Audit, Risk & Assurance Committee

Thu 29 April 2021, 14:00 - 17:00

Teams

Agenda

14:00 - 14:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_29Apr21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes From the Previous Meeting held on 09 March 2021 for Approval

ARA_Item_1.3_Minutes_9 March 2021.pdf (8 pages)

1.4. Matters Arising from Previous Meeting held 09 March 2021

1.5. Committee Action Log

ARA_Item_1.5_Action Log_29 April 2021.pdf (3 pages)

14:00 - 14:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Annual Report 2020-21 (Draft):

2.1.1. Section 2: Annual Accountability Report

To Follow

2.1.2. Section 3: Financial Statements

To Follow

2.2. COVID-19 Financial Control Procedure - Updated

ARA_Item_2.2_C-19 FCP_April 21.pdf (2 pages)
ARA_Item_2.2a_FCP - COVID-19 Update #6 Q1 Update 202122.pdf (20 pages)

14:00 - 14:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Audit Recommendation Tracking

ARA_Item_3.1_Implementation_of_Audit Recommendations.pdf (10 pages)
ARA_Item_3.1a_Audit Recs Appendix C.pdf (1 pages)
ARA_Item_3.1b_Audit Recs Appendix D.pdf (1 pages)
ARA_Item_3.1c_Audit Recs Appendix E.pdf (3 pages)
ARA_Item_3.1d_Audit Recs Appendix F.pdf (2 pages)

ARA_Item_3.1e_Audit Recs Appendix G.pdf (2 pages)
ARA_Item_3.1f_Audit Recs Appendix H.pdf (1 pages)
ARA_Item_3.1g_Audit Recs Appendix I.pdf (1 pages)
ARA_Item_3.1h_Audit Recs Appendix J.pdf (1 pages)
ARA_Item_3.1i_Audit Recs Appendix K.pdf (1 pages)

3.2. Head of Internal Audit Opinion 2020-21

To Follow

3.3. Internal Audit Reports 2020-21

3.3.1. Substantial Assurance

ARA_Item_3.3a_Freedom of Information Follow Up_Final Internal Audit Report_.pdf (12 pages)

3.3.2. Reasonable Assurance

ARA_Item_3.3b_PTHB 2020_21 Progress Against Regional Plans Final Internal Audit Report for client issue.pdf (19 pages)
ARA_Item_3.3c_Grievance Process_Final Internal Audit Report.pdf (18 pages)
ARA_Item_3.3d_PTHB_2021_Follow Up Review_Final Internal Audit Report_for health board issue.pdf (15 pages)

3.4. Draft Annual Governance Programme 2021/22

ARA_Item_3.4_Annual Governance Programme_2021-22_CoverPaper.pdf (2 pages)
ARA_Item_3.4a_Annual Governance Programme_April21_V1.pdf (11 pages)

3.5. Draft Committee Work Programme 2021/22

ARA_Item_3.5_Committee Work Programme 2021-22.pdf (2 pages)
ARA_Item_3.5a_Committee Work Programme 2021-22.pdf (4 pages)

14:00 - 14:00
0 min

4. ITEMS FOR INFORMATION

4.1. IM&T Control and Risk Assessment Audit Report

ARA_Item_4.1_IMT Control and Risk Assessment.pdf (36 pages)

4.2. Procuring Well-Being in Wales Review

ARA_Item_4.2_ENG-Section-20-Procurement-Review.pdf (49 pages)

14:00 - 14:00
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:

08 June 2021 at 10:00AM, Microsoft Teams

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
THURSDAY 29th APRIL 2021
14.00 – 16.00
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 09 March 2021	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 09 March 2021	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Annual Report 2020-21 (DRAFT): a) Section 2: Annual Accountability Report b) Section 3: Financial Statements	Attached	Board Secretary Director of Finance & IT
2.2	COVID-19 Financial Control Procedure – Updated	Attached	Director of Finance & IT
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Recommendation Tracking	Attached	Board Secretary
3.2	Head of Internal Audit Opinion 2020-21	Attached	Head of Internal Audit
3.3	Internal Audit Reports, 2020-21: <u>Substantial Assurance</u> a) Freedom of Information Follow-up <u>Reasonable Assurance</u> b) Progress against Regional Plans c) Grievance Process d) Follow Up Review of 2019/20 'No' and 'Limited' Assurance Reports	Attached	Head of Internal Audit
3.4	Draft Annual Governance Programme 2021/22	Attached	Board Secretary
3.5	Draft Committee Work Programme 2021/22	Attached	Board Secretary

4	**ITEMS FOR INFORMATION**		
4.1	IM&T Control and Risk Assessment Audit Report	Attached	Head of Internal Audit
4.2	Procuring Well-Being in Wales Review	Attached	Director of Finance & IT
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 8 June 2021 at 10:00 am, Microsoft Teams		

Key:

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 9 MARCH 2021 VIA MICROSOFT TEAMS MEETING

Present:

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

In Attendance:

Rani Mallison	Board Secretary
Pete Hopgood	Director of Finance, Information and IT
Osian Lloyd	Internal Audit
Sarah Pritchard	Head of Financial Services
Alison Butler	Audit Wales
Elaine Matthews	External Audit (Audit Wales)
Matthew Evans	Head of Local Counter Fraud Services

Committee Support

Caroline Evans	Head of Risk and Assurance

Apologies

Carol Shillabeer	Chief Executive
Helen Higgs	Head of Internal Audit

ARA/20/108	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/20/109	**DECLARATIONS OF INTERESTS**

	The Committee Chair INVITED Members to declare any interests in relation to the items on the Committee agenda. None were declared.
ARA/20/110	**MINUTES FROM THE PREVIOUS MEETING FOR RATIFICATION** The Committee Chair requested a follow-up on the issue identified in the Counter Fraud Proactive Exercise – Pre-Employment Checks (ARA/20/100), in respect of a lack of engagement by two agencies. Pete Hopgood confirmed an update on this issue will be brought to the next meeting. **Action: Director of Finance and IT** The minutes of the meeting held on 26 January 2021 were RECEIVED and AGREED as being a true and accurate record.
ARA/20/111	**MATTERS ARISING FROM PREVIOUS MEETINGS** There were no matters arising from the previous meeting.
ARA/20/112	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/19/115e (The management response in respect of the timeliness of signing of contract documentation will be picked up with the Director of Planning & Performance): This action has been identified as priority level 3 for implementation and will continue to be tracked via the audit recommendations process. ARA/20/64: To be arranged for March 2021. ARA/20/82: Action closed.
ARA/20/113	**APPLICATION OF SINGLE TENDER WAIVERS (STWs)** Sarah Pritchard presented the previously circulated paper which sets out the requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements.

Sarah Pritchard advised that there were six STW requests made between 1 January 2021 and 28 February 2021 and signed by the Chief Executive, 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
POW2021011	Tender	Parkway Clinic	Dental Surgical Interventions for Children and Young Adults	No NHS Provision available and clinical need	20/01/2021	£30,000	1 year	Prospective	A1
POW2021012	Quote	Nanosonics	Equipment Maintenance	Sole Supplier	03/02/2021	£8,448	1 year	Prospective	A2
POW2021013	Tender	My Dentist	Out of Hours Emergency Dental Service Llandrindod and Newtown	Service continuation in advance of tender	03/02/2021	£74,382	1 year	Prospective	A3
POW2021015	Quote	Consultation Institute	Expert Support advice and Learning to develop service change	Assessed on individual case basis due to Covid pandemic in line with PPN 01/20	10/02/2021	£12,500	1 year	Prospective	A4
POW2021017	Quote	T Ichim Llanfyllin Dental Practice	Emergency and New Dental patient access for North Powys	Service continuation in advance of tender	10/02/2021	£16,163	1 year	Prospective	A5
POW2021018	Tender	E G Davies Machynlleth	Personal Dental Service Contract with focus on vulnerable high needs children	Service continuation in advance of tender	10/02/2021	£28,615	1 year	Prospective	A6

The Committee RATIFIED the approval of the STW.

ARA/20/114

APPROACH TO 2020-21 ANNUAL ACCOUNTS

Pete Hopgood presented the previously circulated paper which outlines the approach and principles to be adopted for completion of the 2020-21 Annual Accounts together with the planned approach to key financial areas.

Pete Hopgood advised that the Health Board has a statutory duty to complete and submit Annual Audited Accounts to Welsh Government. This paper is to inform the Audit, Risk and Assurance 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.

Mark Taylor questioned how the approach fits with the funding commitment from Welsh Government.

	Pete Hopgood advised that we will receive the full COVID-19 funding allocation by 31st March 2021, and will be included in the position. The Committee Chair questioned if the approach has been discussed with Audit Wales. Alison Butler confirmed that the approach had been shared with Audit Wales and welcomed the paper and recognised as good practice. The Committee welcomed the approach and the increased awareness and understanding re Year End approach were appropriate management action and judgement was required. The Committee APPROVED the paper as presented.
ARA/20/115	**AUDIT RECOMMENDATION TRACKING** Caroline Evans presented the previously circulated report which provides an overview of outstanding audit recommendations, and the re-prioritisation for implementation of these audit recommendations during the COVID-19 pandemic. Caroline Evans advised that future updates on progress of the re-prioritised recommendations will be presented to the Audit, Risk and Assurance Committee on the basis outlined in the re-prioritised approach, as follows: -

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

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

Overdue Internal Audit Recommendations

	2017/18	2018/19	2019/20	2020/21	TOTAL OUTSTANDING
	Number	Number	Number	Number	Number
Priority 1	0	0	0	3	3
Priority 2	5	2	19	0	26
Priority 3	1	0	13	0	14
Not Yet Prioritised	0	0	3	2	5
TOTAL	**6**	**2**	**35**	**5**	**48**

Overdue External Audit Recommendations				
	2018/19	2019/20	2020/21	TOTAL OUTSTANDING
	Number	Number	Number	Number
Priority 1	0	0	0	0
Priority 2	2	1	4	7
Priority 3	1	1	2	4
Not Yet Prioritised	1	0	7	8
TOTAL	**4**	**2**	**13**	**19**

Rani Mallison advised that progress on implementation of the Priority 1 recommendations will be presented at the next meeting.
Action: Head of Risk & Assurance

Alison Butler stated the report is really comprehensive, but expressed concern at a large number of outstanding recommendations to be implemented by the end of the year, questioning whether this is achievable.
Rani Mallison stated that a robust assessment was undertaken by Executive Directors, however, we will monitor any slippage and ensure that is brought to future committees.

The Committee RECEIVED and NOTED the Audit Recommendation Tracking update.

ARA/20/116

INTERNAL AUDIT PROGRESS UPDATE
Osian Lloyd presented the previously circulated report which provides progress with the 2020/21 Internal Audit Plan as recorded at March 2021.

Osian Lloyd advised that progress against the Plan is as follows:

	Number of audits finalised: 11 Number of audits issued at draft: 0 Number of audits in progress: 9 Number of audits not started: 0 Year-end reporting: 2 **Total number of audits in 2020/21 plan: 22** Mark Taylor requested that property reviews and scheme reviews look at the early phases of the preparation, to enable the identification of good practice before commitment to the schemes. **Action: Osian Lloyd** The Committee RECEIVED and NOTED the Internal Audit Update.
ARA/20/117	**INTERNAL AUDIT REPORTS, 2020-21:** **a) IM&T CONTROL AND RISK ASSESSMENT (NOT RATED)** Osian Lloyd presented the findings of the review, which sought to establish the processes and mechanisms in place for management of IG/ICT within the organisation. The review sought to provide a baseline picture of the organisation's status and provides suggestions for areas of improvement or future development, therefore an assurance rating has not been allocated. Osian Lloyd advised that the review identified a total of fourteen observations / recommendations. Ian Phillips stated that the scoring is difficult to interpret, particularly as recommendations or areas for improvement have not been identified. Osian Lloyd stated that he would feed the comments back to the IT team. Rani Mallison concluded that the committee given the Committee could not take assurance form the report in its current form, and requested that a revised report be issued and presented at the next meeting. **Action: Osian Lloyd** The Committee RECEIVED and NOTED the update.
ARA/20/118	**INTERNAL AUDIT PLAN 2021-22** Osian Lloyd presented the previously circulated report, which sets out the Internal Audit Plan for 2021/22 detailing the audits to be undertaken and an analysis of the corresponding resources. Osian Lloyd advised that the Plan has been developed in accordance with Public Sector Internal Audit Standard 2010. The Committee RECEIVED and APPROVED the Internal Audit Plan.
ARA/20/119	**EXTERNAL AUDIT UPDATE**

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

Elaine Matthews advised on the following audit work that is currently underway: -

Topic	Executive Lead	Focus of the work	Current status
Orthopaedic services – follow up	Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted
Review of the Welsh Health Specialised Services Committee (WHSSC)	Chief Executive Officer	WHSSC is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales. This work will use aspects of our structured assessment methodology to examine the governance arrangements of WHSSC. Our findings will be summarised into a single national report.	Report in clearance
Test, Trace and Protect	Director of Public Health	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	Report in clearance and due for national publication on 18 March
Quality Governance	Director of Nursing	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Set-up underway
Structured Assessment	Chief Executive	This work will continue to reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. The work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.	Fieldwork underway – Phase 1 Phase 2 due to start in May 2021
Vaccination rollout		This fact-based review will provide a high-level overview on key aspects relating to the administration, planning and approach for the rollout of vaccinations in Wales. This review will not seek to investigate detailed arrangements within health bodies.	Fieldwork underway

The Committee RECEIVED and NOTED the External Audit Update.

ARA/20/120 **EXTERNAL AUDIT PLAN 2021-22**

	Alison Butler and Elaine Matthews presented the previously circulated report, which sets out the External Audit Plan for 2021/22 to discharge the Auditor General statutory responsibilities under the Code of Audit Practice. Elaine Matthews advised that the audit plan sets out an initial timetable for the completion of audit work. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited. The Committee RECEIVED and NOTED the External Audit Plan 2021/22.
ARA/20/121	**COUNTER FRAUD WORKPLAN 2021-22** Pete Hopgood presented the previously circulated report, which presents the proposed Counter Fraud Work Plan for 2021/22, detailing key areas of work to be undertaken by the Counter Fraud Team in the next Financial Year. Pete Hopgood advised that the Work Plan is drafted on the basis that the new Government Functional Standards are to be adopted from 1st April 2021 replacing former NHS Counter Fraud Standard. The resource allocation within the Work Plan is based on an increase in deliverable days for 2020/21. A proposal for this increase has been drafted and is awaiting approval via the relevant processes. The Work Plan is presented as a final draft awaiting confirmation of the funding increase. The Committee RECEIVED and NOTED the Counter Fraud Work Plan 2021-22.
ARA/20/122	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** • None
ARA/20/123	**ANY OTHER URGENT BUSINESS** There was no other urgent business for discussion, and the Chair declared the meeting closed at 10.53 am.
ARA/20/124	**DATE OF NEXT MEETING** 29 April 2021, 2:00 pm, 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
(April 2021)

Minute	Date	Action	Responsible	Progress	Status
ARA/20/100	26 January 2021	Follow-up on the issue identified in the Counter Fraud Proactive Exercise – Pre-Employment Checks in respect of a lack of engagement by two agencies.	Director of Finance and IT		
ARA/19/115e	9 March 2020	The Machynlleth Hospital Primary & Community Care Project recommendation 6 (lessons learnt) would be shared with the Committee, once available.	Board Secretary	This action has been identified as priority level 3 for implementation and will continue to be tracked via the audit recommendations process.	
ARA/20/64	8 September 2020	PPV to attend a pre-meet of the Committee, to provide a broader	Director of Finance and IT / Board Secretary	To be arranged for 2021-22.	

		understanding of the PPV service, and to advise how they can give assurance to the Committee of an anti-fraud culture.			
ARA/20/116	9 March 2021	Request that Internal audit property reviews and scheme reviews consider the early phases of the preparation, to enable the identification of good practice before commitment to the schemes.	Head of Internal Audit	Our capital audit colleagues consider the focus of the audits they will undertake as a matter of course in advance of when planning discussions are held with members of the Executive Team. They typically represent the status of the larger projects at a point in time. For example, a number of reviews have been undertaken on the Llandrindod Wells project in the past across different stages (including limited assurance reports). The scope of the Machynlleth (Bro Ddyfi hospital) review included in the 21/22 has been agreed with the Executive Director of Planning and Performance and the team. This will be the first audit of the development while progressing on site (targeted commencement March 2021). The focus of the 2021/22 review may include an assessment of the following: • Project appointments; • Project Governance and Management arrangements; • Interim valuation and payments processes; • Site Management (including compliance with Covid controls);	Complete

				• Change Management arrangements; • Other – i.e. any other issues identified at the project affecting project delivery.	
ARA/20/117	9 March 2021	IM&T Control and Risk Assessment Audit Report to be reviewed and updated.	Head of Internal Audit	Separate discussion held and I.T. Auditors have responded to specific areas of concern. It was highlighted that the report was not an assurance report, but was looking at the baseline picture / whether processes already existed. The report is included again for information under item 4.1.	Complete

	AGENDA ITEM 2.2
Audit Risk and Assurance Committee	**Date of Meeting: 29th April 2021**

Subject:	**Financial Control Procedure (FCP) – COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE**
Approved and Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Sam Moss, Assistant Director of Finance
Other Committees and meetings considered at:	Strategic Gold Group

PURPOSE:

The purpose of this paper is to provide the committee with the latest iteration / updated 'FCP Covid-19 Decision Making & Financial Governance', highlighting the changes from the previous approved version.

