trained in the NHS JE Scheme, and this training must include an understanding of the avoidance of bias. These trained practitioners must also be committed to partnership working. The make-up of matching panels is a matter for local agreement but panels must operate in partnership. It is good practice for panels to have equal numbers of staff side and management practitioners with four panel members (two of each) being most effective."
We reviewed the health Boards policy to establish is there was further clarification around the make-up of job matching panels. The following was noted from page 14 of the policy:
"Job evaluation Panel will comprise of a cross section of the organisation, a combination of Management and Staff Side representatives who will have attended a Job Evaluation training course."
No reference was evident as to the numbers of members required for each job matching panel or the spilt between management and staff representatives.
</td><td>A lack of clarity regarding processes, resulting in poor coordination of service provision.</td></tr>
<tr><th colspan="2">Recommendations 1</th><th>Priority</th></tr>
<tr><td colspan="2">1.1 Consideration should be given by management to updating the policy to reference the recommended number of members for job evaluation panels and the make up of the panel members.</td><td>Low</td></tr>
<tr><th>Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
</table>

1.1 The job evaluation policy will be reviewed by the Workforce Policy Review group to consider this recommendation.	**January 2023**	**Senior Workforce Business Partner - Resourcing**

Matter Arising 2: Job Match Training - Resource (Operation)	**Impact**
We analysed the number and type of individuals that have undertaken formal job matching training within the Health Board and noted the following. The total number of job matching staff, who have undertaken formal training is 32 individuals as of November 2021. Of these, the number of Management representatives is 22 and Staff Side is 10. Of the 22 management representees, eight of these are classified as inactive; whereby an individual has not attended a panel for a significant length of time e.g. three of these individuals had not attended a panel for over three years. This brings the number of active management representatives to 14. Of these 14 individuals, 10 of them are from Workforce and Organisational Development (71%). Of the 10 staff side representatives; six are classified as inactive leaving only four regular staff side representatives. Audit notes that one of the management representatives can act in the capacity of a staff side representative. As such that would increase the total available staff side representatives to five individuals. We did not note any evaluation that would determine the numbers and type of staff (management and staff side) that would be necessary to deliver an effective job matching process. Management have been trying to raise the need for additional job matchers and have a list of an additional 10 individuals that are awaiting the formal training. However, audit notes that of these 10 individuals, only one is a staff side representative.	Staff resources and skills are not sufficient to operate the process viably.
Recommendations	**Priority**
2.1a Management should consider undertaking an evaluation that would determine the numbers and type of staff (management and staff side) required to deliver an effective job matching service.	**Medium**

2.1b Representatives for all directorates need to be trained in job matching; this would ensure fairness in release time and allow wider ranging views to be included within the job evaluation process	
2.2 Management need to highlight the matter of staff not being released to attend Job Evaluation Panels at the appropriate forum so appropriate action can be agreed to address the issue.	**Low**

Agreed Management Action	Target Date	Responsible Officer
2.1a A further evaluation of the number of required job matchers will be undertaken by the Job Evaluation team.	**June 2022**	**Senior Workforce Business Partner – Resourcing and JE Adviser**
2.1b A formal request to the Executive Team to release staff from each Directorate to participate in job matching training will be undertaken, to ensure that panels consist of a cross section of staff from across Directorates and where possible, differing staffing groups, recognising that this is likely to be more challenging in clinical staffing groups.	**August 2022**	**Executive Director Workforce and OD**
2.2 Where staff are trained and subsequently are not released to attend panels, this will be escalated to the Deputy Director of Workforce & OD.	**October 2022**	**Deputy Director of Workforce**

Matter Arising 3: Job Evaluation Process (Operation)	**Impact**
We reviewed the process for documenting Job Evaluation, including the Computer Aided Evaluation Systems and the Job Matching panels to ensure there was a robust audit trail. We selected a sample of 6 new posts and 4 re-evaluation of existing posts and traced this through the system; we highlighted the following: The Health Boards policy requires the outcome of the Job Evaluation process to be sent to the line managers within two working days. From our sample, two instances exceeded this timeframe. We have been informed this is due to annual leave commitments off staff. We also noted an over-reliance of workforce and organisational development staff for attending job matching panels e.g. We highlighted two panels where all the members were from WOD. On one on the Panels, the Job Description for review was "Workforce & OD Policy Performance Manager", however, two out of the three panel members were from WOD and the independence of the panel could be called into question.	Reputational implications associated with the failure to effectively manage the service.

Recommendations	**Priority**
3.1 Membership of the job matching panels should be representative of the Health Board and be as independent as possible.	**Medium**
3.2 Staff should be reminded of the importance in sending the outcomes from panels to management within an appropriate timeframe.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Wider participation will be sought for job matching panels from across the health board's Directorates. Wherever possible, panels will have	**November 2022**	**Senior Workforce Business Partner - Resourcing**

representatives from outside of the Directorate for the role being evaluated, other than on rare occasions where this is not possible and would cause an unreasonable delay to providing an outcome.		
3.2 Oversight and monitoring will be reviewed to ensure that are outcomes are provided within reasonable and agreed timeframes.	**June 2022**	**Senior Workforce Business Partner – Resourcing and JE Adviser**

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.

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Mortality Reviews
Final Internal Audit Report

March 2022

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
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Executive sign-off:	Kate Wright, Medical Director
Distribution:	Howard Cooper, Safety & Quality Improvement Manager
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.

Audit reports are prepared by the staff of the NHS Wales 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 overall objective of the review was to establish the arrangements and preparedness within the Health Board for the introduction of the Medical Examiners Service. The review also sought to evaluate the current systems and controls in place within the Health Board for the completion of mortality reviews.