RECOMMENDATION(S):

Audit, Risk and Assurance Committee is requested to:

- APPROVE the current version (#6) presented to Audit Committee

Approval/Ratification/Decision	Discussion	Information
✓		

EXECUTIVE SUMMARY:

This is the latest version of the Covid Financial Control Procedure and has been updated to reflect governance and decision making arrangements during the Covid 19 Pandemic.

Version Control

Following the publication of the WG guidance on 30th March 2020 an initial draft of the FCP was submitted for approval at Gold (version #1).

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

Currently PtHB is on version 6 of the FCP.

Approval & Publication

Each version of the Financial Control Procedure (FCP) is presented to Gold / Executive Committee for approval:-

- Version 1 – w/c 13th April 2020
- Version 2 – w/c 27th April 2020
- Version 3 – w/c 11th May 2020
- Version 4 – w/c 24th June 2020
- Version 5 – w/c 25th Jan 2021
- Version 6 - w/c 26th April 2021

At relevant timed the latest FCP is shared will all staff via Daily Bulletin and is available on the intranet site, enabling the latest version to be available to PtHB staff at all times. Version 6 will be uploaded to the intranet following sign off by Audit, Risk & Assurance Committee.

FCP – COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

Document Reference No:	PTHB / FCP	
Version No:	6 (Q1 Update 21/22)	
Issue Date:	April 2021	
Review Date:	n/a	
Author:	Deputy Director of Finance	
Document Owner:	Finance Department	
Accountable Executive:	Director of Finance	
Approved By:	Gold	
Approval Date:	April 2021	
Document Type:	Policy	Non-clinical
Scope:	PTHB wide (including Hosted Services)	

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

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

Version Control

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

	Revision = detail on the authorisation limits changed to direct the reader to the Approved Signatory Forms as per PtHB standard operating processes. Addition = Section 15 Capital: to ensure there is clarity on the management and approval of capital expenditure which may need to vary from the approach used for revenue	
6	Update # 5 Revision = update on commencement of standard BC processes pending launch of new IBG process. Revision = additional cost centres added since August Revision = section Gold Reporting Revision = Reimbursement Section New = Adult Social Care Section Revision = LTA payments to simply FCP and refer to general principles only Revision = TRACs process Revision – 2 Way Matching linked to updates by NWSSP and All Wales P2P	
7	Update #6 Removed = section on Investment Benefit Group as this will go live in May 2021. Removed = section on Budget Holder Meetings and changes to FCP 21 as this no longer applicable in 2021/22. Updated = section 3 on covid expenditure and the processes to be followed Updated = section 4 to reflect how funding flows in 2021/22, which is different to the process in 2020/21. Updated = section 5 to reflect new guidance issued at end March in relation to 2021/22. Updated = section 7 to reflect ongoing reporting requirements to WG. Updated = section 8 to reflect savings plan for 2021/22 as per Annual Plan.	

	Updated = section 9 to reflect LTA contract payment process agreed between WG and NHSE Updated = section 10 to reflect changes in IMTP process for 2021/22 Updated = section 14 linked to extension of 2way matching process by All Wales P2P	

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

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

Circulated to the following for Consultation

Date	Role / Designation

Evidence Base

IMPACT ASSESSMENTS

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

1 Policy Statement / Introduction

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

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

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

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

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

2 Objective

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

3 Definitions

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

4 Responsibilities

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

4.1 Staff Group or Specific Role

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

4.2 Other staff

5 Monitoring Compliance, Audit & Review

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

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

6 References / Bibliography

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

COVID-19 Financial Guidance_FINAL.doc

FINANCIAL CONTROL POLICY

COVID 19 DECISION MAKING & FINANCIAL GOVERNANCE

1. Introduction

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

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

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

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

2. Interpretation

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

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

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

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

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

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

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

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

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

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

Non Pay (Revenue):

- All dedicated COVID-19 expenditure needs to be raised against the relevant cost centres set up to support Covid-19 and its component parts as per the full list provided under the pay section below.
- The approval limits for these dedicated cost centre will be noted on the Approved Signatory Forms as per PtHB standard operating processes. Orders between £25,000-£50,000, should be presented to Gold as part of the monthly Finance Report. All orders over £50,000 must first be approved by Gold Command before being signed by CEO and Chairman as required and in line with the SFI.
- Requests to commit expenditure will need to be supported by either a small summary or an email detailing the key information in Appexdix B. An example of information needed is included in template found in Appendix B. It is the responsibility of the Director for that service area to ensure that the Finance Team are provided with Appendix B or other schedule/business case, completed and approved as per the directions on the form. Where the appendix or supporting information is not submitted directly from a Director there must be a sufficient audit trail to ensure it is clear that the Director has approved this request.
- Using the received Appendix B's or other information including data from the Financial Ledger, the Monthly Gold report the paper will include:
    - Those orders already raised on the system. This list will be updated monthly so the Health Board can see the total value of services and goods ordered placed since the start of the Financial Year.
    - Orders Over £5k for which 3 Quotes Not Secured as per Interim Covid-19 FCP using the latest information from Procurement.
    - Summary of all WHS charges allocated to Covid-19, using the data from the WHS feeder file.
    - List of requests received that require approval from Gold. And where deemed helpful the appendix B forms or other supporting information submitted will be embedded into the report should Gold members require full details on the expenditure requested.
- This report will ensure expenditure is both captured and reported and approved by Gold. It is the intention that all expenditure is approved in advance, but where this is not possible this report will ensure that all expenditure not approved in advance is approved retrospectively in a timely manner and included in one of the categories reported on above.

- From Mth 1 Reporting 2021/22 only expenditure from 1st April 2021 will be included in the report. All previous expenditure is captured in 2020/21 reports.
- It will be the responsibility of the Director of Finance to update the Finance Team on the decisions made by Gold.

Pay:

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

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

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

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

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

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

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

COVID-19 Gold Reporting Summary:

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

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

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

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

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

In 2020/21 WG issued guidance and funding to support care homes. In April 2021 WG issued an updated guidance, copy embedded below.

Support for Adult Social Care in the Cc

The detailed actions to ensure compliance with this guidance will be provided to Gold/Exec Team for approval as required during 20201/22.

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

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

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

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

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

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

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

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

8. Savings

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

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

9. Changes to LTA Payments - (Change SFI)

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

the 1st of each month and then at the end of the financial year adjustments are made for under or over performance.

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

All block arrangements are presented and approved at All Wales DOFs, via DDOFs, and at these meetings are representatives from WG. The approvals made at All Wales DOFs will then drive the payment/recovery/performance monitoring for PTHB, which will be consistent across Wales.

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

FCP 21 states that the letter of Accountability will be issued 28 days after approval of the IMTP. In 2021/22 there is no IMTP but an annual plan, which will be finalised during Q1.

Therefore, the approach will be to issue letters to the Directors during Q1 to establish the baseline position and for these to be returned within 28 days of being issued.

11. Procurement Hierarchy

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

12. Changes TRACs Approval Process

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

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

To avoid delays effective from 30th March 2020 there is an option for all TRACS orders added from this date to be automatically approved to ensure

all posts are processed as efficiently and effectively as possible. However if possible Finance should continue to check and approve.

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

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

13. Capital

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

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

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

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

14. Two Way Matching

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

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

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

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

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

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

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

15. Advanced Payments

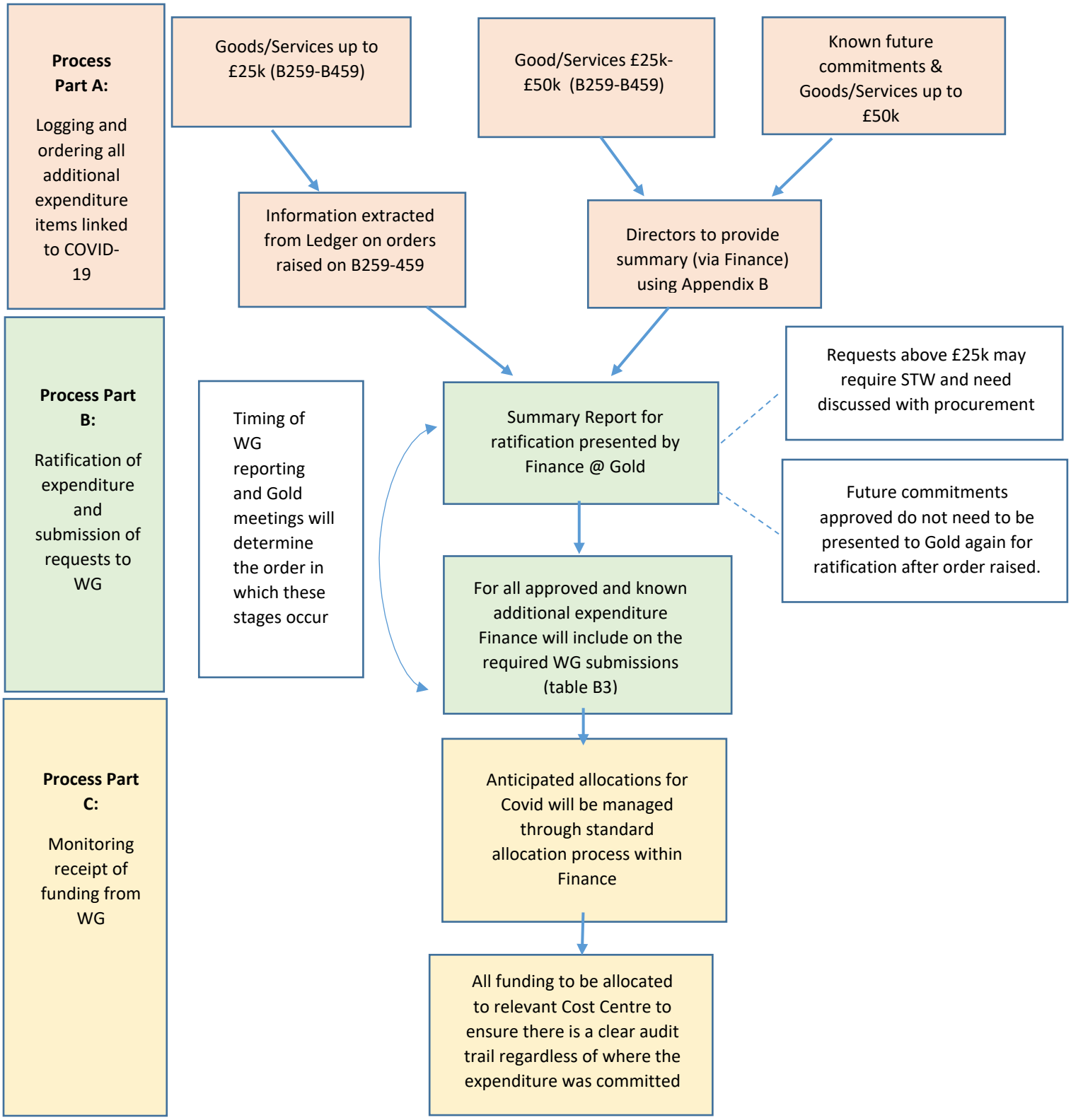
In April 2020 Welsh Government guidance was issued to all Health Boards in respect of requests for advance payments.

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

A copy of the guidance is provided below:

Advance Payments - Guidance FINAL.pdf

APPENDIX A – PROCESS MAP COVID 19 REVENUE EXPENDITURE NON PAY



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

APPENDIX B – FUNDING REQUEST TEMPLATE

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

AGENDA ITEM: 3.1

AUDIT, RISK AND ASSURANCE COMMITTEE	DATE OF MEETING: 29 APRIL 2021
Subject :	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Board Secretary
Prepared by:	Head of Risk & Assurance
Other Committees and meetings considered at:	N/A

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to note the current position, following the re-prioritisation of Audit Recommendations for implementation during the COVID-19 pandemic.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

INTRODUCTION:

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this has subsequently led to NHS organisations, including Powys Teaching Health Board, needing to focus on preparations and plans for dealing with an expected surge in demand of patients requiring interventions. The nature and scale of the response depends on the course of the disease. The situation is changing constantly and will require an agile response.

Whilst the health board operates in unprecedented times, the Board remains accountable as always. The Good Governance Institute advise that during this developing situation, boards should be mindful of their statutory duties but equally they must be conscious of and receptive to the expectations that their staff, stakeholders and communities will reasonably place upon them.

Auditors, via internal and external audit teams, play an important independent role in providing the Board with assurance on the effectiveness and appropriateness of internal controls, systems and processes. It is therefore important that recommendations from such audits are implemented in a timely manner, ensuring that the health board operates effectively and efficiently, mitigating any identified risks.

During the pandemic, the priority of implementing audit recommendations will need to be balanced with the level of resources required to plan and respond to the impact posed by COVID-19.

BACKGROUND AND ASSESSMENT:

As the health board has been responding to the COVID-19 pandemic, capacity to implement audit recommendations across services has inevitably been reduced. Whilst there is recognition of the significant pressure on services, there does need to be a balance between managing capacity pressures and challenges presented by the COVID-19 pandemic and managing the 'business as usual' issues and risks.

Directorates previously reprioritised their audit recommendations according to the following criteria: -

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

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

INTERNAL AUDIT

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

Overdue Internal Audit Recommendations					
	2017/18	**2018/19**	**2019/20**	**2020/21**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**	**Number**
Priority 1	0	0	0	6	6
Priority 2	5	2	19	3	29
Priority 3	1	0	20	1	22
Not Yet Prioritised	0	0	1	5	6
TOTAL	**6**	**2**	**40**	**15**	**63**

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

EXTERNAL AUDIT

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

Overdue External Audit Recommendations				
	2018/19	**2019/20**	**2020/21**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**
Priority 1	0	0	0	0
Priority 2	2	1	4	7
Priority 3	1	1	2	4
Not Yet Prioritised	0	0	6	6
TOTAL	**3**	**2**	**12**	**17**

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix H – Recommendations Completed since the last reporting period

Appendix I – Priority level 2 External Audit Recommendations
Appendix J – Priority level 3 External Audit Recommendations
Appendix K – Not Yet Prioritised External Audit Recommendations

NEXT STEPS:

Executive Directors are required to ensure that a comprehensive progress update and explanation is provided against any remaining outstanding Priority 1 recommendations, which were due for implementation by 31st March 2021.
Directorates will be asked to provide updates of implementation of priority level 2 recommendations, which are due for implementation during quarters 1 and 2.

2017/18 Internal Audits

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

2018/19 Internal Audits

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

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				Audit Recs Not Yet Due			All Audit Recs Implemented
												Priority			Not Yet Prioritised				
			H	M	L	H	M	L	H	M	L	1	2	3		H	M	L	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0				×
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1											✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0											✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3											✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3											✓
192006	Records Management	No Assurance	6	0	0	1	0	0	3	0	0	0	5	0	0	2	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3											✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	0	0	0	3	0	0	1	2	0				×
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2											✓
192010	111 Service	Reasonable	2	3	0	0	1	0	0	1	0	0	4	0	0	1	2	0	×
192011	Catering Services Follow-up	Reasonable	0	3	2	0	2	1	0	1	1	0	0	2	0				×
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	0	3	1	2	0	0	0	0	2	0				×
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4											✓
192014	Care Homes Governance	Limited	1	2	3	0	0	3	0	0	0	0	3	0	0	1	2	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	0	3	0	0	0	0	0	1	1	0	1	0	1	×
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	0	0	0	2	0	0	0	2	0				×
192017	Dental Services: Monitoring of the GDS Contract Follow-up	Reasonable	0	0	2	0	0	2											✓
192018	IT Service Management	Reasonable	0	2	1	0	2	1											✓
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	1	4	1	1	4	0	0	0	1	0	0	1	0				×
192020	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	0	0	0	1	0	0	1	0				×
192021	Capital Assurance Follow Up	Substantial	0	1	0	0	1	0											✓
192022	Outpatients Planned Activity	Reasonable	1	3	0	0	0	0	0	0	0	0	0	3	1	1	3	0	×
192023	Estates Assurance Follow Up	Reasonable	0	1	2	0	1	1	0	0	1	0	0	1	0				×
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1											✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0											✓
192026	Risk Management and Board Assurance	Limited	2	3	0	0	0	0	2	3	0	0	5	0	0				×
192027	Welsh Language Standards Implementation	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0				×
192028	Section 33 Governance Arrangements Follow Up	Reasonable	0	2	1	0	0	0	0	0	0	0	0	3	0	0	2	1	×
TOTAL			**23**	**63**	**32**	**9**	**43**	**26**	**7**	**12**	**4**	**0**	**19**	**20**	**1**	**6**	**9**	**2**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				Audit Recs Not Yet Due			All Audit Recs Implemented
												Priority			Not Yet Prioritised				
			H	M	L	H	M	L	H	M	L	1	2	3		H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0											✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	0	1	0	1	2	0	6	0	0	0	1	2	0	×
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	0	1	0	1	0	0	3	1	0	0	2	1	×
202104	Annual Quality Statement	Not Rated	0	1	0	0	1	0											✓
202105	Advanced Practice Framework	Not Rated																	✓
202106	Capital Systems	Substantial	0	0	4	0	0	3	0	0	0					0	0	1	×
202107	GP Access Standards	Substantial	0	0	1	0	0	1											✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	0	0	0	0	0	0	0	0	0	5	3	1	1	×
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	0	0	0	0					0	0	14	×
TOTAL			**5**	**11**	**22**	**0**	**3**	**5**	**1**	**3**	**0**	**6**	**3**	**1**	**5**	**4**	**5**	**17**	

2018/19 External Audits

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

2019/20 External Audits

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

2020/21 External Audits

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

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?
													Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Primary, Community and Mental	R1	Complex Care Steering Group 1.1 The CCSG should meet bi-monthly, as stated in its terms of reference, and should report back assurance from other key governance forums, for example, the JIMP, S33 JOG, etc. Minutes should clearly evidence	1.1 Meeting schedule to be implemented and monitored. 1.2 Reinstate the Highlight Report which will be adapted to include Care Home Key metrics. 1.3 The Complex Care Steering Group	Jan-20	Closed	2	Closed		01.04.2021 - Implementation of the Quality, Safety and Experience FNC and CHC group The Purpose of the group is to	Quality Dashboard developed, and joint work with LA to develop a joint dashboard progressing. We are working to	Changed High Cost Panel into the Value Based Assurance Framework, so that issues related to CHC packages that are	Implemented August 20	Yes
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R1	ICT should consider undertaking a formal ITIL maturity level assessment. They should assess their current level, and a target level formally agreed, where necessary with a plan to reach the level.	Accept recommendation – A full ITIL maturity level assessment will be conducted to review current status in order to assess and plan future target level and actions with timescales to reach set standards.	Sep-20	Closed		Closed	12/4/21 - Whilst the recommendation was accepted there is no		Commitment from PCC to undertake the maturity level assessment and ongoing covid pressures			
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R2	Key date information should be added to the register. As a minimum the following dates should be included: when added; when last reviewed; when next due for review; expected resolution.	Accept recommendation – Key dates will be added to the problem register to ensure adequate management and tracking of problems.	Feb-20	Complete		Complete		12/4/21 - Problem management documentation has been updated and amended to give a target completion				Yes within supporting documentation
192018	IT Service Management	Reasonable	Director of Finance, Information and IT	Head of Digital Services	R3	All subjective terms should be replaced with clearly defined number ranges.	Accept recommendation – A review of incident categorisation terminology to be considered and a framework to support decision making will be agreed and implemented.	Jun-20	Complete		Complete		12/4/21 - Incident management process document has been reviewed and where appropriate subjective terms				Yes within supporting documentation
202104	Annual Quality Statement	Not Rated	Director of Nursing & Midwifery		R1	The Patient Experience Steering Group (or equivalent group focusing on patient experience) should continue to be considered as the editorial forum for the AQS, with AQS being a standing agenda item. It is important that this group receives adequate support to focus on the	1. The AQS will a standing agenda item in the patient experience steering group from this point forward, and continue to be so in any further iteration of the group, for as long as the AQS is required of the health board.	Oct-20	Closed		Closed		The AQS for 2019-20 was presented at EQS and approved by the HB and published. The 2020-21 AQS is no longer required. Going		Changed High Cost Panel into the Value Based Assurance Framework, so that issues related to CHC packages that are		
202106	Capital Systems	Substantial	Director of Planning and Performance	Head of Capital	R1	Management Control Plans should be prepared for all projects, in accordance with the Capital Procedures and shared with relevant parties (e.g. the client) to enable cooperation towards achieving set deadlines	Whilst the aforementioned project commenced outside of the management of the Capital Team, it is acknowledged that all capital projects require a Management Control Plan.	Jan-21	Complete		Complete		Management Control Plans are implemented for all schemes from 2021/22				y
202106	Capital Systems	Substantial	Director of Planning and Performance	Head of Capital	R3	Project files should include a clear audit trail of all adviser appointments, including: • how the advisers had been selected (e.g. from a 'select list' or via competitive quotation exercise); • requests for quotations etc.; • quotations received (where applicable);	A summary of the information will be included in the respective capital files. However, it is recognised that the Capital team have mitigating controls in place for review of appointments through the monthly meetings held with NWSSP:	Feb-21	Complete		Complete		Confirmation of consultant appointment routes included in contract file for all schemes from 2021/22				y
202106	Capital Systems	Substantial	Director of Planning and Performance	Head of Capital	R4	The 'fee-bid' document should be updated to include Professional Indemnity Insurance for submission prior to appointment	The fee-bid document will be updated accordingly.	Feb-21	Complete		Complete		Insurance checks are required for all Oracle 'services' purchase orders and applies for all schemes from 2021/22				y
202107	GP Access Standards	Substantial	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R1	1.1 The health board should ensure that its GMS CAF covers GP access issues that are not addressed by the current and updated Access Standards. 1.2 From March 2021 onwards, the health board should consider incorporating reporting on the	1.1 The GMS CAF incorporates wider assurance on Access and pulls together various strands to provide holistic access assurance. The CAF includes the Access Standards, practice opening hours, appointment availability and times,	Mar-21	Complete		Complete						

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				No. of months past agreed deadline
												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Assistant Director of Estates & Property	R1	The Fire Safety Policy should be updated to: a) Demonstrate compliance with the current regulations [WHTM 05-01 (2019)]; b) Reflect the current fire safety management structure within the THB	Should there be substantial changes to legislation, then policy documents would be updated and presented to Board for ratification. Where only minor updates, a decision would be made as to whether they would warrant a full review of the	Jan-21	Overdue	1	Partially complete	The Fire Safety Policy has been reviewed against, and is consistent with WHTM 05-01; the fire safety management structure,	The fire safety policy is due for review in August and has already been reviewed against current WHTM's. The document cannot be			2
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health Services	R2	The current fire safety management structure should be formally clarified, documented and approved at an appropriate forum (e.g. Fire Safety Group), ensuring commitment and support from both Executive Team / Board and Operational Managers	Papers will be presented to the Executive Committee for the escalation of Fire Risk to the Corporate Risk Register. It has been acknowledged that there is a lack of clear site management arrangements and further work is being undertaken by the	Jan-21	Overdue	1	Partially complete	This item was discussed during the January Fire Safety Group and is ongoing.	The fire safety policy is due for review in August and has already been reviewed against current WHTM's. The document cannot be			2
202102	Estates Assurance – Fire Safety	Limited	Chief Executive	Executive Director of Primary Care, Community & Mental Health Services	R3	Individual fire safety roles and responsibilities should be formally documented (e.g. via terms of reference), assigned and accepted, ensuring appropriate management arrangements within localities	Once the operational site structures have been finalised, a document will be issued to the relevant officers providing clarification on the role.	Jan-21	Overdue	1	No progress					2
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R5	Site staff should receive instruction / training to ensure the local fire management folders are appropriately used and fully completed	The key priority is to address the site management responsibilities (as per recommendation 2). Once this has been finalised, it will be a collective responsibility to ensure the required training is delivered.	Jul-21	Not yet due	1	No progress					#NUM!
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Fire Safety Advisers	R6	Sample checks should be made during Fire Safety Adviser site visits to ensure folders are being completed as required	A checklist will be added to the folders for officers [either Fire Safety Advisers / Estates Officers / Responsible Persons] to provide a signature to confirm appropriate completion.	Jul-21	Not yet due	1	No progress					#NUM!
202102	Estates Assurance – Fire Safety	Limited	Director of Workforce & OD and Support Services	Executive Director of Primary Care, Community & Mental Health (in	R7	Fire Warden and Incident Coordinator roles will be confirmed with immediate effect to ensure there is sufficient coverage in each location in the event of an incident / evacuation	These roles will be allocated upon finalisation of the roles and responsibilities of the Senior Operational Managers (see recommendation 2)	Apr-21	Not yet due	1	No progress					#NUM!

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?				
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Dec-20	Mar-20	Overdue	2	Partially complete		Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-20		34	3	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Dec-20	Mar-20	Overdue	2	Partially complete		Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-20		34	3	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Dec-20	Mar-20	Overdue	2	Partially complete		Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-20		34	3	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed	Apr-18	Dec-20	Mar-20	Overdue	2	Partially complete		Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	31-Dec-20		35	3	26/02/2019
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	May-18	Dec-20	Mar-20	Overdue	2	Partially complete		Competing priorities in the corporate governance team	Support on policy development is being provided to the organisation as and when required	Dec-20		34	3	26/02/2019
181909	Occupational Therapy S	Reasonable	Board Secretary		R5	The Records Management Policy, Health Records Procedure and Safe Haven and Information Policies should be reviewed and updated as necessary so that they comply with General Data Protection Regulations (GDPR). A consistent approach to records management	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	Apr-19	Dec-20	Nov-19	Overdue	2	Partially complete	A revised Records Management Framework is being developed.	Impact of COVID-19 on the IG team	IG advice and support is provided to the organisation when requested.	31-Dec-20		23	3	26/02/2019
181927	Engagement with Primary Care Providers Follow-up	Limited	Director of Primary, Community and Mental Health		R1	1. To ensure constructive and continued engagement with the primary care clusters, the health board should move forward with implementation of the Primary Care Transformation Programme. Particular attention should be paid to the establishment of a Primary	Agreed. Progress has been made in this area however the formal framework for Cluster Development (note – the term Primary Care Transformation programme is not being used) is due to the Cluster Leads meeting at the end of June 2019.	Jul-19	Sep-20	Jul-20	Overdue	2	Partially complete	Engagement with clusters has remained active during covid 19 albeit with a covid focus. Cluster framework was delayed			Sep-20		20		30/05/2019
192006	Records Management	No Assurance	Board Secretary		R1	The health board should strengthen its leadership arrangements and the coordination of its approach to enable effective records management. Individual roles and responsibilities should be reviewed, defined and documented accordingly, either within the most appropriate	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	Feb-20	Dec-20		Overdue	2	Partially complete	A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of RM Improvement Group and approval delayed due to COVID-19.	A Records Management Project Risk Register has been developed. Existing policies and procedures remain	31-Dec-20		13	3	14/11/2019
192006	Records Management	No Assurance	Board Secretary		R2	In order to ensure correct and up to date policies and procedures are accessible to all staff, policies and procedures need to be reviewed and updated to reflect current legislation, All Wales guidance and current working practices. Once updated and approved, the policies and	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	Feb-20	Dec-20		Overdue	2	Partially complete	A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed. Existing policies and procedures remain	31-Dec-20		13	3	14/11/2019
192006	Records Management	No Assurance	Board Secretary		R3	The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	Mar-20	Dec-20		Overdue	2	Partially complete	A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	Establishment of Records Management Improvement Group delayed due to COVID-19.	A Records Management Project Risk Register has been developed.	31-Dec-20		12	3	15/11/2019
192006	Records Management	No Assurance	Board Secretary		R4	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	Apr-20	Apr-22		Deadline Revised	2	Partially complete	A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		11	#NUM!	14/11/2019
192006	Records Management	No Assurance	Board Secretary		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the	Apr-20	Apr-22		Deadline Revised	2	Partially complete	A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the	COVID-19	A Records Management Project Risk Register has been developed.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed		11	#NUM!	14/11/2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R3	The health board should assess the effectiveness of initiatives to reduce stress amongst its employees and where some are considered more effective these could be promoted further and identify whether there are any barriers to accessing initiatives. The health board may wish to	HR Business Partners and HR advisors using the available reports will monitor where there are high level of stress. These reports will be discussed during their caseload meetings and a targeted approach can be looked at for the areas	May-20			Overdue	2	Partially complete	We will be monitoring stress levels and discussing it in caseload meetings. The stress management toolkit is part of the absence		work on COVID has prevented progress.	Due to the work on Covid and the OH Manager's secondment to cover the Wellbeing Hub, there is no new update at this time.		10	1454	14/11/2019

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?				
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R1	We recommend that remedial actions are developed for all areas where they are absent.	Red Rated Actions: Going forward the assessment will include the following narrative: "Current status - Working with providers to ensure end to end reporting is in place by the end of the financial year	Feb-20	Sep-21		Deadline Revised	2	Partially complete	End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept	Reliant on input and agreement from 3rd parties: Advanced, Shropdoc &	Monthly data continued to be received from Shropdoc which provides assurance on the 2nd line triage and	Sep-21		13	#NUM!	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R3	We recommend that the health board agree a suite of metrics that WAST will submit regularly and that these be reviewed quarterly (see also recommendation 2 which is related).	End to end reporting remains a problem but has progressed. Once this is in place the availability of data will be considered and then debated with WAST/111 for future use and monitoring via the OOH Performance Management Group.	Mar-20	Sep-21		Deadline Revised	2	Partially complete	End to end reporting service specification agreed with Advanced, Shropdoc, 111 and PTHB. To be implemented by Sept	reliant on WAST		Sep-21		12	#NUM!	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Director of Primary Community Care & Mental Health	R4	We recommend that a process to review patient complaint and feedback received by WAST in relation to the 111 service is implemented.	This will be raised with WAST/111 to seek that such feedback is provided via the National 111 and OOH Implementation Programme Board. A similar request will be made to for the sharing of Powys resident information directly with Powys	Jan-20	Sep-20		Overdue	2	Partially complete	111 attendance at OOH Performance Mgt meeting. Patient complaints/concerns and compliments reviewed as part of the		Powys representation into national 111 Ops group. Expectation that 111 will provide local data at future Powys quarterly OOH	Sep-20		14	6	
192010	111 Service	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R5	We recommend that the 111 service activities are reviewed to ensure that all risks have been captured and that the risk scoring of 111 service reporting is reviewed to ensure that residual risk is not understated.	Specific risk relating to general OOH standards will be reviewed. Consideration of a risk around the metric reporting by 111 (bearing in mind this is a national service) will be considered by the OOH Performance Management Group.	Feb-20	Sep-21		Deadline Revised	2	Partially complete	111 attending OOH Performance Mgt Group meeting. Performance reviewed and exceptions documented. Risks			Sep-21		13	#NUM!	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance and	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review	Dec-20	28/09/2021		Deadline Revised	2	Partially complete	July 2020 - CL will need speak to Hayley about how the capacity can be made available for the action below – as this was going to be taken	Not completed, but due to the WG's approach to the financial system and ability of care homes during C-19, this action has not been a		Sep-21		3	#NUM!	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the	Apr-20	28/07/2021		Deadline Revised	2	Partially complete	Out of county reviews are up to date. 3.1 remains in draft format and we are working to try and make it a Powys wide	Covid has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised	Jul-21		11	#NUM!	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices;	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	Mar-20	28/04/2021		Deadline Revised	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	LA have requested to review the SOP and have contested some areas of the SOP 4.2 Covid has impacted on the way in which	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21		12	#NUM!	
192015	Primary Care Clusters	Reasonable	Director of Primary, Community and Mental Health	Director of Primary Community Care and Mental Health	R4	We recommend that the health board devise and implement a comprehensive cluster governance framework to strengthen control of cluster operation going forward.	This document is already under revision and will be implemented for 2020/21.	Apr-20	Sep-21		Deadline Revised	2	Partially complete	Due to covid implications and deployment of former cluster manager to the mass vaccination programme the			Sep-21		11	#NUM!	
192026	Risk Management and Board Assurance	Limited	Board Secretary	Head of Risk & Assurance	R1	a. Finalise the current version of the RMF and ensure placed on the health board's intranet in a location that is easy for all employees to locate. b. Finalise the RMF Toolkit and append to the RMF. c. Finalise the Risk Management training plan and	Agreed.	Sep-20			Overdue	2	Partially complete	c. A T&F Group has been established with other RM colleagues through the Wales Deputy Board Secretaries Network, to					6	1454	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ Head of Risk & Assurance	R2	a. Improve the level of documented scrutiny in the Board and sub-board committee meeting minutes around rationale for making changes in risk scores for individual risks in the CRR, the achievement of deadlines for completion of mitigating actions. b. Ensure the on-going improvement of	Agreed.	Dec-20			Overdue	2	No progress						3	1454	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Head of Risk & Assurance	R3	Ensure that the Directorate Risk Register template, as documented in the RMF Toolkit (and appended to the Risk Management Framework) is adopted by all Directorates and fully populated for discussion at Risk and Assurance Group meetings going forward.	Agreed. This work is ongoing, with an original deadline of 31st March 2020 assigned. This deadline has been extended in light of current arrangements in response to COVID-19.	Dec-20			Overdue	2	Partially complete	Directors have been written to, to remind them that there is an expectation that Directorates will need to manage their					3	1454	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ Head of Risk & Assurance	R4	a. Ensure that going forward, reviews of the Directorate Risk Registers at Risk and Assurance Group meetings are appropriate to the task required, i.e. to discuss risk scores and consider risks for recommendation to the Executive Committee to be escalated to the Corporate Risk	Agreed	Dec-20			Overdue	2	Partially complete	Directors have been written to, to remind them that there is an expectation that Directorates will need to manage their					3	1454	26/09/2020
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary/ Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their	Agreed	Mar-21			Overdue	2	No progress						0	1454	26/09/2020