Overview

Our overall assurance rating reflects the matters that require management attention, which include:

- Finalising Standing Operating Procedures detailing the processes to be undertaken for proving patient records to the Medical Examiners Service and also the process for receiving information back from them.
- Ensuring that any Stage 2 reviews that have been identified are recorded, monitored and feedback is provided to the relevant staff along with the bereaved family (where applicable).

Report Classification

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

Assurance summary

	Assurance objectives	Assurance
1	The Health Board has appropriate arrangements in place in readiness for the introduction of the Medical Examiners Service.	Reasonable
2	Current procedures ensure mortality reviews are completed on all deaths and outcomes are effectively reviewed, analysed and reported with actions taken to address issues identified.	Reasonable

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedure	1	Design	Medium
2	Cases referred back to the HB	1	Design	Medium
3	Lessons learned effectively	1	Operation	Medium
4	Current Process - Reporting	2	Design	Medium
5	Current Process – Feedback	2	Operation	Low
6	Current Process – Completion of Reviews	2	Operation	Medium

1. Introduction

1.1 The audit of Mortality Reviews was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Teaching Health Board ("The Health Board").

1.2 The relevant lead Executive Director for the review was the Medical Director.

1.3 In 2013 the Chief Medical Officer for NHS Wales recommended that all patients who die in a hospital in NHS Wales have a mortality review. The purpose of the reviews is to generate learning about the quality of care and treatment and to identify and act on any concerns in the post-Francis era of candour.

1.4 Case note mortality reviews are a 2-stage process – the first is a universal mortality review (Stage 1), which is an initial screening of all deaths. If any concerns are identified that individual's case is subject to a more in-depth Stage 2 review. This involves an in-depth case note review which can, where necessary coordinate with the Putting Things Right process.

1.5 The Medical Examiner Service for Wales provides independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to Her Majesty's Coroner.

1.6 The Medical Examiner Service has been created because it has been recognised that an independent scrutiny of a death, undertaken by a Medical Examiner, who is a qualified and trained doctor but who is independent of any care provided and the organisation who provided it, allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

1.7 The Medical Examiner Service for Wales has been operational and covering all areas of Wales since 1st January 2021, scrutinising deaths that have occurred both in hospital and in the community. However, the impact of COVID 19 has meant that the capacity required to scrutinise all deaths in Wales not referred directly to a Coroner has not yet been reached. The intention of UK Government is to legislate to make this a requirement from 1st April 2022, but the service in Wales continued to build up its capacity during 2021.

Audit Risks

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

- The Health Board is not prepared for the launch of the Medical Examiner Service.
- Non-compliance with Welsh Government requirements to complete and report mortality reviews; and
- Threats to patient safety / opportunities to improve mortality rates are not identified or addressed / implemented.

2. Detailed Audit Findings

Objective 1: The Health Board has appropriate arrangements in place in readiness for the introduction of the Medical Examiners Service, including the following areas:

Objective 1a: Appropriate and consistent scanned notes are available.

2.1 A Standard Operating Procedure (SOP) setting out the steps that will need to be completed by key staff within the health to comply with the Medical Examiner process has been drafted but has not yet been approved.

2.2 The draft SOP includes confirmation of the patient notes and records that are required to be scanned and submitted for disclosure to the Medical Examiners Service.

2.3 The draft SOP needs to be completed, formally approved and distributed to all relevant staff as soon as possible. Management will need to ensure that all the information within the final SOP is applicable to Powys Teaching Health Board and that staff who will be responsible for providing the documentation to the Medical Examiners Service are aware of the SOP and the information they need to send. **(Matter arising 1)**

Objective 1b: Notes are sent to the Medical Examiner within the required time following death.

2.4 The draft SOP for the Medical Examiners Service Process clearly states the timescales for provision of information, as stipulated by the Medical Examiners Service.

Objective 1c: Cases referred back to the Health Board by the Medical Examiner are subject to appropriate review.

2.5 Discussion is currently ongoing about the process that will need to be implemented for cases being referred back into the Health Board for further investigation. A brief outline of the process has been proposed.

2.6 Management will need to ensure that cases referred back are appropriately recorded, monitored and feedback is appropriately provided to the relevant staff.

2.7 Going forward the mortality reviews undertaken by the Medical Examiners Service will be fed back to both the Health Board and the bereaved family. This may have an impact on the Health Board as the bereaved family may be more informed than previously and may ask more questions regarding their relative's care.

2.8 The final SOP referenced in matter arising 1 will also need to detail the process for cases being referred back into the Health Board, so that all staff members who will be involved will be aware of the process along with establishing the reporting structure. **(Matter arising 2)**

Objective 1d: Lessons are effectively learned following the mortality review process.

2.9 Going forward all lessons learned from Stage 1 and 2 reviews will need to be actively monitored and recorded as at present this isn't consistently happening, so there is a lack of opportunity for identification of trends and patterns.

2.10 Management should consider putting in a new process for capturing and monitoring all feedback that will be provided by the Medical Examiners Service which relates to the Stage 1 reviews. This process could also record the feedback and outcomes from any stage 2 reviews that will be carried out by staff within the Health Board **(Matter arising 3)**

Conclusion 1: The Health Board has begun the process of preparing for the introduction of the Medical Examiners role. However, they will need to ensure that effective processes are implemented, and these are documented within an approved SOP, to ensure full compliance with all the requirements of the Medical Examiners process.

Objective 2: Current procedures ensure mortality reviews are appropriately completed for all deaths within the Health Board's hospitals and outcomes are effectively reviewed, analysed and reported with actions taken to address issues identified.