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202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development & Assistant	R1	• The remaining health and safety policies, procedures and guidance should be reviewed to ensure they accurately reflect current working practices and detail roles, responsibilities and reporting structures. • Once approved, the policies, procedures and	• Analysis to be undertaken on policy review date with any outstanding or due policies to be reviewed. • Re-draft and complete sign off of any due policies. • Communicate reviewed policies to	Mar-21	Jun-21		Deadline Revised	2	Partially complete	Risk Mgt Framework template returned to date – 19 V&A incidents report paper to H&S group 9/2/21	1 outstanding policy	Policies were extant whilst being reviewed.	Anticipate sign off of the Corporate Health & Safety Group in June 2021.	Health & Safety policies available on Intranet	0	#NUM!	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R2	• The Health and Safety Team should undertake an exercise to provide assurance that appropriate risk assessments are in place across all sites and services throughout the health board and to manage any issues raised. • These risk assessments should then inform the	All service leads will be asked to confirm risk assessments, safe systems of work and SOPS that are in place for their service areas. This will be a desk top collation request utilising the key service contacts on each site (22 sites). Once	May-21			Not yet due	2	No progress						#NUM!	1454	
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services		R4	• The health board should review the terms of reference of the Health and Safety Group, including confirming who should be in attendance. • Attendance of members at the group should be monitored and where a member of the Group is unable to attend, an alternative representative	• Terms of Reference for the Health & Safety Group to be drafted and approved, via the Executive Team and Health & Safety Group. • Attendance of members of Health & Safety Group to be tracked and	Sep-21			Not yet due	2	No progress						#NUM!	1454	

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171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	Director of Primary, Community and Mental Health		R4	The Health Board should introduce a formal policy which clearly sets out the process of prescribing medicines. This should include the following: • roles and responsibilities • monitoring and reporting arrangements • processes for processing and approving changes	Concise collation of advice for practitioners from professional guidance, and contractual arrangements that they should already be working to, may be a helpful reminder.	Apr-18	Sep-20		Overdue	3	Partially complete	Medicines Policy has been delayed until January to be approved by Med Safety and Governance Group. The advice will be attached	Chief Pharmacist new in post and needs time to understand/amend governance arrangements to ensure that when	Reminder, and links, send to HB employed prescribers on GMC advice	Sep-20		35	6	27/03/2019
192001	Deprivation of Liberty Safeguards	Limited	Director of Nursing & Midwifery		R3	The health board should put in place a formal agreement (for example, a Service Level Agreement) with the LA for the services provided by the Powys DoLS Team. This should include: I. clear details of the service provided, including who is responsible/liable for each aspect of the	Agreed.	Oct-19			Overdue	3	Partially complete	**19.9.19:** Meeting with DoLS Team manager in PCC scheduled for **27.9.19**. Draft document has been prepared.			1 month		17		10/07/2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R1	The health board must approve, promote and publish the new Policy and Toolkit. Line Managers should be provided with adequate training in line with the requirements of the 'Stress Management and Wellbeing in the Workplace Policy' on how to identify, manage and	The Stress Management Policy and Toolkit was approved on October 23rd 2019. It was agreed that the policy and toolkit will be reviewed in 9 months (July 2020) to ensure approaches are current and fit for purpose.	Jul-20	Dec-21		Deadline Revised	3	Partially complete	We will be monitoring stress levels and discussing it in caseload meetings. The stress management toolkit is part of the absence		Work on COVID-19 has prevented progress. Mass Vaccination roll out has had an impact on the capacity of the OH service. Staff	Due to the work on Covid and the OH Manager's secondment to cover the Wellbeing Hub, there is no new update at this time.		8		14/11/2019
192008	Staff Wellbeing (Stress Management)	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of OD/ Deputy Director of Workforce & OD	R2	The Occupational Health service has recently upgraded its case file software 'Cohort' which should provide the service with on demand reporting. This should be used to monitor or identify trends with stress related referrals with appropriate action being taken where trends are	The recently upgraded software is due to be able to interface with ESR; this in turn will provide management reports relating to referrals and absence reasons. A stress steering group will be set up that seeks to monitor information, and data.	Apr-20			Overdue	3	Partially complete	Bi-directional ESR/Cohort interface not yet progressed and no date confirmed by Mediate. Rapid access available for managers	Bi-directional interface postponed due to Covid-19 priorities	Clinical psychologist working alongside OH Registered Mental Health Nurse in developing on-line Mental Health	Unable to provide date for bi-directional interface at this stage, the work will resume in Q2.		11		14/11/2019
192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R2	In order to ensure the effective governance of the service, the health board should continue to hold the monthly Facilities Management Team meetings. The health board should also consider producing a standard agenda and method of recording for the local team meetings to ensure	Agree The Department welcomes and accepts the recommendation. We will implement the recommendation to set agendas and record local team meetings in a format that reflects the Facilities Management Team (FMT) meeting.	Feb-20	Sep-20		Overdue	3	Partially complete	Regular management teams have been suspended during Covid 19 escalation, as reported to the Board Secretary in March	Covid 19 escalation.	During Covid 19 Escalation there have been thrice weekly briefings between the Assistant Director and his direct reports. FMT	Jul-20	Yes	13	6	
192011	Catering Services Follow-up	Reasonable	Director of Workforce & OD and Support Services	Assistant Director Facilities & Support Services	R5	We concur with management intentions, that regular spot checks of PADRs should take place to ensure; • all PADRs are completed to the required standard; • all staff are using the correct form to ensure	Agree. The department welcome's the auditor's confirmation that PADR compliance has been sustained at above the health board's target of 80%. The department is happy to confirm our commitment to sustaining and improving	Mar-20	Sep-20		Overdue	3	Partially complete	Suspended due to Covid 19 escalation.	Covid 19 escalation.	Action has resumed following Covid 19 escalation.	Sep-20	Yes	12	6	
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R1	(a) That the health board progresses its discussions with Welsh Government to ensure all parties are aware of the practical inconsistencies between the historic Welsh Government Hosting Agreement and the reality of the relationship between CHC and the health board, with the aim of agreeing an	(a) and (b) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will	Apr-20			Overdue	3	Partially complete	Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		11		
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Director of Workforce & OD and Support Services	Director of Workforce & OD and Support Services	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will	Apr-20			Overdue	3	Partially complete	Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement; however	Awaiting confirmation of meetings with Welsh Government.		Meeting held with WG & CHCs to discuss final amendments. Awaiting finalised document from WG.		11		
192015	Primary Care Clusters	Reasonable	Director of Primary, Community and Mental Health	Assistant Director of Primary Care	R5	We recommend that clusters conduct a review of patient information resources and that up to date cluster newsletters and other documents covering cluster service developments and achievements are provided on cluster and health board web pages.	This will be considered by the clusters and factored into their work programme for 2020/21. Prioritisation of this may vary across the 3 clusters and thus the deadline set allows that local flexibility.	Sep-20	Sep-21		Deadline Revised	3	Partially complete	Due to covid implications and deployment of former cluster manager to the mass vaccination programme the			Sep-21		6		
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and	The Executive Directors will develop detailed objectives and actions that will enable the achievement of each of the key priority deliverables within the Organisational Development Framework. For each action there will be action	Mar-20	Sep-20		Overdue	3	No progress	Objectives and actions aligned to the Framework have been put on hold due to Covid-19	Covid-19 work superseded this piece of work	This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		12	6	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R2	We recommend that the health board either seek to incorporate all of the OD Strategic Framework priority themes in the health board's existing performance monitoring framework or consider implementing a dedicated framework to manage the delivery of the OD Strategic Framework	Agreed Executive Directors will report progress against actions through the following performance monitoring governance mechanisms: • IPR reporting where appropriate	May-20	Dec-20		Overdue	3	No progress	Performance reporting aligned to the OD Framework put on hold due to Covid-19	Covid-19 work superseded this piece of work	This will be reviewed as part of the re-introduction of BAU	end of Qtr 3		10	3	
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	Director of Planning and Performance	Assistant Director of Estates & Property	R6	A lessons learnt exercise should be undertaken in consultation with appropriate parties and reported to Board. (O)	Accepted. As PTHB develops a major project pipeline, it is important that the organisation employs a lessons learned regime. A review will be undertaken of the project at Machynlleth from inception to the point of the FBC resubmission.	Sep-20	Oct-20		Overdue	3	Partially complete	Lessons learnt framework currently under development	Delayed due to covid	FBC submission date revised due to covid - currently no risk	Oct-20		6	5	
192020	Welsh Risk Pool Claims Management	Substantial	Director of Nursing & Midwifery	Assistant Director Quality & Safety	R1	Management should consider reviewing the reporting mechanisms on compensation claims to ensure that all claims are captured. For example, the format could be enhanced to distinguish between new claims, ongoing claims and closed claims from one period to the next.	The recommendation is accepted. Future claims reports will distinguish between new claims, ongoing claims and closed claims from one period to the next.	Oct-20			Overdue	3	No progress	The reports scheduled September 2020 onwards will be set out in the described way. This will then enable readers to distinguish	None	Information relating to claims is categorised and recorded to support differentiation between new, ongoing and closed claims.	Oct-20		5		

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														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?				
192022	Outpatients Planned Activity	Reasonable	Director of Primary, Community and Mental Health		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are	Mar-21			Overdue	3	No progress						0		26/09/2020
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R3	The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This	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	Mar-21			Overdue	3	Partially complete						0		26/09/2020
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R4	Continue to work with the commissioned health boards and trusts in Wales and England to enhance the reporting of commissioning services data to include Powys outpatient follow-up appointments waiting times and to discuss exceptions with them.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21			Overdue	3	No progress						0		26/09/2020
192023	Estates Assurance Follow Up	Reasonable	Director of Planning and Performance	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		Jan-21			Overdue	3	Partially complete	Management Plan updates complete and for formal review by Asbestos Group in January	COVID-19 delays	Changes to Management Plan are well understood by management team with strengthening of structure in place with	Jan-21		2		26/09/2020
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: • the roll of out awareness sessions, keeping records of attendance; • increasing the frequency and content of internal communications; and	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to	Mar-21			Overdue	3	No progress						0		26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R1	The deed of variation to the Overarching Agreement requires completion and signing to demonstrate agreement by both the health board and county council of the amendments proposed during 2019/20. The Reablement agreement needs to be brought	There has been an inevitable impact on the signing of 2020/21 S33 Agreements by April 2020, in light of the COVID-19 Pandemic. 2020/21 Agreements will therefore be signed later in the year. PTHB will therefore work towards	Apr-21			Not yet due	3	No progress								26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R2	The health board should continue strengthening the arrangements in place to ensure it receives the assurance it needs over the governance of the Section 33 agreements in place. This could be achieved by: • working with the county council to establish the	The remit and constitution of JPB will be revisited and will be articulated through the Overarching Agreement Deed of Variation (linked to Finding 1). S33 Oversight by JPB and Board Committees will continue to be strengthened	Apr-21			Not yet due	3	No progress								26/09/2020
192028	Section 33 Governance Arrangements Follow-up	Reasonable	Board Secretary		R3	There is a need for a further final accuracy check of the Section 33 Agreements before they are signed.	A Quality Check process will be established in advance of the signing of agreements.	Apr-21			Not yet due	3	No progress								26/09/2020
202103	Health and Safety Follow-up	Reasonable	Director of Workforce & OD and Support Services	Health & Safety Team	R3	The health board should resume the roll out of health and safety training sessions once practicable, in particular the programme of accredited IOSH Working Safely courses to ensure managers have a full understanding of their roles and responsibilities and those of their employees.	IOSH working safely one day programme will run in conjunction with managers development programme. Programmes scheduled quarterly. Delivery will be through the Health & Safety Team. First course due to commence in October 2021	Oct-21			Not yet due	3	No progress								

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												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
192022	Outpatients Planned Activity	Reasonable	Director of Finance, Information and IT		R2	The health board should investigate options for the implementation of an electronic referral management system as a replacement for the manual activities that currently cover the processes from initial patient referral up to booking of a patient's outpatient appointment	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	Mar-21	Overdue		No progress					0	26/09/2020
202106	Capital Systems	Substantial	Director of Planning and Performance	Assistant Director of Estates & Property	R2	The change control process defined within the Capital Procedures should be reviewed and clarified to ensure it reflects actual process and is not left open to interpretation		Jun-21	Not yet due		No progress					0	
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R1	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21	Not yet due		No progress					0	
202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Mental Health Partnership Manager	R2	Responsibilities for delivery and arrangements for monitoring and reporting on implementation of specific actions within the Together for Mental Health delivery plan should be formally documented and mapped to the delivery plan. This will enable the Mental Health Planning & Delivery	The (reviewed) National Together for Mental Health Delivery Plan (2019-2022) released in October 2020 is undergoing significant focus and preparation to reflect a Powys regional perspective. This re-vision needs to also align with related	Jun-21	Not yet due		No progress					0	
202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Mental Health Partnership Manager	R3	Terms of reference for the amalgamated MH Officers Group / Performance Subgroup should be documented and reflect the groups responsibility for monitoring performance against the Together for Mental Health delivery plans. The Hearts & Minds: Together for Mental Health	The Mental Health Officers Group (MHOG)/Performance Subgroup is being re-engaged and the best, most efficient way of monitoring performance, as a multi-agency operational group, is being discussed with partner agencies along	Jun-21	Not yet due		No progress					0	
202108	Partnership Governance – Programmes Interface	Limited	Director of Primary, Community and Mental Health	Mental Health Partnership Manager	R4	Membership of the MH Planning & Development Partnership Board should be reviewed to ensure appropriate representation from each partner organisation and the terms of reference updated accordingly.	It has always been the intention, upon receipt of the reviewed T4MH Delivery Plan, to adjust membership if this was needed to align with new priority areas and gaps. The majority of partner agencies and members remain	Jun-21	Not yet due		No progress					0	
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R5	Arrangements for reporting assurance to the Health Board on the effectiveness of the Live Well: Mental Health partnership need to be determined.	Reporting arrangements will be reviewed and clarified through the Partnership Governance Framework development and ongoing implementation. This reporting mechanism will also need to reflect existing reporting arrangements to	Sep-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O1	The organisation should maintain oversight of the extent to which IM&T satisfies obligations (regulatory, legislation, common law, contractual), internal policies, standards and professional guidelines. A register of compliance requirements for all IM&T	The Informatics team structure has recently been strengthened and this will support the development of a formal register. The Informatics team will work and liaise with the Information Governance team and other departments	Jul-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O2	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,	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	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O3	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	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O4	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	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O5	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	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21	Not yet due		No progress					0	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				No. of months past agreed deadline	Date Added to Tracker
												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O6	The development of the strategy should consider the wider ICT strategy implications and the supporting technical infrastructure.	The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O7	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.	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	Apr-22	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O8	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	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O9	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	Oct-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O10	A suite of cyber security KPIs should be developed in order to show the status of cyber security and the progress of the team in managing issues.	Appropriate KPI's are included as part of the work to review the current S33 and is ongoing to ensure that appropriate.	Dec-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O11	The health board should encourage appropriate groups of staff to complete the all wales NHS cyber training.	This is available on ESR and all staff encouraged to complete, we will continue to explore if this can be made mandatory.	Dec-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O12	Critical assets should be identified and be subject to enhanced monitoring an assessment for risk / replacement.	Action to completed with PCC partners as part of S33 arrangements.	Dec-21	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O13	In order to ensure best value approach, differing continuity options should be defined and the differing options to deliver this assessed/ costed.	The current procedures and process will be reviewed with PCC partners to ensure up to date and different options identified if available.	Apr-22	Not yet due		No progress					0	
202109	IM&T Control and Risk Assessment	Not Rated	Director of Finance, Information and IT	Assistant Director Digital Transformation & Informatics	O14	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	Oct-21	Not yet due		No progress					0	

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?
												Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
181951	Structured Assessment 2018	Director of Finance, Information and IT	R7	The Health Board should review and update the Standing Financial Instructions given that the last update was in 2016.	The Standing Financial Instructions will be reviewed and approved during 2019/20	Nov-19	Oct-20	Nov-19	Complete		Complete	12/4/21 Revised SFI were published at start of April 2021 these will now need to be taken through the HB governance for		Prior to ratification the existing SFIs in place remain fit for purpose until reviewed documentation issued.	Dependent on the timing of future committees and Boards. Therefore is also work ongoing with Finance Academy to	Yes
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I3	Implement consistency in the recording and monitoring of economic fraud risk in line with the Health Board's risk management policy and strategy.	Fraud risk will be managed in line with the Health Board's risk management framework; utilising established policy, procedure and systems. This will enable effective management of risk by the risk owners with specialist support from the Counter Fraud Team.	Aug-20			Complete		Complete	12/4/21 The Counter Fraud Team have been undertaking a series of formal risk assessments based on key risks identified by NHS			Process is implemented to record and monitor fraud risk. Further is planned to embed and improve on this throughout 2021/22.	
202153	Audit of Accounts	Director of Finance, Information and IT	1	We recommend that management reiterate to the finance team the importance of updating each reference when a journal is entered to ensure that it maintains a unique reference.	The Finance Department as part of its innovation programme is reviewing the process for completing and signing of off all journals. This recommendation will be added to the revised process and (1) a revised naming convention proposed to ensure the risk of duplication is	Sep-20			Complete		Complete	12/04/21Email sent to all staff to remind by DDOF on 16th February 2021. This will continue to be monitored to identify training				Yes
202153	Audit of Accounts	Director of Finance, Information and IT	2	We recommend that management remind the finance team the importance is entering a journal correctly.	Work will be undertaken with the Finance Systems Team and the Oracle Central Systems Team in Cardiff to understand whether there is an option within the Oracle Ledger system to prevent these errors being uploaded within the system and a 'rejection' notice issued to the person attempting	Sep-20			Complete		Complete	12/04/21Email sent to all staff to remind by DDOF on 16th February 2021. This will continue to be monitored to identify training				Yes
202153	Audit of Accounts	Director of Finance, Information and IT	5	We recommend that management ensure that entries made into the ledger agree with the underlying calculations.	All finance team members will be reminded of the requirement to ensure that journal entries made match the supporting evidence for journals.	Sep-20			Complete		Complete	12/04/21Email sent to all staff to remind by DDOF on 16th February 2021. This will continue to be monitored to identify training				Yes
202153	Audit of Accounts	Director of Finance, Information and IT	6	We recommend that management reiterate to the wider team that notice to raise income should be made as soon as possible to allow the Health Board to record its income accurately.	The wider finance team and departments that receive income will be reminded of the requirement for timely submission of invoice requests particularly at the end of the financial year.	Mar-21			Complete		Complete	12/04/21The service are reminded of this as part of the annual year end closedown communication letter, which specifically states				Yes

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				No. of months past agreed deadline	No. of months past revised deadline
											Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
181951	Structured Assessment 2018	Board Secretary	R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Deadline Revised	2	No progress	To be taken forward in Q2.	Delayed in light of COVID-19	Clinical and Stakeholder engagement is undertaken via other means	31-Mar-21	17	0
181951	Structured Assessment 2018	Board Secretary	R4	The Health Board's internet pages do not provide access to current policies such as the counter fraud policy. The Health Board should update its internet site to provide easy access to current policies and strategies.	The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	Oct-19	Mar-21	Deadline Revised	2	Partially complete	The Policy Management Framework is under development	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	31-Mar-21	17	0
192051	Structured Assessment 2019	Board Secretary	R2	Board committees were restructured and streamlined in 2019. The Health Board should evaluate the whole of the new committee structure to ensure that decision making, assurance and scrutiny are appropriate and that mental health, information governance and workforce have sufficient coverage in the new committees.	The Board will undertake a self-assessment of its effectiveness at a development session in February 2020. In addition, the Board's Committees will undertake a self-assessment of effectiveness, respectively, during Q4 of 2019/20. This work will inform the annual review of Terms of Reference	Apr-20	Mar-21	Deadline Revised	2	Partially complete	The Board had scheduled its annual self-assessment and reflection to take place in April 2020 (to include consideration of the	COVID-19	In its absence, implementation of the Board Development Plan will continue into its second year to support improved	Mar-21	11	0
202152	Structured Assessment 2020	Board Secretary	17	The Health Board's legacy website had a form to enable members of the public to raise questions of the Board in advance of board meetings. This form is no longer available on the new website. Given little use was made of the facility, the Health Board is considering how to improve its engagement with the public in its Board meetings in future.	To be considered in-line with the roll out of live streaming of board and committee meetings.			Overdue	2	No progress						
202152	Structured Assessment 2020	Board Secretary	23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	• Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.			Overdue	2	No progress						
202152	Structured Assessment 2020	Board Secretary	31	The Board is under pressure because it holds two Independent Member vacancies, while the Chair and five experienced Independent Members are due to step down during the next two years. The Public Appointments process was suspended during the pandemic but is scheduled to resume in October. To support the Board during this period	• 2 x Independent Member Vacancies out to advert, via public Appointments. Interviews scheduled for January 2020. • Induction Programme to be developed, linked with National Programme (via Public Bodies Unit)			Overdue	2	No progress						
202152	Structured Assessment 2020	Board Secretary	46	In 2019, we reported that the Performance and Resources Committee was unable to provide detailed scrutiny of the most up-to-date financial position prior to board meetings and recommended the schedule of meetings was reviewed to ensure the timing of meetings supports effective detailed scrutiny. While the Health Board's aspiration is for the	• Linked to 2019 Structured Assessment Actions and Update. Business Cycle to be reviewed, recognising the impact of COVID-19 during 2020.			Overdue	2	No progress						

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				No. of months past agreed deadline
											Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	
181951	Structured Assessment 2018	Board Secretary	R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21	Deadline Revised	3	Partially complete	Report templates and masterclasses for senior managers will be delivered in Q2.	COVID-19 arrangements have taken priority over this work.		31-Mar-21	21
192051	Structured Assessment 2019	Director of Workforce & OD and Support Services	R3	The All Wales Attendance at Work Policy was recently implemented with the delivery plan developed in partnership with Trade Unions. The Health Board should evaluate and report on how the change in approach is working in practice for staff and managers.	A review will be undertaken in partnership with Trade Unions to assess the impact of the All Wales Policy in its implementation.	Sep-20		Overdue	3	Partially complete	Union representative has been identified to work on PULSE survey.	COVID-19 work took priority.	WOD and Trade Unions held regular meetings during COVID-19 to discuss workforce issues.	The work will re-assume in Q2.	6
202152	Structured Assessment 2020	Director of Workforce & OD and Support Services	30	The Medical Director retired after the first phase of the pandemic with appropriate interim arrangements secured until a permanent successor can be recruited.	•Recruitment process underway.			Overdue	3	No progress					
202152	Structured Assessment 2020	Director of Therapies & Health Sciences	44	The Health Board is undertaking a programme of work to refresh its patient experience framework as part of the improving clinical quality assurance framework.	•Linked to 2019 Structured Assessment actions. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.			Overdue	3	No progress					

PTHB Ref. No.	Report Title	Director	Ref.	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline
											Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I1	Implement mandatory counter-fraud training for some or all staff groups.	Implementation of mandatory counter fraud training would be seen as gold standard in terms of assisting to develop a counter fraud culture within the Health Board. There are a range of options from face to face delivery of training to mandatory counter fraud e- learning. Mandatory learning	Mar-21	Mar-22	Deadline Revised		Partially complete	12/4/21 The Counter Fraud Team now have a presence as part of the Health Board's Mandatory Induction Programme to deliver	Congested mandatory and statutory learning schedule for staff may be barrier to full implementation for all staff.	Training has been or will be delivered to staff at higher irks of exposure to fraud.	Formalisation of Mandatory training for staff at higher risk of exposure to fraud will be explored in 2021/22.		
202151	Effectiveness of Counter-Fraud Arrangements	Director of Finance, Information and IT	I2	Consider the Local Counter-Fraud Specialist capacity required to resource required levels of proactive and investigative work, including staff training, and build in resilience to the team.	Whilst increased capacity is accepted to lead to greater impact and return within Counter Fraud work, economies of scale have yet to be explored in detail. A more dynamic, joined up approach to counter fraud work across Health Boards could lead to better resilience and improved preventative	Apr-21		Not yet due		Partially complete	Proposal received to be approved and implemented from April 2021.			Apr-21		
202152	Structured Assessment 2020	Director of Nursing & Midwifery	41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received	•Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Not yet due		Partially complete	Paper to Clinical QG Group and EQS next week, shows progress in some areas, and other areas affected by COVID-19. CQFIP up to	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021.	Implementation overseen by QGG and EQS.			
202152	Structured Assessment 2020	Director of Nursing & Midwifery	43	The Health Board has a process for responding to national Patient Safety Alerts and Notices. A review of the system for implementation is underway and will be revised as necessary.	•Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Not yet due		Partially complete						
202153	Audit of Accounts	Director of Finance, Information and IT	3	We recommend that management review and implement consistency in creation of purchase order conventions and to remind all staff with receipting responsibility of the necessity to ensure receipts are entered in the same convention as the purchase order. This will negate examples of the significant accounting entries highlighted during the audit taking place.	This will require a joint approach with the procurement team in Shared Services and receipting staff within the Health Board to ensure that the required process is followed correctly. This will include general communication to all users of the system to mitigate errors by providing some	Dec-20	Oct-21	Deadline Revised		Partially complete	12/04/21 This work has been delayed due to covid - however part of oracle upgrade due in July 2021 a training programme will be			Linked to Oracle Upgrade and the training programme due to be launched along side this.	Yes	
202153	Audit of Accounts	Director of Finance, Information and IT	4	We recommend that management ensure that contracts are signed.	The Health Board will work to ensure all contracts are signed within the financial year. Should this not be possible due to the any issues with the contractual documentation then the Board/Audit Committee will be advised of the breach in the SFI's by the end of the Financial Year in which the	Mar-21		Overdue		Partially complete	Due to Covid there will be contracts that will not be signed in 2020/21 e.g. LTA contracts with England, which have been				Yes	

Freedom of Information (FoI)

Follow-up

Final Internal Audit Report

2020/21

Powys Teaching Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Review reference:	PTHB-2021-18
Report status:	Final
Fieldwork commencement:	28th February 2021
Fieldwork completion:	15th March 2021
Draft report issued:	23rd March 2021
Draft report clearance meeting:	26th March 2021
Management response received:	26th March 2021
Final report issued:	06th April 2021
Auditors:	Helen Higgs – Head of Internal Audit Martyn Lewis, Information Management & Technology (IM&T) Audit Manager Kevin Seward, Senior IM&T Auditor
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Committee:	Audit, Risk & Assurance Committee

ACKNOWLEDGEMENT

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

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.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

This follow-up review of Freedom of Information (FoI) was completed in line with the 2020/21 Internal Audit Plan.

Our 2019/20 review of Freedom of Information (FoI) arrangements within Powys Teaching Health Board (the 'health board') or (the 'organisation') sought to provide the health board with assurance as to the extent to which FoI accountability, policies and procedures, performance measurement controls, and reporting mechanisms to monitor compliance were in place and in operation throughout the organisation. This review was completed in October 2019 and delivered a limited assurance opinion.

The Freedom of Information Act (the Act) came into effect on 1 January 2005. This affects all public sector organisations including the health board. The Act is intended to ensure openness, transparency and accountability of all public organisations. Under the Act, all public bodies have a legal duty to ensure that the public, staff and other organisations are able to access information about how they operate and make decisions about their performance.

The health board has a statutory responsibility to respond to these requests initially to inform the applicant whether the information falling within the scope of their request is held and later to provide that information.

2. Scope and Objectives

The purpose of this follow up review was to assess whether the health board has implemented the Internal Audit recommendations made following our review of FoI in 2019/20.

The scope of this follow-up review does not provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

3. Associated Risks

The overall risk considered in the follow up review is failure to implement agreed audit recommendations and therefore, continued risk of non-compliance with the Freedom of Information Act. Without a robust governance process for ensuring the effectiveness of FoI procedures there is a risk that information may not be made available in compliance with the Act resulting in regulatory action and/or reputational damage.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

The current review considers all recommendations made (high, medium or low priority). This report **does not** provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides the assurance level against the implementation of the agreed action plan only.

Considering the progress made against the action plan the follow-up review opinion is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial assurance		All recommendations implemented and operating as expected.

5. Assurance Summary

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

	Area	Priority 2019/20 audit	Direction of travel	Priority 2020/21 audit
1	FoI Performance Reporting	Medium	Recommendation implemented.	Closed
2	Limited FoI Resources	Medium	Recommendation implemented.	Closed
3	FoI Performance Compliance	High	Recommendation implemented.	Closed
4	Published FoI Disclosures	Low	Recommendation implemented.	Closed
5	SharePoint FoI Documentation	Low	Recommendation implemented.	Closed

Area		Priority 2019/20 audit	Direction of travel	Priority 2020/21 audit
6	IG related Policies	Low	Recommendation implemented.	Closed

6. Summary of Audit Findings

Our prior audit identified a number of issues regarding the arrangements in place within the health board to ensure that obligations in respect of FoI were met. This broadly fell into the following areas: resources to effectively coordinate and monitor FoI requests, general Information Governance policies are outside their review date, FoI performance, FoI reporting and maintaining the disclosure logs and supporting documentation.

It is pleasing to note that excellent progress has been made by the health board against all six of the recommendations made in our 2019/20 audit report.

The six findings from the previous audit are considered **fully implemented** and are therefore closed, these are as follows:

Previous Finding 1: FoI Performance Reporting (previously medium priority)

Our review of health board papers confirms that management reporting is now delivered through the Executive Delivery & Performance Group with assurance reporting to the Performance & Resources Committee.

The process for dealing with FOI requests has also been improved to ensure efficiencies, Executive Directors are now informed of live requests through routine alerts as a measure to avoid breaches.

Previous Finding 2: Limited FoI Resources (previously medium priority)

Since our last review of FoI, the organisation has given consideration to the resource level within the Information Governance Team, there have been two appointments made and the team manager is now full time. These changes are more in line with the workloads required to promptly complete legislative compliance work such as that required under GDPR and FoI.

Previous Finding 3: FoI Performance Compliance (previously high priority)

The Information Governance manager for the health board was able to provide evidence to show that the organisation has taken opportunities to improve its FoI response performance. They have developed more detailed reports which are received by the Performance and Resources Committee and fortnightly FoI and subject access request (SAR) updates which are distributed to the Executive Team, allowing operational monitoring at a frequency better suited for managing performances on live FoI requests.

Previous Finding 4: Published FoI Disclosures (previously low priority)

Through discussion with the health board Information Governance manager and independent verification by ourselves we can confirm that the organisation has updated the published disclosure. At the time of audit all completed responses had successfully been uploaded to the disclosure log and this process has been embedded into the Information Governance Team's local desktop guidance to ensure that this is maintained going forward.

Previous Finding 5: SharePoint FoI Documentation (previously low priority)

The previous audit identified a number of backing documents to support the FoI process were unavailable due to a technical fault on the IG team's network file storage. At the time we recommended the organisation ensure that the information lost from the Information Governance Team network file storage area be recovered as soon as practicable. This was completed shortly after the audit and the Information Governance Team were able to demonstrate the recovered folders and files as part of this follow-up review.

Previous Finding 6: IG related Policies (previously low priority)

Our 2019/20 audit of highlighted that the health boards FoI policy and some of the wider Information Governance policies were outside their review date. We recommended that the health board review and update its Information Governance related policy and procedural documentation, specifically as part of the review, the health board should act on the guidance from the national Information Governance Management Advisory Group (IGMAG) to reclassify the FoI policy as a procedural document.

We can confirm from our follow-up review of the health boards Information Governance policies and FoI procedural documents that they have been updated and communicated via the health board intranet site. As training and awareness sessions are currently not taking place as routinely as they

did pre Covid, a section was added to the January information Governance Alert to ensure staff are aware of the changes.