2.11 Mortality reviews are carried out on all deaths every six months by someone from the Senior Clinical Review team which is made up of the Medical Director / Assistant Medical Director / Senior Nurse & Senior Therapist.

2.12 If the person carrying out the mortality review isn't satisfied with the information or care within the patients notes at the initial stage 1 review, then this will lead to a stage 2 review being carried out.

2.13 Stage 2 reviews would then be brought back for discussion where the Senior Clinical Review Team would identify any lessons learned and would raise whether there was some aspect of positive or concerning practice that should be reviewed or feedback provided.

2.14 There is a Learning from Experience Group which meets on a quarterly basis where discussions are held on Mortality Reviews which were carried out by the Senior Clinical Review Team.

2.15 Mortality rates for all Powys residents are reported bi-annually to the Patient Experience, Quality and Safety Committee. The report breaks down the deaths into sub sections to provide the committee with more in depth details.

2.16 Although Mortality Reports are presented to the Patient Experience, Quality and Safety Committee and issues are raised within the reports, there is no consistent follow up or reporting of any outcomes. **(Matter arising 4**)

2.17 Mortality reviews are discussed at length during the Learning from Experience Group but there is a lack of evidence to show that feedback has been provided to the relevant staff, or that the issue is being recorded and monitored to ensure lessons have been learned. **(Matter Arising 5)**

2.18 Testing was carried out on nine completed mortality review forms. It was not clear I one case what the outcome from a further investigation had been as there was no follow up form. The testing also established that there were various issues noted with the medical records on the mortality review forms, but it is unclear whether any feedback was provided to the relevant staff. **(Matter arising 6)**

Conclusion 2: The current processes ensure that mortality reviews are being undertaken for all deaths and the outcomes are reported to the Patient Experience, Quality and Safety Committee. As the Medical Examiners Service will be taking over the Stage 1 reviews, it would be beneficial to the Health Board if they could ensure that any feedback which is provided to them is recorded and all staff are made aware in order to learn from any mistakes. The Health Board will be carrying out Stage 2 reviews, and with the Medical Examiners Service liaising more closely with the bereaved relatives, it is important to ensure that lessons learned can be evidenced and that there is an appropriate audit trail.

Appendix A: Management Action Plan

Matter Arising 1: Standard Operating Procedure (Design)	**Impact**
Standard Operating Procedures are in the process of being drafted to ensure all staff are aware of the new process for mortality reviews, which is being taken over by the Medical Examiners Service. Our discussions highlighted that: • Most patient records are filed within the same section of the medical records, but some can be entered into different sections which could make it more difficult for clerical staff who will be required to collate the information to be provided to the Medical Examiners Service and may struggle to find the necessary documentation; • Some of the elements of the new Medical Examiner role won't be applicable due to the nature of the set-up of Powys Teaching Health Board which is made up of numerous community hospitals • There is currently a large piece of work being carried out within the Health Board to standardise the paperwork and streamline any forms retained within the medical records, making them more user friendly and avoiding duplicating other documentation. This will hopefully help the staff who need to scan the medical records.	Potential risk of: The Health Board is not prepared for the launch of the Medical Examiner Service.
Recommendation 1	**Priority**
The Standard Operating Procedure should be finalised and formally distributed to all relevant staff as soon as possible. The issue of the new Standard Operating Procedure can be used to reiterate to the staff members / doctors who are completing the medical records information such as: • which sections the Patient information should be filed within; • that the cause of death must be clearly identified; and	**Medium**

• that the medical notes must be legible. It may be appropriate to highlight in the Standard Operating Procedure, guidance that is applicable only to Powys Teaching Health Board in order that all staff / community staff / GPs are aware of the requirements from the Medical Examiners Service. Standardised paperwork, along with streamlined forms should be agreed and distributed to all relevant staff to make them aware of what patient information is necessary.		
Agreed Management Action 1	**Target Date**	**Responsible Officer**
A SOP is being finalised. This has been shared with the Medical Examiner Service. A pilot will shortly commence on 2 hospital sites in collaboration with the Medical Examiner service so that any outstanding issues can be identified. This includes the referral form to the ME service which contains all of the information required. There have been ongoing updates to primary care but the finalised SOP will be formally discussed with Health Board and Primary Care clinical staff ahead of roll out.	April 22	Medical Director / Assistant Director Q&S / lead nurse Community

Matter Arising 2: Cases referred back for Stage 2 reviews (Design)	Impact
It was evident during our review that the process for cases that are referred back to the Health Board from the Medical Examiners Service for a stage 2 review is still being discussed. At present there is no Standard Operating Procedure in place for this process but a draft one is being discussed and is planned to be produced as soon as possible. It is anticipated that the information will come back from the Medical Examiners Service into the Putting It Right team, where the cases can be filtered into: • Nothing to investigate; and • Further investigation (Level 2 review) required. It is anticipated that any further investigation work will hopefully be carried out by a Health Board Multi-Disciplinary Panel (MDT) which will be held bi-monthly initially. This will then be reviewed to assess whether they are required to meet more or less frequently depending on how many cases are referred back by the Medical Examiners Service. The Panel will report into the Patient Experience, Quality and Safety Committee Powys Teaching Health Board should be mindful that the Medical Examiners Service will feed back to the organisation and also the Next of Kin. Further scrutiny into a patients' death will then be the Health Board's responsibility, along with liaising with the bereaved family. Patterson,Liz 03/18/2022 14:33:10	Potential risk of: The Health Board is not prepared for the launch of the Medical Examiner Service.