7. Summary of Recommendations

Summary of the recommendations by implementation status:

Actions Implemented in Full	Actions Implemented in Part	Actions Not Implemented
6	-	-

Priority ratings of the previous findings:

	2019/10	2020/21
High priority	1	-
Medium priority	2	-
Low priority	3	-
Total	**6**	**-**

Audit Assurance Ratings

 **Substantial assurance**: **Follow up -** All recommendations implemented and operating as expected.

 **Reasonable assurance**: **Follow up** - All high level recommendations implemented and progress on the medium and low level recommendations.

 **Limited assurance: Follow up -** No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **No Assurance**: **Follow up -** No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

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

Confidentiality

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The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Progress against Regional Plans

(South Powys Pathways Programme, Phase 1)

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Review reference:	PTHB-2021-05
Report status:	Final
Fieldwork commencement:	25th February 2021
Fieldwork completion:	19th March 2021
Draft report issued:	25th March 2021
Draft report clearance meeting:	6th April 2021
Management response received:	13th April 2021
Final report issued:	14th April 2021
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Committee: Audit Committee

ACKNOWLEDGEMENT

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

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.

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

1. Introduction and Background

Powys Teaching Health Board (the 'health board') is unlike other health boards in Wales in that it is primarily a commissioning organisation reliant upon neighbouring healthcare providers for the care of the population it serves. Commissioning work spans the continuum through health promotion, primary care, secondary care, specialised services, individual patient commissioning, continuing healthcare, partnership commissioning and joint commissioning with the local authority. As a highly rural area with no district general hospital, the vast majority of admitted patient care and secondary care outpatients is delivered beyond the borders of the health board. The health board is increasingly working in collaborative arrangements with its partners to best respond to the complexity of the arrangements for both health and social care delivery.

One of the significant current strategic change programmes incorporated into the health board's planning cycles is the South Wales Programme. Following public consultation, recommendations were approved in 2014 in relation to the future configuration of consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (A&E) for South Wales and South Powys.

In March 2020 the health board established the South Powys Pathways Programme (SPPP) Board to prepare for changes anticipated under the South Wales Programme in response to the opening of the Grange University Hospital (GUH) and under the Powys Health and Care Strategy. The Programme Board is chaired by the health board's Chief Executive Officer and includes representation from the Welsh Ambulance Service NHS Trust (WAST), Cwm Taf Morgannwg University Health Board (CTMUHB) and Aneurin Bevan University Health Board (ABUHB).

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation in the areas being reviewed. Any weaknesses identified were then brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence. The impact of the Covid-19 pandemic was taken into consideration in our assessment of the appropriateness of the arrangements in place.

The overall objective of this review was to carry out an assessment of the health board's engagement with and contribution to progressing the South Wales Programme (SWP), including the development of the Grange University Hospital as a Specialist Centre for Critical Care (SCCC).

The scope of the review covered the following aspects:

- facilitating engagement activities with the Powys population and health board staff;
- participation at / with the key forums and partners;
- operationalising and implementing the models of care;
- contribution in the delivery of actions relating to this strategic change programme;
- ongoing communication updating the public and staff on developments and progress; and
- monitoring and reporting of activities, including escalation through to Board.

3. Associated Risks

The key risks considered in the review included fragmented and unsustainable service models as a result of service reconfiguration of neighbouring NHS bodies, leading to a failure in the delivery of safe and effective care for the health needs of the health board's patient population.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Progress against Regional Plans is **reasonable** assurance.

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

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

5. Assurance Summary

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

					
1	Stakeholder engagement and consultation			✓	
2	Models of care			✓	
3	Delivery of actions			✓	
4	Communication of service changes			✓	
5	Monitoring and reporting			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of System / Control

The findings from the review have highlighted two issues that are classified as weaknesses in the system control/design for Progress against Regional Plans.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the operation of the designed system/control for Progress against Regional Plans.

6. Summary of Audit Findings

Overview

The South Powys Pathways Programme Board (SPPPB) had to be suspended in order to deal with the first COVID 19 peak of 2020, but was reinstated during the recovery period. It was anticipated that the winter of 2020/21 would be extremely difficult due to the pandemic. Aneurin Bevan University Health Board (ABUHB) was one of the areas hardest hit in Wales in the first peak and its experience led it to seek Ministerial approval to bring forward the opening of the new Grange University Hospital (GUH) to mid-November 2020 from spring 2021. The approval for this was given on 27 August 2020.

Responding to the early opening of the GUH was identified as a key strategic priority for Powys Teaching Health Board. In the approved South Wales Programme model, Prince Charles Hospital (PCH) in Merthyr Tydfil was recognised as being of strategic importance for South Powys offering the nearest District General Hospital (DGH) for the majority of the South Powys population. Nevill Hall DGH in Abergavenny was no longer to provide consultant-led accident and emergency services, consultant-led maternity & neonatal services and inpatient children's services.

Following the announcement, the scope and phasing of the Programme Board was amended to focus, in Phase 1, on the changes needed to emergency and urgent care flows. The compressed timescale of the opening, whilst also managing the active pandemic, was a significant challenge. This involved intense working across four organisations and a high degree of co-operation was needed, working together to ensure the safety of patients within this period of civil contingency.

The review examined the work undertaken by the health board's SPPPB in the first phase response to the outcome of the 2014 South Wales Programme (SWP) affecting the emergency service and urgent care provision for the population of South Powys and changes to the sites at which ABUHB provide maternity and inpatient paediatric services following the opening of the GUH. Future phases of the SPPPB are to develop and deliver the planned strategic pathway change to consultant-led maternity & neonatal care to PCH, also decided in the original consultation, and have not been challenged in this audit.

Our review was initially planned to cover the full scope of this change programme but due to the outbreak of Covid-19 and the accelerated opening of the GUH, the programme was broken down into two phases (phase 1 covered emergency and urgent care, phase 2 covers strategic changes to consultant-led maternity & neonatal care). Therefore the level of assurance provided in our review is limited to Phase 1 in this context.

The programme, which has operated under exceptional circumstances, appears to be a success overall to date. Lessons learned in the changes delivered so far, highlighted in the programme's phase 1 closure report, will however, need to be taken forward and addressed in phase 2.

7. Detailed Audit Findings

Findings are set out by audit objective in the section below and where appropriate, repeated along with recommendations in the action plan in Appendix A that follows

Objectives 1 and 2: Stakeholder engagement and consultation

We reviewed engagement activities during the period between the determination of the changes of the SWP in 2014 and the launch in March 2020 of the SPP Programme to implement them. These included periodic stakeholder updates, publications (including the health board's IMTP) and consultation and launch of the major trauma network.

During that period, ongoing work on the development and delivery of the Health and Care Strategy for Powys had created a framework for continued dialogue with stakeholders and communities about the future model for health and care in the County, including relationships with neighbouring health boards and Trusts, and this served to maintain dialogue with communities and stakeholders.

The South Powys Pathways (SPP) programme was launched in March 2020 to implement agreed changes to clinical services impacting Powys patients. We reviewed the SPP local engagement plan to engage with key stakeholders in relation to the accelerated opening of the Grange University Hospital and associated impact on Nevill Hall Hospital and on Powys residents to assess its reach and effectiveness. As well as patients, service users and carers and public and communities, which are covered later in this report under objective 4, we noted this included a broad range of partner organisations (local and national), health board staff and contractors, professional bodies (including trade unions) and political scrutiny and regulatory organisations. We saw evidence of key collaborative events involving partners and stakeholders including clinical summits, regular meetings with the local authority, primary care cluster leads, neighbouring health boards and WAST as well as regular briefings with partner organisations and the third sector.

Clinical involvement was key but challenging due to the Covid-19 context. Work streams were established to ensure appropriate clinical involvement and the health board organised a range of clinical summits and clinical-operational meetings. In addition, there was clinical membership on the Programme Board. We noted a reference in meeting minutes to perception of the late engagement of some clinicians in the overall development process and to the benefits of doing so earlier. This is also recognised as a

key learning point within the phase 1 closure report, around the awareness of the findings of the SWP amongst frontline staff and their active involvement in planning and preparing for the forthcoming changes. The closure report states the challenge and learning around continued clinical conversations will be reflected in the Phase 2 plan (**Recommendation 1**).

Objective 3: Models of care

Our review examined in detail only the revisions to the emergency care provision (Emergency Department and emergency admissions including paediatric) and changes to the sites at which ABUHB provide maternity and inpatient paediatric services following the opening of the new Grange University Hospital (GUH). Strategic changes to consultant-led maternity and neonatal services also included in the change programme are the subject of a second phase of the SPP programme to follow on from the accelerated Phase 1. Regarding the former, we noted the work done in estimating changes to patient volumes to GUH and PCH that would result from the opening of the GUH and Nevill Hall Hospital becoming a Local General Hospital, that these sites were forecasting capacity to receive these and that a readiness assessments had been carried out to confirm that the four main health bodies involved were able to implement the changes in co-ordinated way. We did, however, note a lack of a process model in the health board for collaborative programmes of this type (**Recommendation 2**).

Objective 4: Delivery of actions

We noted the SPP programme had a Project Initiation Document and an Integrated Impact Assessment schedule, along with high level and task level project plans. These then filtered down to four workstreams, each with a task level plan, and these regularly provided the programme team with a highlight report to monitor and track progress. Following the announcement of the early opening of the GUH in November 2020, the health board amended the scope and phasing of its Programme Board to focus, in Phase 1, on the changes needed in a compressed timescale to prepare and deliver emergency and urgent care flows. This meant that the Consultant-led Maternity and Neonatal elements of the broader programme originally planned for delivery in time for the original GUH opening date of March 2021 were not included in the accelerated phase 1 in 2020. We noted in comparing the original and revised task level plan that key elements of the original concerning emergency care service provision were brought forward to be addressed immediately. The most significant change in terms of original delivery plan was the Maternity workstream work which in the original plan was scheduled to be completed before the opening of the

Grange but in the accelerated plan for the early opening, this was rescheduled to run as phase 2, in 2021.

We noted that project documentation recorded phase 1 task level deliverables as 80% complete, 14% on track and 6% at risk of being late (the latter two relating to the Maternity workstream) at its closure in December 2020 but because we had no sight of the phase 2 plan or its resourcing, were unable to assess the status of its rescheduled deliverables or comment on any other aspects of these.

One of the key learning points recognised within the phase 1 closure report is that the resourcing of the South Powys Programme and workstreams requires further consideration going forward. This was exacerbated by the pandemic where individuals had to cease working on other priorities and intense work was needed including out of hours. Managing cumulative risk became enormously hard at times and there was an impact on both front line and management staff and the management and pace of work on other major priorities and risks.

Objective 5: Communication of service changes

We reviewed the communication and engagement plan for informing those affected by the changes to services from 17th November 2020. We noted the materials, channels, meetings and events employed to reach and inform these groups as to where services would be provided in the future. We examined a range of presentations, briefings, information booklets, social media posts and Powys and other health board web-pages used to set out the forthcoming changes and update key stakeholders on progress to date and next steps. Although the health board have no analysis of webpage/ social media traffic that would evidence audience reach, we were informed feedback was sought through the stakeholder networks to gain assurance the information booklet was indeed reaching households. Having examined the communication tools and techniques used and considered their audience reach, scope and coverage, we did not raise any findings or recommendations in this area.

Objective 6: Monitoring and reporting

Updates on strategic change programmes were considered by the Strategy & Planning Committee via the 'Strategic Change Update' papers presented. This included consideration of the impacts and opportunities for Powys of the ABUHB Clinical Futures development initiative.

Programme governance including monitoring and reporting is set out in the Programmes Project Initiation Document. We noted that four workstreams were in place for the delivery of the SPP programme, that each provides regular update reports to the SPP Programme Team which in turn regularly

reports to the SPP Programme Board. We reviewed documentation of a range of meeting packs for both SPP Programme Team and Board including meeting agendas, papers, minutes, action logs, task level project plans and risk registers. The SPPPB in turn reports to the Experience, Quality & Safety sub-committee of the PTHB Board via the Executive Team Strategic Planning and Commissioning Group. We note there are no formal reporting relationships with other groups and forums although stakeholders in the change programme are updated through respective engagement channels covered earlier in this report. We assess the monitoring and reporting activity surrounding the SPP Programme as appropriate and did not raise any findings or recommendations in this area.

8. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**-**	2	-	2

Finding 1 Clinical engagement in the development process (Design)	Risk
Clinical involvement was key but challenging due to the Covid-19 context. Work streams were established to ensure appropriate clinical involvement and the health board organised a range of clinical summits and clinical-operational meetings. In addition, there was clinical membership on the Programme Board. We noted a reference in meeting minutes to perception of the late engagement of some clinicians in the overall development process and further references in the phase 1 closure report to the value of early clinician engagement in the design of new patient pathways. The Phase 1 closure report also recognises a key learning point around the awareness of the findings of the SWP amongst frontline staff and their active involvement in planning and preparing for the forthcoming changes, which was signalled may lead to them feeling plans had been made without their input. The closure report states the challenge and learning around continued clinical conversations will be reflected in the Phase 2 plan. This is therefore raised as an issue but is given only a medium priority as we have not seen reference to any adverse impacts of late engagement which would have warranted a higher rating.	Patient pathways developed do not take into consideration key clinical constraints/ opportunities
Recommendation 1	**Priority level**
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.	**Medium**

Management Response 1	Responsible Officer/ Deadline
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.	Hayley Thomas, Director of Planning and Performance (Clare Lines, Assistant Director- Transformation- SRO) November 2021

Action Plan

Finding 2 Documented process for collaborative programmes (Design)	Risk
Whilst we noted the SPP programme had a Project Initiation Document and an Integrated Impact Assessment schedule, along with high level and task level project plans, the health board do not record a process model for managing collaborative change programmes. The need for clear processes for assessing the potential impact on other health boards and the other risks those organisations are also managing is reflected as one of the key learning points recognised within the phase 1 closure report. The leadership and governance arrangements for system change must also be clearly identified. Noting that the majority of these elements have been incorporated into the SPP Programme, factors to consider in the scope of a collaborative change programme framework could include: • Programme definition, scope and purpose • Leadership • Governance • Resources / Skill sets • Dependencies / interdependencies • Stakeholders • Risks • Contingency • Communication & Engagement – staff / partners / patients • Capacity • Timescales	Programme timelines and objectives are threatened through time and resource constraints

• Demographics • Funding and other constraints • Pre-existing commitments • Data management	
Recommendation 2	**Priority level**
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.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
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.	Hayley Thomas, Director of Planning and Performance (Clare Lines, Assistant Director- Transformation- SRO) September 2021

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Grievance Process

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	PTHB-2021-24
Report status:	Final
Fieldwork commencement:	25 February 2021
Fieldwork completion:	08 April 2021
Draft report clearance meeting:	25 March 2021
Draft report issued:	24 March 2021 09 April 2021
Management response received:	15 April 2021
Final report issued:	16 April 2021
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Committee Audit Committee

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

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1. Introduction and Background

The review sought to provide Powys Teaching Health Board ('the health board') with assurance that grievance cases are managed appropriately.

A grievance exists when an employee feels that they need to raise and resolve an issue, concern or complaint. NHS Wales is committed to promoting good employment relations between its employers and its employees, which includes the appropriate management of employee grievances.

The health board encourages grievances to be resolved informally by the employee through discussion with their line manager, or through a process of mediation. However, where this is not possible other managers may be allocated to a case to ensure that grievances are dealt with promptly, fairly and consistently.

2. Scope and Objectives

The objective of the review was to assess the adequacy of the arrangements in place for the management of the grievance process. We have considered the length of time to resolve, including appointing independent managers where required, tracking and communicating progress and whether the health board is doing all that it can to avoid delays.

Specifically, the audit sought to assess the following control objectives:

- there are appropriate guidance/procedures and supporting policies in place for the management of the grievance process and these are utilised appropriately;
- actions are undertaken promptly, in a way that is fair, consistent and without discrimination, including feedback to staff involved;
- effective monitoring arrangements are in place to ensure cases are progressed and outcomes communicated;
- appropriate individuals are involved in the grievance process and are adequately supported to ensure they have the necessary skills, information and guidance to comply with required standards; and
- reporting arrangements are in place and sufficient data is provided to the Board.

We have considered the impact of the Covid-19 pandemic in our assessment of the appropriateness of the arrangements in place.

3. Associated Risks

The main risk considered in the review was inappropriate management of grievance cases, exposing the health board to the risk of litigation.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with 'Grievance Process' is **Reasonable assurance**.

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

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

5. Assurance Summary

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

					
1	Guidance and procedures				✓
2	Actions taken in accordance with the policy			✓	
3	Monitoring arrangements			✓	
4	Staff support				✓
5	Reporting arrangements			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for 'Grievance Process'.

Operation of System/Controls

The findings from the review have not highlighted any issues that are classified as a weakness in the operation of the designed system/control for 'Grievance Process'.

6. Summary of Audit Findings

The health board has adopted the All-Wales Grievance Policy ('the policy'). Whilst this policy is overdue for review, it remains extant until the All Wales Respect and Resolution Policy is approved.

A record of grievance cases is maintained on a tracker which is used to actively monitor progress. There were eleven grievance cases between January 2019 and February 2021. The policy sets out timescales for each stage of the grievance process, and whilst we noted some exceptions to the timescales being met, we are satisfied that there are appropriate reasons for these delays.

Fortnightly grievance and disciplinary caseload review meetings are held. These are operational meetings which focus on progress updates and knowledge sharing. We contacted managers involved in the process who stated that Workforce provided useful advice and were supportive throughout the process. They also felt the process was balanced, fair and well structured.

The number of grievance cases, along with a brief description, is reported to the Remuneration and Terms of Service Committee. Although this has not occurred during the Covid-19 pandemic, we were advised that reporting will resume in May 2021.

Our review has identified one medium priority finding in respect of improving monitoring and assurance reporting of grievance cases within the health board.

7. Detailed Audit Findings

Objective 1: There are appropriate guidance/procedures and supporting policies in place for the management of the grievance process and these are utilised appropriately.

The health board has adopted the All-Wales Grievance Policy ('the policy'), approved by the Welsh Partnership Forum in March 2016, with a review date of March 2019. The policy is available to staff on the health board's intranet site and includes guidance and template documents for each stage of the grievance process.

Whilst the Grievance Policy is overdue for review, it remains extant until the All Wales Respect and Resolution Policy is approved. This policy, which we understand will incorporate the grievance process, was due to be published in 2020 however this has been delayed due to the Covid-19 pandemic. We are advised that Workforce & Organisational Development (WOD) colleagues will be attending a workshop in March 2021 to discuss implementation of the policy. The policy also encourages informal resolution and mediation and is aimed at securing constructive and lasting solutions to workplace disagreements, conflicts and complaints. It does not appear to require actions to be taken within the timescales set out in the current Grievance Policy.

Objective 2: Actions are undertaken promptly, in a way that is fair, consistent and without discrimination, including feedback to staff involved.

A record of grievance cases is maintained on a tracker which is used to actively monitor progress. Electronic case files are maintained separately

for each grievance. A total of 17 grievances are recorded on the tracker since 2019, six of these were withdrawn/not received:

	Reached stage 1	Reached stage 2	Reached stage 3 (appeal)	Withdrawn/not received*
2019	0	1	1	2
2020	2	4	1	4
2021	1	1	0	0

**these are included on the tracker as grievances expected as a result of another process i.e. as part of a disciplinary case the staff member has said they intend to raise a grievance.*

The record of grievance cases was reviewed to confirm it contains sufficient information to enable progress monitoring. A record of informal grievance discussions (stage 1) is not recorded on the caseload tracker unless this progresses to stage 2. There is no requirement within the policy for records to be kept by WOD, with line managers expected to keep records on personnel files.

The Policy sets out the actions required and timescales for each stage of the grievance process:

Grievance stage	Actions required	Further actions required	Record of outcome
1	Informal grievance discussion within 7 calendar days	---	Written record of grievance
2	Formal grievance hearing within a further 14 calendar days	Documentation sent out staff member 7 calendar days before hearing	Written outcome within 7 calendar days
3	Grievance appeal within a further 21 calendar days	Appeal to be received by staff member within 14 calendar days	Written outcome within 7 calendar days

We reviewed a sample of five grievance cases against the requirements of the policy. Our sample included coverage across a range of departments, sites and which had concluded at various stages of the process. Of the five cases that had reached **stage 2:**

- all employees were written to acknowledging the receipt of the grievance;
- the grievance hearing was held within 14 days for two out of the five cases. The delays in the remaining three cases (hearing held after 23,29 & 85 days) were due to information required from a disciplinary

case, the need to meet with the staff member to establish the grounds for the grievance, and sickness of the member of staff who raised the grievance;

- documentation was sent out for all cases at least 7 days prior to the hearing;
- the outcome was communicated within 7 days for four of the cases. The delay for the remaining case (28 days) was due to staff sickness of the person who heard the grievance; and
- the letters to the employees included reasons for the grievance either being rejected or upheld and their right to appeal the decision.

Two of the grievances in our sample had progressed through to **stage 3**:

- one request to appeal was not received by the employee within 14 days of receipt of the outcome of the hearing (25 days);
- neither of the appeals were heard within 21 calendar days of the receipt of the letter of appeal. The original appeal hearing for one of these was initially scheduled within 21 days, however two requests were received from the staff member for it to be delayed due to the union representative being unable to attend and Covid-19 symptoms in the family (60 days). The other appeal hearing was delayed as the acknowledgement was not sent for two weeks. There is however reference to a conversation with the employee within ten days of receiving the appeal request (29 days);
- both appeals were heard by an appropriate manager, at a Head of Service and Assistant Director level; and
- the employee was informed of the outcome within 7 calendar days for one of the cases. The delay with the other case (17 days) was agreed with the employee due to the need to review tapes of previous hearings.

Whilst exceptions have been noted above, we are satisfied that there are appropriate reasons for the majority of the delays. The Policy allows for an alternative timescale provided the parties mutually agree.

The grievance policy also states the 'status quo' will continue until the grievance has been resolved or the grievance procedure has been exhausted. For the sample of grievances reviewed one person was moved to another role, however we were advised there was also an ongoing disciplinary case at the time.

The Policy does not require formal feedback to be provided to any staff that may be the subject of a grievance, we were advised that it would be expected that this would be undertaken as part of the line management arrangements. We asked a sample of managers who had been involved in

the process whether any feedback had been provided to staff who were the subject of a grievance. We were advised that where the individual that was the subject of the grievance was aware that a grievance had been raised, the outcome was shared and verbal feedback provided. It was suggested that it would be useful for employees to be directed towards support following the grievance process.

The All Wales Respect and Resolution Policy includes the development of toolkits to outline support available. In addition, the health board's intranet site includes a link to the Health and Wellbeing site which outlines help available to staff, including counselling.

Objective 3: Effective monitoring arrangements are in place to ensure cases are progressed and outcomes communicated.

The Grievance Policy requires that an accurate record of all grievance cases should be maintained on the Electronic Staff Record (ESR). We were advised that ESR is not used to record grievance cases, and that this is common practice across counterpart organisations. This information is instead recorded in the caseload tracker spreadsheet.

Fortnightly grievance and disciplinary caseload review meetings are held. These are operational meetings which focus on progress updates and knowledge sharing. We were advised that debrief sessions are undertaken where necessary, for example following a complex case, and that lessons learned are shared via the caseload review meetings. These meetings are not documented; however, progress is recorded on the comments section of the caseload tracker.

Compliance with the timescales set out within the policy is not formally monitored, however this data is captured on the caseload tracker. We were advised that any instances of non-compliance would be discussed at the caseload review meetings.

The policy states '*An accurate record of all grievance events should be maintained on the Electronic Staff Record (ESR), to ensure that any necessary follow up action is taken, and to enable the organisation to detect any potential trends or patterns of behaviour. This information must be disaggregated by equality strand and routinely collected, analysed and reported on to ensure that grievance processes are fair and equitable for all individuals and groups, and to demonstrate that the Powys Teaching Health Board are meeting their employment equality monitoring duties'.* As above, we were informed that this information is discussed as part of the caseload review meetings, however adherence to the policy requirements are not formally monitored or reported.

Refer to finding 1 in Appendix A

Objective 4: Appropriate individuals are involved in the grievance process and are adequately supported to ensure they have the necessary skills, information and guidance to comply with required standards.

Grievances are usually manged within the chain of command within a service. Where there is perceived to be an issue or the grievance is against a person within the line management chain, an independent manager will hear the grievance or appeal. For the sample of five grievance cases reviewed we confirmed that these had been heard by an appropriate member of staff, either within the line management chain or an appropriate senior manager from the health board.

WOD Business Partners provide advice and support for managers who are involved in the grievance process. The overall message received from the sample of managers contacted to determine whether they felt they had sufficient support and if they found the process to be effective, was positive. Staff stated that WOD provided useful advice and were supportive throughout the process. It was also stated the process was considered balanced and fair, and well structured, with hearings arranged, conducted and documented in detail.

We also discussed the process with trade union representatives We were advised that they have a good relationship with WOD Business Partners and work with them to resolve issues before they reach a formal stage, and that this is often successful.

Objective 5: Reporting arrangements are in place and sufficient data is provided to the Board.

An 'Employee relations update report', which provides an update on disciplinary, grievance and dignity at work cases, was previously received by the Workforce & OD committee. This Committee was replaced by the Performance and Resources Committee in 2019 and whilst it receives workforce reports, the employee relations report is now presented to the Remuneration and Terms of Service Committee. The Terms of Reference for this Committee has not been updated since 2016 so does not reflect the current reporting arrangements in respect of employee relations matters.

The Committee received an employee relations report in August 2019, November 2019 and February 2020. The reports received reconciled to the caseload tracker held within WOD, although current reporting on grievance is limited to the number of ongoing cases and a description. There has been no reporting during the Covid-19 pandemic, with the next report due to be presented in May 2021. Whilst number of cases are low, periodic (e.g. annual) analysis of the number of cases, descriptions, sites, departments,

compliance with timescales etc. could provide additional helpful context to Committee members.

Refer to finding 1 in Appendix A.

8. Summary of Recommendations

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

A summary of these recommendations by priority is outlined in the table below.

Priority	High	Medium	Low	Total
Number of recommendations	**0**	**1**	**0**	**1**

Finding 1 Monitoring and Reporting (Design)	Risk
An update on the grievance cases is included in the 'Employee Relations' report presented to the Remuneration and Terms of Service Committee. The Terms of Reference for the Committee has not been updated since 2016 so do not reflect the changes to reporting requirements for employee relations matters, which was previously received by the Workforce & OD Committee. Current reporting on grievance is limited to the number of ongoing cases and a description. The Remuneration and Terms of Service Committee received an employee relations report in August 2019, November 2019 and February 2020. There has been no reporting during the Covid-19 pandemic, with the next report due to be presented in May 2021. Whilst number of cases are low, periodic (e.g. annual) analysis of the number of cases, descriptions, sites, departments, timescales etc. could provide additional helpful context to committee members. There is no formal monitoring or reporting of compliance with the policy, including timescales, trends or patterns and lessons learned. Whilst we note that this will be discussed as part of the caseload review meetings, as these are not minuted there is no documented evidence that assurance is provided to the Board (via the Remuneration and Terms of Service Committee) that the policy is being adhered to and actions are being taken in line with requirements.	The Board (or sub-committee) does not receive assurance in respect of compliance with the grievance policy.
Recommendation 1	**Priority level**
a) The Terms of Reference for the Remuneration and Terms of Service committee should be updated to reflect new reporting requirements for employee relations matters. b) Information reported to the Committee should include compliance with the timescales set out within the policy and the monitoring requirements i.e. trends, lessons learned.	**Medium**

We note that the All Wales Respect and Resolution policy will be replacing the current grievance policy, and these arrangements should be reflected when considering the implementation of the suggested recommendations.	
Management Response 1	**Responsible Officer / Deadline**
a) The Board's Committee Structure and supporting Terms of Reference are scheduled for review in Quarter 1, 2021/22. The Remuneration and Terms of Service Committee will retain responsibility for receiving updates on employee relations matters and the Terms of Reference will be updated accordingly. b) The relevant information will be included to the committee as identified.	Board Secretary June 2021 Director of WOD May 2021

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Trust. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Follow Up Review of 2019/20 'No' and 'Limited' Assurance Reports

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	PTHB-2021-36
Report status:	Final
Fieldwork commencement:	8 March 2021
Fieldwork completion:	12 April 2021
Draft report clearance meeting:	N/A
Draft report issued:	14 April 2021
Management response received:	20 April 2021
Final report issued:	22 April 2021
Auditors	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit
Executive sign off	Rani Mallison, Board Secretary
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Committee Audit Committee

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

ACKNOWLEDGEMENT

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

Please note:

1. Introduction and Background

The purpose of the follow-up review of 2019/20 'no' and 'limited' Assurance Reports was to assess and report whether Powys Teaching Health Board (the 'health board') has implemented the Internal Audit recommendations raised. One 'no' and five 'limited' Assurance Reports were issued during 2019/20:

- Risk Management and Board Assurance - an assessment of the effectiveness of the health board's risk management and Board assurance systems, to establish whether the process is in line with the Risk Management Framework and Board Assurance Framework;
- Records Management - to assess the adequacy of the arrangements in place for the management of health records, including compliance with policies and procedures. The audit did not review the content or accuracy of health records.
- Welsh Language Standards Implementation - to evaluate and determine the adequacy of the systems and controls in place over the implementation of phase one of the Regulations and how lessons were learnt to inform the second phase due later in 2019/20;
- Care and Nursing Homes Governance - to provide assurance on the governance arrangements between the health board and care homes settings; and
- Deprivation of Liberty Safeguards (DoLS) - to review the process for DoLS applications to ensure that they are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice and health board procedures.

The review on progress with implementation of the recommendations raised within the 2019/20 Freedom of Information (Limited Assurance) have been followed up separately. In addition, the follow up review on the 2018/19 Health and Safety audit (Limited Assurance) was reported in September 2020.

2. Scope and Objectives

We tested a sample of recommendations, focusing on those rated high and medium priority and recorded as being implemented, to provide assurance on progress with implementation. Reliance is placed on the health board's monitoring mechanisms, principally the Audit Recommendations Tracker, to scrutinise implementation of the remaining recommendations raised within these reviews, in particular any that are overdue.

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plans only.

3. Associated Risks

The overall risk considered in the follow up review is failure to implement agreed audit recommendations and therefore continued exposure to the risks identified in the original audits.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

This report does not provide assurance against the full review scope and objective of the original audits. The 'follow-up review opinion' provides the assurance level against the implementation of the agreed action plan only. Considering the progress made against the action plan the follow-up review opinion is **Reasonable Assurance.**

RATING	INDICATOR	DEFINITION
Reasonable Assurance		All high level recommendations implemented and progress on the medium and low level recommendations.

5. Summary of Audit Findings

We assessed the health board's recommendation tracker process, which had been in place for less than 6 months, during the Summer of 2019. The audit recommendations tracker, originally based on the audit tracker adopted by Welsh Ambulance Services NHS Trust (WAST), has now been in place for two years.

The health board's tracker is a standard agenda item on the Audit, Risk and Assurance Committee (ARAC) meeting. This provides the Committee with the opportunity to scrutinise the health board's progress in implementing recommendations raised. The tracker is also presented at the Executive Committee prior to the ARAC. In addition, the Risk and Assurance Group receives the tracker in order to strengthen the link between the risks arising from audit reports to the health board's risk management process. Unfortunately, this Group has only met once during 2020-21 due to the pandemic. Management of the Corporate Risk Register has been led by Executives during this period.

The audit tracker is maintained by the Head of Risk and Assurance who is part of the Board Secretariat Directorate. The Directorate receives all audit

reports (both internal and external) for inclusion in committee papers which ensures that the recommendations tracker includes all recommendations raised. The Head of Risk and Assurance requests updates from relevant directors six to eight weeks prior to the ARAC meetings, allowing time for updates to be provided and reflected on the tracker. The tracking process is currently a manual process (Excel spreadsheet) and management are working with the health board's Information Team to develop a web-based solution to enable the database to be updated locally by Directorates, and offer simpler and more timely reporting processes.

During our previous audit, we noted from the March 2019 ARAC minutes that the Committee Chair has confirmed his expectation that Executive Directors would be called to attend the committee meeting if performance against implementation of recommendations was not deemed sufficient. Although this has not been deemed necessary to date.

At the May 2020 meeting, the ARAC approved a re-prioritised approach for for the implementation of outstanding audit recommendations, which enabled services to balance their response to audit findings with the level of resources required to plan and respond to COVID-19. This was based on the following criteria:

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

Our recommendations on Risk Management and Board Assurance, Records Management, and Care and Nursing Homes Governance have all been classified as priority level 2. Therefore, in line with the definitions above, they are not expected to be implemented until quarters 1 and 2 of 2021/22. As a result, our follow up review has focused on all four high priority recommendations raised in the 2019/20 Welsh Language Standards and DOLS reports, all of which are recorded as implemented. Our testing confirmed that all were appropriately classified as completed on the tracker. However, it is recognised that further action is required to mitigate the risks identified which are reflected on departmental risk registers.

6. Detailed Audit Findings

This section captures a summary of our previous findings from our testing sample, along with the progress made to implement the associated recommendations.