Recommendation 2		Priority
The Standard Operating Procedure referenced with Matter arising 1 should be produced which: • Identifies the pathway for all cases referred back from the Medical Examiner Service; • Clarifies the role of the Multi-Disciplinary Panel and who will sit on the Panel. • Confirms the reporting arrangements for the Multi-Disciplinary Panel and who they will be accountable to; and • Clarifies the outcomes and how they are to be communicated with the family.		**Medium**
Agreed Management Action 2	**Target Date**	**Responsible Officer**
The new Assistant Director for quality and safety has started in post since conclusion of the audit. The process for receiving and dealing with referrals back into the Health Board has therefore been agreed and incorporated into the SOP. The ME process will be reported via Patient Experience, Quality and Safety Committee.	April 2022	MDA

Matter Arising 3: Lessons are effectively learned (Operation)	**Impact**
In the current Health Board process for managing mortality reviews, feedback is generally provided to the relevant clinical staff at the time of the review. However, no records are currently kept of any issues raised so there is no way at present of identifying any trends or patterns across the Health Board Likewise there is no evidence to confirm that lessons are being learned.	Potential risk of: Threats to patient safety / opportunities to improve mortality rates are not identified or addressed / implemented.

Recommendation 3	**Priority**
Going forward the Medical Examiners Service will provide feedback to the next of kin along with the relevant care organisation for further action, so there will need to be a process in place within the Health Board to ensure that all issues are fed back to the relevant people. Where further investigation is required, there should be an adequate audit trail to show that these issues are being monitored and addressed to provide reassurance to the bereaved family along with the Medical Examiners Service and the Board.	**Medium**

Agreed Management Action 3	**Target Date**	**Responsible Officer**
All patients will be logged on the datix mortality module which will document all process, communication and actions. This will be therefore available to audit	April 2022	Medical Director / Assistant MD Q&S

Matter Arising 4: Current mortality process – reporting (Design)	Impact
A bi-annual Mortality Report is currently produced and presented at the Patient Experience, Quality and Safety Committee and this provides analysis on the deaths of the Powys residents. However, where issues have been raised within the report under "Conclusions of the Senior Review Team" or "Cases of Potential Clinical Concern" subsequent updates are not always provided detailing what actions have been taken, if feedback was provided, whether any outcomes were identified or how they were addressed.	Potential risk of: Non-compliance with Welsh Government requirements to complete and report mortality reviews

Recommendation 4	Priority
The Health Board should ensure that where issues have been raised and presented in the Mortality Report, further updates are consistently provided to the Patient Experience, Quality and Safety Committee in order to provide assurance that issues are being addressed and that there is an appropriate audit trail.	**Medium**

Agreed Management Action 4	Target Date	Responsible Officer
All significant issues are reported through PEQS and will continue to be reported once the ME process has been rolled out. Themes from less significant issues are discussed and fed back. The method for recording this will be reviewed.	April 2022	Medical Director

4

Matter Arising 5: Current mortality process – Feedback (Operation)	Impact
A summary of the mortality reviews which are undertaken by the Senior Clinical Team is currently presented at the Learning from Experience Group and it is evident that detailed discussions are held. However, it is unclear whether feedback has been provided to the relevant clinical staff, whether there were any outcomes from further reviews, and whether any stage 2 reviews are actively monitored and recorded.	Potential risk of: Non-compliance with Welsh Government requirements to complete and report mortality reviews

Recommendation 5	Priority
With the Medical Examiners Service shortly taking over the process of providing Stage 1 mortality reviews, the Health Board may want to use the Learning from Experience Group for discussing any feedback that is provided to identify whether there are any issues that could be quickly resolved i.e. missing documentation, illegible notes, missing patient / doctor information. Likewise, the Health Board may want to consider reporting Stage 2 reviews to the Learning from Experience Group in the same way.	**Low**

Agreed Management Action 5	Target Date	Responsible Officer
Learning will be fed back to individuals and teams where appropriate. Themes and significant issues will be discussed and shared more generally via the MDT review panel and learning group. Patterson,Liz 03/18/2022 14:33:10	Ongoing	MDT review panel / learning group

Matter Arising 6: Current mortality process – Completion of Reviews (Operation)	**Impact**
We carried out a review of a sample of nine completed Mortality Review Forms One of the nine was identified as needing further investigation. There was no follow up report to identify if and when the investigation had been carried out by the panel and what the outcome was. The investigation was required to establish: • if the information held in Datix was correct; and • whether there had been any issues on transfer of the patient. Further findings from the review of the forms are noted as follows: • In four cases the patients were admitted for palliative care but the last days of life care documentation was not completed for these patients; • One had incomplete admission documentation; • In three cases the notes did not include the cause of death • In two cases the medical notes were not located; • In two cases the forms were not electronically signed by the reviewer; and • In seven cases no concerns were raised by the reviewer despite raising issues on the mortality review form. There was no evidence of feedback being given.	Potential risk of: Non-compliance with Welsh Government requirements to complete and report mortality reviews.
Recommendation 6	**Priority**
Management should ensure that going forward, all relevant staff are made aware of any issues raised by either the Medical Examiners Service or the Multi-Disciplinary Team, with clear and concise feedback provided and reported. A record of all issues that are identified should be recorded so that patterns / trends can be recognised and addressed.	**Medium**

Agreed Management Action 6	Target Date	Responsible Officer
This will be recorded on datix mortality review and shared via the MDT review panel and learning group.	ongoing	MDT review Panel

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.

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Archwilio Cymru
Audit Wales

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

Date issued: March 2022

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.

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Contents

Audit, Risk & Assurance Committee Update

About this document

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

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Charitable Funds Account	Audit fieldwork has been completed. The audit team are working with officers to agree the final audit report which will be provided to the Charity and those charged with governance imminently.
Audit of the 2021-22 Accountability Report and Financial Statements	Audit planning and interim audit testing are underway.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment (Phase 2) – Corporate Governance and Financial Management Arrangements	January 2022
Review of Quality Governance Arrangements	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	Date of publication realigned with anticipated publication date of national planned care work May 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	looks to tackle the significant elective backlog challenges.	
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.	Fieldwork underway May 2022

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 Details of future events are available on the GPX website. Events include a second COVID-19 learning week being held during week commencing 21 March 2022.

NHS-related national studies and related products

6 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.

7 **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
Joint working between emergency services	January 2022

8 The Auditor General is also seeking views on the Auditor General's Forward Work Programme for 2022-23 and beyond

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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

2022 Audit Plan – **Powys Teaching Health Board**

Audit year: 2021-22

Date issued: March 2022

Document reference: 2871A2022

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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

Contents

2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on the Health Board's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit, Risk and Assurance Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 I also report on your charitable funds' account. I will issue a separate Audit Plan for these accounts later in the year, following confirmation of whether a full audit or independent examination is required.

9 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

10 The following table sets out the significant and other risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business;
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
During the audit of the 2020-21 Remuneration Report, we identified a significant number of errors within the senior officer remuneration disclosures. If the quality of the Report is not improved for the 2021-22 disclosures, there is a risk of material misstatement.	We will discuss with officers the proposed method for the preparation and quality assurance review of the Remuneration Report during our audit planning.

Financial audit risks	Proposed audit response
There is a risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 10 shows a year-to-date surplus of £149,000 and a forecast year-end break-even position. This, combined with the outturns for 2019-20 and 2020-21, predicts a three-year surplus of £198,000. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	We will focus our testing on areas of the financial statements which could contain reporting bias.
Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include fraud, error and regularity risks of additional spend, treatment and valuation of assets and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Financial audit risks	Proposed audit response
Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.

11 In addition to my responsibilities in respect of the audit of the body's statutory financial statements set out above, I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of Whole of Government Accounts.

Performance audit work

12 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

13 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

14 During 2020-21 I consulted public bodies and other stakeholders on how I will approach my duties in respect of the Well-being of Future Generations (Wales) Act 2015 for the period 2020-2025. In March 2021, I wrote to the 44 public bodies designated under the Act setting out my intentions, which include:

- carrying our specific examinations of how public bodies have set their well-being objectives, and
- integrating my sustainable development principle examinations within my local audit programme.

15 My auditors are liaising with the Health Board to agree the most appropriate time to examine the setting of well-being objectives.

16 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning. I also plan to use an element of the 2022 audit fee to respond to aspects of service delivery where my insight and knowledge across Wales will provide value to NHS bodies. The exact focus of this work will be confirmed following a broader consultation on my overall programme of audit work for Audit Wales for 2022-23 and beyond (see paragraphs 17 and 18).
Locally focused work	Where appropriate, I will also undertake performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit Risk and Assurance Committee.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

17 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

18 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

19 We will provide updates on the performance audit programme though our regular updates to the Audit Risk and Assurance Committee.

Fee, audit team and timetable

20 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

21 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures.

22 The estimated fee for 2022 is set out in **Exhibit 3**. This represents a 3.7% increase compared to your actual 2021 fee, due to the increase in our fee rates.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	£162,386	**£156,577**
Performance audit work:		
• Structured Assessment	£40,099	£45,901
• All-Wales thematic work[3]	£53,172	£48,040
• Local projects	£16,734	£12,138
Performance work total	**£110,005**	**£106,078**
Total fee	**£272,391**	**£262,655**

23 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

24 The estimated audit fee does not include the audit of the Charitable Funds financial statements. We shall discuss this with the Director of Finance later in the year, following confirmation of whether a full or independent examination is required.

25 Further information on my fee scales and fee setting can be found on our website.

[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

[3] As detailed in the respective audit plans.

Audit team

26 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director (Performance Audit)	02920 320500	dave.thomas@audit.wales
Derwyn Owen	Audit Director (Financial Audit)	02920 320500	derwyn.owen@audit.wales
Alison Butler	Audit Manager (Financial Audit)	07807 839460	alison.butler@audit.wales
Anne Beegan	Audit Manager (Performance Audit)	02920 829341	anne.beegan@audit.wales
Alice Rushby	Audit Lead (Financial Audit)	02920 320500	alice.rushby@audit.wales
Bethan Hopkins	Audit Lead (Performance Audit)	02920 829363	bethan.hopkins@audit.wales

27 We can confirm that team members are all independent of you and your officers. There is one potential conflict of interest that I need to bring to your attention. Alison Butler's husband is the Director of Finance and Corporate Services for the NHS Wales Shared Services Partnership, which forms part of Velindre NHS Trust. We have put arrangements in place to ensure any actual or perceived conflicts of interest are addressed. The Engagement Director will provide further updates if any specific issues arise.

Timetable

28 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	January – March 2022	March 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements	February - June 2022	June 2022
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

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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: 3.8

Audit Risk and Assurance Committee	**Date of Meeting: 22 March 2022**
Subject:	**Audit Wales WHSSC Committee Governance Arrangements – Update**
Approved and Presented by:	Interim Board Secretary
Prepared by:	**Committee Secretary & Head of Corporate Services, WHSSC**
Other Committees and meetings considered at:	Executive Committee 9 March 2022

PURPOSE:

The purpose of this report is to provide the Health Board's Audit Committee with an update on progress against the recommendations outlined in the Audit Wales "WHSSC Committee Governance Arrangements" report.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- NOTE the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, and

- NOTE the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.

Ratification	Discussion	Information
	✓	✓

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

The purpose of this report is to provide the Health Board's Audit Committee with an update on progress against the recommendations outlined in the Audit Wales "WHSSC Committee Governance Arrangements" report.

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

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

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

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

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

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

HB Audit Committees received an update on progress against the recommendations in August/September 2021, and this report provides a further update on progress, and outlines feedback received from Audit Wales at the Joint Committee held on the 18 January 2022.

WHSSC Management Response

The report outlined 4 recommendations for WHSSC and progress against the actions outlined within the management response have been monitored through the WHSSC Integrated Governance Committee (IGC).

The IGC received updates on progress on the 12 October and 13 December 2021 noted the positive progress made and endorsed the tracker for submission to the Joint Committee.

The Joint Committee received the updated tracker report and an update from Audit Wales on the progress made against the recommendations on the 18 January 2022 and noted:

- that Audit Wales thought the WHSSC response to the recommendations was comprehensive and well thought out and that they were particularly pleased to note there had been ongoing oversight and scrutiny of progress by the Integrated Governance Committee (IGC), and

- that the only area for concern was around pan Wales recovery planning due to the ongoing volatile environment as a result of the pandemic.

The Joint Committee noted that majority of actions had been completed and there were only three areas of partial compliance in relation to:

- R3b page 12 – relating the appointment of an AMD for Public health – despite proactive efforts to recruit, we have been unable to fill the position,
- R4a page 14 and R4b page 18 – stakeholder engagement exercise to develop a new specialised services strategy – The timetable for this is being revised in response to the system pressures related to the current wave of the pandemic and the letter from the CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.

Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and progress against the WG management responses is monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief Executive.

An update was received from Welsh Government on the 15 December 2021 advising that the advice on the NHS Executive was still being considered by the Minister for Health & Social Services.

During the meeting on the 18 January 2022 Audit Wales advised that they had written to the Chief Executive NHS Wales, and an initial response letter had been received setting out a high-level overview of actions to be taken in response to the recommendations. The report had been considered by Senedd Cymru's Public Accounts and Public Administration Committee (PAPAC) following which the Chair of that Committee has written to the Director General/Chief Executive NHS Wales requesting an update on progress which is awaited.

Governance & Risk

Following the Joint Committee's approval of the tracker report on the 18 January 2022 the document has been shared with the NHS Wales Board Secretaries in HBs for inclusion on HB Audit Committee agendas in February/March 2022 to ensure that all NHS bodies are able to maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee of each HB in Wales.

A further update on progress will be given to the Joint Committee and HB Audit Committees in summer 2022.

Risk management is a key element of developing WHSSC's services and risk assessments are undertaken as required.

Governance and Assurance	
Link to Strategic Objectives	
Link to Integrated Commissioning Plan	**-**
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care
Principles of Prudent Healthcare	Only do what is needed Reduce Inappropriate Variation
Institute for HealthCare Improvement Quadruple Aim	**Improving Patient Experience (including quality and Satisfaction)**
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety, and patient experience.
Finance/Resource Implications	Some improvement actions may require the application of additional resources.
Population Health	There are no specific population health implications related to the activity outlined in this report.
Legal Implications (including equality & diversity, socio economic duty etc)	There are no specific legal implications related to the activity outlined in this report. There are no adverse impacts concerning equality and diversity or the socio economic duty.
Long Term Implications (incl WBFG Act 2015)	The WHSSC management responses take into consideration the long-term impact of decisions, to support better working with people, communities, and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	Integrated Governance Committee 13 December 2021 – Supported Joint Committee – 18 January 2022 - **Approved**
Appendices	Appendix 1 - WHSSC Audit Wales Governance Report Tracker – Jan 2022
NEXT STEPS:	

The Committee is asked to:

- NOTE the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, and

- NOTE the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.

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

Audit Tracker– Update January 2022

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

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response was presented to the Joint Committee on the 13 July 2021. Progress against actions to address the recommendations will be monitored through the Integrated Governance Committee (IGC).

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Quality governance and management				
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.				
a) We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each Joint Committee (JC) meeting have evolved to include additional detailed analysis of the position and any key points to promote effective focus and discussion. For 2021 the position is very stable with an improving underspend position.	Completed

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

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			In addition, to ensure effective governance we have reviewed the structure of the committee report template for routine reports (including for quality, performance and finance) and have updated it to include a section on governance, quality and risk which specifically captures key areas of concern to promote effective focus and discussion. This ensures effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients. This will be used from January 2022 onwards. The new template was considered by the Corporate Directors Group Board (CDGB) in September and in November 2021, and was considered by the Integrated Governance Committee (IGC) on the 12 October and will approved by them on the 13 December 2021. The JC received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			concern. The presentation was also given to the Management Group (MG) sub committee on the 23 September 2021 for assurance.	
b) We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Mar 2022	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each JC were reset to include more explicit, measurable intentions to measure achievement against. This includes detailed analysis of the position and any key points to promote effective focus and discussion. Detailed activity performance reports are prepared on a monthly basis and provide qualitative information and quantitive data to the JC and MG. The reports detail delivery by provider and specialty against historic performance and waiting times. Prospectively activity reports will also include performance compared to provider agreed recovery plans and waiting list profiles. A presentation dashboard format of the waiting times position has been agreed and details variation from agreed activity delivery, referral rates and overall waiting lists whenever possible.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			The activity dashboard will evolve and align to the quality and outcome reporting that is currently being developed by Welsh Government (WG). The WHSSC Commissioning Assurance Framework (CAF) was considered by the JC in May 2021 and approved in September 2021. Assurance against the CAF is achieved through service specifications, Service Level Agreement (SLA) and performance monitoring through the Quality and Patient Safety Committee (QPS) and the Integrated Governance Committee (IGC).	
c) We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted.	Sept 2021	Chair of WHSSC	The Joint Committee received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and concern. The Recovery presentation encouraged wide-ranging discussion and it was agreed that structured highlight reports will be presented to the JC from November 2021 onwards. Following on from the recovery discussion WHSSC have requested further detailed plans from providers as	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			additional detail was required from HBs in some areas. As part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked on a development programme, which included the JC participating in an equity workshop in May 2021, and there are plans for further development sessions to review the Integrated Commissioning Plan (ICP) and to revisit equity going forward.	
d) We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sep 2021	Chair of WHSSC/ Committee Secretary	Each JC meeting receives a Chairs assurance report from each of the sub-committees which provides an update on the business discussions of each sub-committee meeting. Each relevant chair is asked to present the Chairs report and to outline any salient points during the JC meeting. The Chair of WHSSC invites the Chair of the Quality & Patient Safety Committee (QPSC)/and or the Director of Nursing and Quality as Executive lead to provide a verbal update based on the written report at each JC meeting.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Programme Management				
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.				
a) Building Programme Management competency/capacity A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • undertaking a recruitment exercise to appoint 3 dedicated Project Manager roles (2 generic PM roles and one to specifically support Traumatic Stress Wales (TSW)), The posts work as part of the PMO hosted within the planning directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introduce new specific templates for project initiation, project highlight reports, risk assessments and project closure reports,	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			• develop a project management training package, • provide project highlight updates to JC. Programme Management arrangements are now in place for all new programmes of strategic work (e.g. Paediatrics and Mental Health).	
b) Programme management on WHSSC commissioned services. Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to Joint Committee.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • the programme management arrangements for the All Wales Positron Emission Tomography (PET) Programme demonstrate how WHSSC has developed and strengthened its approach to programme management and the Programme Business Case (PBC) for the project was approved by HBs and endorsed by Welsh Government (WG) Ministers on the 25 August 2021. The All Wales PET Programme Board will utilise its governance structure and reporting arrangements to provide ongoing assurance on	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			progress and it is proposed that it reports into the JC going forward, • we have appointed 3 dedicated Project Manager roles. The posts work as part of the PMO hosted within the planning Directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introducing specific templates for project initiation, project highlight reports, risk assessments and project closure reports, • developing a project management training package, • providing project highlight updates to JC. With increased project and programme management capacity and competency, this structured approach will be adopted consistently for all future major projects.	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
c) HB Commissioned Services – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.	Oct 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of projects for new commissioned services. Each project has its own specific terms of reference outlining the purpose and scope of the project, and including the membership and roles and responsibilities. Where services are not the sole responsibility of WHSSC we ensure that the membership includes representatives from Health Boards (HBs), professional groups etc and that the project plan includes measurable milestones with regular reports on progress being presented to the reporting sponsor, for example the JC.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Recovery Planning				
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.				
a) Managing backlog of waits whilst reducing harm i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	Sep 2021 Jul 2021 From Apr 2021 In Place	Director of Finance Director of Nursing & Quality Director of Planning	i. Real time monthly monitoring and reporting of waiting times are presented to the MG on a monthly basis and to each JC meeting through regular performance reports, which include trend analysis and information on comparisons to support effective performance management, ii. WHSSC have discussed recovery plans with Welsh providers through Service Level Agreement (SLA) meetings and received recovery positions from each of the welsh providers of tertiary services. There was an initial delay in receiving the recovery plans, and some detail is still awaited, iii. WHSSC hold regular Reset and Recovery meetings with services	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			to monitor performance against plans. A joint Executive to Executive meeting has been agreed between WHSSC, CVUHB, SBUHB and BCUHB, in order to discuss the welsh position across the plans and where necessary identify alternate pathways or welsh patients. Any Significant variance from plans will be managed through the WHSSC escalation process, discussed with the relevant provider and reported to the QPS Committee and the JC, iv. The final Commissioning Assurance Framework (CAF) was formally approved by the JC on the 7 September 2021 and is supported by a Performance Assurance Framework, Risk Management Strategy, Escalation Process and a Patient Engagement & Experience Framework, v. Following on from a discussion at JC in February 2021, as part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			on a development programme, which included the JC participating in an equity workshop in May 2021. The findings of the workshop were shared with HBs and Welsh Government.	
b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact.	In place Q3/Q4 2021-22	Director of Finance Director of Nursing & Quality Director of Planning Medical Director	i. The introduction of demand monitoring comparing historical levels for high volume specialities is routinely undertaken and the findings are reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway Development. Demand monitoring continuously features as part of the ICP process, board presentations to HBs and through strategic reviews highlighting variations in access using data systems, ii. Despite proactive efforts WHSSC have not been able to appoint an Associate Medical Director for Public Health and alternative models are being explored.	Partially Completed
c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19	In Place	Director of Finance	Information pertaining to the financial consequences of services that were commissioned and under delivered as a consequence of COVID-19 are	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels.			monitored through block contracts which remain in place during 2021-22 with the position reviewed for 2022-23. The planned position for 2022-23 will be return to cost and volume contracting to ensure full incentives to deliver commissioned volumes. WHSSC are fully participating in the English recovery incentive process with additional funding secured from Welsh Government.	
d) Reporting Analysis We will review and analyse the business intelligence gathered from the actions outlined in points a, b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	We have reviewed and analysed the business intelligence gathered from real-time monitoring and reporting of waiting times, demand monitoring compared to historical levels for high volume specialties and contract monitoring and developed a full information reporting system which provides monthly updates on delivery against historic activity levels, delivery against recovery plans, referral levels against plan and waiting list positions.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			We report our analysis and outcomes to the JC, Welsh Government and the MG as appropriate.	(green)
Specialised Services Strategy				
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient • outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); currently commissioned, which should continue.				
a. Embrace New Innovations i. We will continue to utilise our well-established horizon scanning process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery, ii. We will continue to develop our relationship with NICE, AWMSG and	Jul 2021 Q3	Managing Director Director of Finance Director of Nursing & Quality	i. The dual processes of horizon scanning and prioritisation is firmly embedded in WHSSC's commissioning practice and has been applied successfully since 2016. The process helps ensure the NHS in Wales effectively commissions' new and innovative treatments that are both clinically and cost effective, and are made available in a timely manner.	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long-term ambitions and to inform how we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan.	2021-22 In Place Dec 2021 Dec 2021	Director of Planning	Horizon scanning identifies new interventions which may be suitable for funding, and prioritisation allows them to be ranked according to a set of pre-determined criteria, including clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP). A horizon scanning exercise was undertaken by the Medical Directorate between January and May 2021, which informed the new Interventions Prioritisation Panel on the 20 July 2021, and the Clinical Impact Advisory Group (CIAG) prioritisation day on the 3 August 2021, ii. WHSSC continues to develop its relationships including: a. Three members of the WHSS team are current members of NICE appraisal committees (AC – TA committee A; ID – TA committee D; SD – HST committee). AC is also Chair of the NICE Welsh Health Network,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			b. WHSSC has a built a strong working relationship with HTW. A MoU was signed in 2018 (currently being updated) and WHSSC is represented on their Assessment Group, Appraisal Group and Stakeholder Forum. A joint proposal to support all Wales policy development of HTW guidance was supported by MG in June and the HTW Executive Board in July 2021. Funding for two posts (Project Manager and Admin) to support this work is now being sought from WG c. WHSSC also has a close working relationship with AWMSG, focused mainly on medicines management and horizon scanning. A MoU is now being developed between WHSSC and AWMSG to formalise these links and to share knowledge and expertise. The appointment of a WHSSC Medicines Management Pharmacist (due to start January 2022) will	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			further strengthen this partnership. iii. We continue to engage with developments for digital and Artificial intelligence (AI) iv. We continue to attend the four nations' specialised services commissioners meetings, v. We continue to build upon our existing relationships with the Royal Colleges, vi. We continue to develop our work on value-based commissioning, vii. We have developed a communication and engagement plan to support and inform the strategy which will be presented to the CDGB in January 2022, viii. It was previously agreed with Joint Committee that a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			system pressures related to the current wave of the pandemic and the letter from Judith Paget CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.	
b. Approach to Review of Services will be considered in strategy engagement **i.** The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the	Sept 2021 March 2022	Director of Finance Director of Nursing & Quality Director of Planning	i. The draft new specialised services strategy: a. It was previously agreed with Joint Committee a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the system pressures related to the	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
development of an outcome manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.			current wave of the pandemic and the letter from Judith Paget, CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities. b. On the 28 September 2021 the WHSSC executive team met with Improvement Cymru (IC) to discuss and explore potential options for them to support WHSSC in developing its new specialist services strategy and WHSSC agreed to hold a Quality Improvement workshop facilitated by IC in January 2022 and to develop improvement and audit days with nursing teams with a view to undertaking our own internal competency assessment to drive improvement, and considered predictive modelling for interventions, and international collaborative networks,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			c. WHSSC are required to agree annually those services that should be planned on a national basis and those that should be planned locally (section 1.1.4 WHSSC SO's), to support this, following a discussion at the JC 7 September 2021 a workshop was held with the MG on the 25 November 2021 to evaluate the commissioning of services. MG members were requested to submit expressions of interest to evaluate specific commissioned services in order to evaluate the merits of the service being commissioned locally at HB level or through WHSSC. d. A recovery workshop was held with the MG on the 16 December 2021 to discuss recovery Planning and Quality and Outcome Improvement for Patients. ii. The annual prioritisation panel with HB's to assess new specialised services that could be commissioned was held on the 20 July 2021,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			iii. The process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services was undertaken between January and May 2021 and informed the prioritisation panel on the 20 July 2021, iv. We have investigated opportunities for strengthening our information function through internal re-organisation and investment and have strengthened the staffing model of the information function to enable more timely information. The WHSSC staffing structure has been reviewed to include a senior outcomes commissioner to design outcome systems and monitor and report outcomes.	
Welsh Government Recommendation - Independent member recruitment				
R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: I am aware there have been challenges in securing nominations from health boards			WG update received 15/12/21 WHSSC are in discussions with WG on the IM remuneration and time commitment issues and a report was	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.			presented to the Chairs group in October 2021 requesting their views. The Chair of WHSSC and the Committee Secretary meet with WG officials on a monthly basis to progress the IM remuneration discussions. A progress report will be presented to the Joint Committee on the 18 January 2021.	
Welsh Government Recommendation - Sub-regional and regional programme management				
R6 This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened.			WG update received 15/12/21 This is linked to R2 and an update will be received in due course.	

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The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.				
Welsh Government Recommendation - Future governance and accountability arrangements for specialised services				
R7 A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner			WG update received 15/12/21 Welsh Government have advised that the advice on the NHS Executive is still being considered by the Minister. The Public Accounts and Public Administration Committee has written to the Director General/Chief Executive NHS Wales following her recent appearance before them to ask for an update on the WHSSC Audit Wales Reports recommendations 5, 6 and 7 and a	

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and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate. In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.			response will be issued in due course.	