Welsh Language Standards Implementation

Previous Finding 1 – Impact assessment

The draft compliance notice for the Welsh Language Standards was issued by the Welsh Language Commissioner to all NHS Organisations in July 2018. The final notice was issued in November 2018. However, our original audit found limited evidence to demonstrate that an assessment of the Regulations had been undertaken within the health board until the completion of the Baseline Assessment in January 2019. The results from the baseline assessment highlighted the position across the health board as 'inadequate'. As a result, the implementation of the Welsh Language Standards was escalated and raised on the health board's corporate risk register.

Our follow up review found regular updates on the Welsh Language Standards have been presented to the Executive Committee and Board throughout 2020-21. In September 2020, the health board published its first Annual Welsh Language Standards Monitoring Report and an Annual Welsh Language and Equality Workplan has also been developed. In addition, the Welsh Language Service Leads Steering Group continues to review the legislation and to monitor the implementation process across the health board. Going forward, the health board will continue to review future changes in legislation and associated implications, and it has been agreed that the Executive Lead will raise issues at a senior level and update reports will continue to be presented to the Board.

We were informed that the health board has established a more efficient relationship with the Welsh Language Commissioner's (WLC) Office and has liaised with Health Boards across Wales to develop a coordinated approach

to achieving compliance. The health board has taken part in two formal appeals processes with the WLC which were discussed and approved by both the Executive Committee and the Board.

Previous Finding 2 – Action plans and resource requirements

Our original audit found, following the appointment of the Service Improvement Manager of Welsh and Equality in April 2019, there had been increased activity and progress towards the assessment and implementation of the Standards. The Service Improvement Manager introduced the directorate action plans and established the Welsh Language Service Leads Group in July 2019.

Despite this, the majority of directorate action plans were still under development and needed to be finalised in time to feed into the health board's overall compliance assessment. As this had not been completed, we were unsure of its format, how it will be used to co-ordinate implementation and whether it will detail the resource requirements to comply with the Standards.

Our current audit identified that departmental action plans have been completed and progress has continued to be monitored every 6 months via the Welsh Language Service Leads Steering Group. This mechanism enables the health board to manage compliance with the Welsh Language Standards and continue work to ensure continuous improvements to Welsh language service provision. A review of the action plans provided shows the majority were updated during February and March 2021. Further examination of these has also identified standards that have not been met and actions with overdue target dates. It is recognised that the last 12 months has proved challenging and it has been difficult to progress some of the actions within some clinical areas which have been required to focus their efforts on the response to the COVID-19 pandemic. We were informed by the Service Improvement Manager of Welsh and Equality the next steps it to feed the information from the revised departmental action plans into the compliance matrix and determine a course of action for those standards which remain non-compliant or are proving challenging.

A full compliance assessment was undertaken in July 2020. The first Welsh Language Standards Annual Monitoring Report was published in September 2020 which highlighted some of the achievements and good practice throughout 2019-2020. A Welsh language action plan has been developed which includes more specific actions to progress Welsh language objectives and address improvement areas. This will include further promotion of the Standards, the Active Offer Principle and Welsh language and cultural awareness. The health board's Equality Impact Assessment (EIA) policy has also been reviewed and a new EIA template developed which includes consideration of the impact on the Welsh language. EIA training has also

been developed and sessions will be delivered to managers and staff in due course.

A review of the available resources to implement Welsh language and equality objectives has also been undertaken. This resulted in funding allocation to recruit a full-time internal translator and a part-time Welsh language and equality officer which are currently in progress. In addition, a tender process to establish a service level agreement with a selection of external Welsh language translation providers was completed in January to allow the health board access to more timely translation services to meet the increasing demand in line with the requirements of the Standards.

Deprivation of Liberty Safeguards (DoLS)

Previous Finding 1 – Managing Authority – Non-compliance and ineffective oversight

Our original audit identified a number of areas of non-compliance with the DoLS Code of Practice and health board procedures, which demonstrated a lack of understanding of the Mental Capacity Act 2005 (MCA), DoLS and the Managing Authority role amongst ward staff. This represented a significant risk to the health board and was reflected within the Nursing & Midwifery Directorate risk register. Whilst training was undertaken during 2018, there remained an evident lack of understanding amongst the staff interviewed. Additionally, our review of the health board's DoLS processes highlighted ineffective governance and oversight mechanisms.

A paper providing an update on the progress of the LPS was presented to the Executive Committee on 7 April 2021. This gave an overview of the Mental Capacity (Amendment) Act 2019, which received Royal Assent on 16 May 2019 and provides for the repeal of the DoLS contained in the MCA, and their replacement with a new scheme called the Liberty Protection Safeguards (LPS). In July 2020 the government announced the new legislation will come into force 1st April 2022. The current DoLS system will run alongside LPS for one year following its commencement to enable those subject to DoLS to be transferred to LPS in a managed way.

The health board developed a DoLS Standard Operating Procedure in October 2019 for front line staff. This was updated in March 2020 in line with All Wales Safeguarding procedures. Regional guidance was also issued during the Covid-19 pandemic by the Mid and West Wales Safeguarding Board. In addition, the DoLS ward audit was introduced in December 2020 to provide monthly overview of every patient admitted and ensure that the DoLS process is monitored. The findings from the first snap shop audits have been shared with the Lead Nurse who will provide a report to the safeguarding strategic group.

The health board has recognised the need to have a solid foundation from which to build LPS upon, this includes ensuring staff have the required knowledge and skills in relation to MCA and DoLS. A suite of resources and have been developed in the past 12 months, including 7 minute briefings and newsletters, to support practitioners improve their skills. In addition to this, MCA training for all patient facing staff is now mandatory. These are being delivered in alternative ways, including utilising teams, question and answer sessions and modular training, to enable a more flexible approach given the impact of the Covid-19 pandemic and the rurality of Powys and difficulty in leaving the ward environment for a full day when travel is incorporated. DoLS Signatory Training was completed in October 2020 with 15 staff now able to authorise DoLS applications. All signatories were able to shadow the process between November and February and a rota is now in place. This increase in signatories will enable the timely sign off of authorisations.

Previous Finding 2 –Timeliness of Application and Authorisation

During 2018/19, the health board experienced issues with ensuring applications are made within the timescales, although we understand the position to be improved on previous years. We understood these timescales to be reflective of national challenges. Action had been taken to reduce the backlog of overdue DoLS authorisations, for example through recruiting a second BIA (due to start in July 2019) and the use of BIAs from an external agency. However, a backlog of 13 overdue applications remained at the end of 2018/19 and the percentage of urgent applications completed within seven days of receipt remained at 17% in quarter 4. It was clear further action was necessary to reduce the backlog, improve timeliness of authorisation and reduce the number of unlawful deprivations of liberty to acceptable levels. This risk was also included in the Nursing & Midwifery Directorate risk register.

The health board continues to closely monitor the DoLS application volumes, including within the quarterly reporting to the Strategic Safeguarding Group. Further analysis, including compliance with required timescales is also undertaken for monitoring with support from the Local Authority. This shows the number of DoLS requests has increased significantly this year compared to last year (354 requests between April 2020 to February 2021, compared to 228 requests in the same period of the previous year). At the same time this increased workload has resulted in the negative impact on performance in relation to the timeliness of requests being completed (28% of requests were completed within the required timescales during 2020/21, down from 41% in the prior year). It is likely that the suite of resources and training programmes (see previous finding 1) has contributed to this, creating a gap between demand and the capacity to undertake DoLS assessments, demonstrated by the large number of assessments still pending each quarter. We were informed that

a number of internal and external factors that contribute to this and, whilst the health board has increased the number of signatories to sign off DoLS requests (see previous finding 1 above), we understand a lack of Best Interest Assessors (BIA's) is causing a bottle neck.

The paper presented to the Executive Committee on 7 April 2021 (referred to in previous finding 1 above) also described the planning required to ensure the health board is prepared for the changes to the process for managing the assessment, authorisation, monitoring and reporting. The health board currently employs one BIA and the current shortfall is estimated at six Best Interest Assessments each week. Support with assessments was sought from staff within the health board who hold the BIA qualification, however staff roles have changed and their availability to support with assessments needs further exploration. Money secured from Welsh Government has been used to address some of the current backlog. However, once the additional Welsh Government funded assessments have been allocated the backlog is expected to increase again. Nationally the number of DoLS assessments requested and completed continues to rise every year. This trend is likely to continue with the increasing age demographics of the population of Wales.

The paper also sets out that the new processes for LPS are designed to facilitate integration of the MCA within everyday practice. One of the implications of this, amongst others, is that the BIA role will no longer exist meaning staff will need to arrange or undertake the assessments and consultations that were previously carried out by the BIAs / Medical Assessor. The health board is currently exploring how the identified gap in BIAs can be best met to meet the demand of assessments and prevent further backlogs. Given the consequences, should the risk materialise, is that patients could be unlawfully deprived of their liberty and the health board subject to challenge and fines, it remains on the Directorate risk register with a high score of 16.

Audit Assurance Ratings

 **Substantial assurance**: **Follow up -** All recommendations implemented and operating as expected.

 **Reasonable assurance**: **Follow up** - All high level recommendations implemented and progress on the medium and low level recommendations.

 **Limited assurance: Follow up -** No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **No Assurance**: **Follow up -** No action taken to implement recommendations.

Prioritisation of Recommendations

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

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
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The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Trust. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Office details:

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

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

Contact details

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

AUDIT, RISK AND ASSURANCE COMMITTEE	**Date of Meeting: 29 April 2021**
Subject :	**Annual Governance Programme 2021/22**
Approved and Presented by:	Board Secretary
Prepared by:	Board Secretary
Other Committees and meetings considered at:	Executive Committee, 21 April 2021

PURPOSE:

The purpose of this paper is to present the draft Annual Governance Programme for 2021/22. The Annual Governance Programme outlines key governance priorities, informed by internal audit, external audit and the board's review of its effectiveness.

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

The Audit, Risk & Assurance Committee is asked to consider the draft Annual Governance Programme.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to CONSIDER the draft Annual Governance Programme for 2021/22, in readiness for Board approval and ongoing implementation.

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

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

ANNUAL GOVERNANCE PROGRAMME 2021/22

April 2021

Purpose
Powys Teaching Health Board is committed to improving governance on a continuing basis through a process of evaluation and review. This programme of work has been designed to strengthen the health board's governance arrangements, ensuring they are robust and fit for purpose. Further, at the time of developing this programme of work, the organisation continues to respond to the ongoing challenges of the COVID-19 pandemic and so inevitably there is a need to ensure the organisation's governance arrangements remain agile and proportionate.

The Board approved its Organisational Development (OD) Framework in May 2019. The OD Framework outlines the development priorities to improve organisational effectiveness, enabling the health board to be best placed to deliver against its commitments for the population of Powys (set out in the strategic priorities of the Board). An agreed organisational Operating Model underpins the OD Framework. This seeks to balance the key elements that exist within any organisation, knowing that a lack of focus in any area will have an impact on the others: Strategy; People; Structure; Process; and Culture.

The Annual Governance Programme therefore focuses on:

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

This programme of work will address areas identified for improvement over recent months, informed by Internal and External Audit and the Board's reflections on its effectiveness.

What is Governance?
For the NHS in Wales, governance is defined as:
"A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives."

In simple terms, it refers to the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector. The effectiveness of governance arrangements has a significant impact on how well organisations meet their aims and objectives[1].

Governance is a wide-ranging term; it encompasses concepts such as leadership, stewardship, accountability, scrutiny, challenge, ethical behaviour, values, partnership working and control. It is the process by which leaders execute their responsibilities and authority and how they account for that authority in relation to those that have entrusted them with assets and resources.

[1] The Good Governance Guide for NHS Wales Boards

NHS leaders are increasingly aware that high quality and sustainable healthcare depends on boards and organisations that are capable of building and maintaining mature, sophisticated partnerships across the complex, multi-faceted local health and social care landscape. Whilst boards and staff of NHS organisations demonstrate daily their deep commitment to providing effective, safe, compassionate care, instances of serious failure have provided very painful lessons and have undermined public trust.

Assessment of Existing Governance Arrangements

External Audit
On an annual basis, Audit Wales (External Audit) undertakes a Structured Assessment which seeks to examine the arrangements NHS bodies have in place to support good governance, sound financial management, and the efficient, effective and economical use of resources.

During 2020, Audit Wales undertook its Structured Assessment work at a time when NHS bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. The work was therefore designed within this context and predominantly focussed on corporate arrangements for ensuring that resources are used efficiently, effectively and economically.

In respect of governance, Audit Wales concluded its Structured Assessment work in November 2020, reporting:
"Overall, we found that the Health Board has maintained good governance arrangements during the pandemic. The Board adapted its governance arrangements to maintain openness and transparency, support agile decision making and ensure effective scrutiny and leadership during the pandemic. The Board is committed to using learning to help shape future arrangements.
The Health Board's risk management system ensured it was well placed to respond to COVID-19-related risks. The Health Board is strengthening its quality assurance arrangements, including updating key policies and adapting its commissioning assurance arrangements."

The report of Audit Wales set out its findings along with those improvement opportunities identified through the work undertaken. These improvement actions have been accepted by management and will be addressed through the implementation of the priority actions set out within this Annual Governance Programme.

Internal Audit
The Head of Internal Audit Opinion 2020/21 concluded that **"***The Board can take* ***reasonable assurance*** *that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively."*

Whilst Internal Audit was able to provide the board with a reasonable level of assurance, areas of weakness were identified for improvement. This Annual Governance Programme includes actions which will address the areas for improvement in governance, identified by internal audit.

The Board's Review of Effectiveness

The Board remains committed to the evaluation and review of its governance systems, processes and business conduct on a regular basis to support continuous improvement.

In April 2021, the Board undertook a process of self-review on the effectiveness of board and committee arrangements, including conduct of business, to ensure that arrangements remain fit for purpose and aligned to its updated annual strategic priorities.

This Annual Governance Programme is therefore cognisant of those required improvements identified by the Board.

Governance Objectives

The following objectives have been established to strengthen the health board's governance arrangements, ensuring they are robust and fit for purpose. This will be achieved by maintaining a robust framework for governance that considers the organisational context and strives for continual improvement.

1. Ensuring Clarity of Purpose, Roles, Responsibilities 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
   b) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of the organisation, along with strengthened internal control
   c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical
   d) Further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship.

2. Ensuring Board Effectiveness
   a) Review and strengthen the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure
   b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum and the Stakeholder Reference Group
   c) Ensure openness and transparency in the conduct of board and committee business

d) Further improve the quality of information to the Board and its Committees
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
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and engagement
h) Review and implement arrangements for the development, review, approval and publication of policies delegated by the Board
i) Review Board Champion Roles, ensuring clarity on purpose and responsibility.

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
   b) Promote a Risk Management Toolkit to support staff in the identification, recording and management of risk
   c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks
   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])
   e) Embed the Board's Assurance Framework, aligned to the Corporate Risk Register and Organisational Risk, where appropriate;
   f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.

In addition to the above, there are a number of supporting frameworks and plans which, when implemented, will contribute to the effectiveness of organisational governance. These include the:

- Clinical Quality Framework;
- Records Management Improvement Plan;
- Information Governance Annual Workplan;
- Improving Performance Framework.

Delivery and Monitoring

The workplan required to deliver these objectives is attached at **Annex A**. This provides clarification on the actions required, responsible lead and associated timescales.

Delivery of the Annual Governance Programme will be overseen by the Audit, Risk and Assurance Committee, included as a key programme of

work to support the Committee in assuring the Board on the effectiveness of the organisation's governance arrangements.

Objective	Planned Deliverables	Lead
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	Quarters 1-2, 2021/22: • Adopt amendments to Standing Orders, as per nationally-led work • 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 • Board Scheme of Delegation and Reservation of Powers presented to Board for approval in September 2021/22 Quarter 4, 2021/22: • Adopt revised Standing Financial Instructions as per nationally-led work • Undertake an assessment of compliance with Standing Orders	• Board Secretary • Director of Finance & IT (SFIs)
b) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of the organisation, along with strengthened internal control	Quarters 1-4, 2021/22: • Organisational Structures to be confirmed via Organisational Realignment Working Group • 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	• Board Secretary with all Executive Directors
c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Quarters 1-2, 2021/22: • Identify all existing partnerships and collaborations to inform development of a Framework • Mapping of these partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes Quarters 3-4, 2021/22: • Development and population of a Partnership Register	• Board Secretary with Director of Planning & Performance

Objective	Planned Deliverables	Lead
	• 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	Quarters 1-4, 2021/22: • Embed Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee • Fully implement an electronic system to support recording and reporting of declarations made	• Board Secretary
2. ENSURING BOARD EFFECTIVENESS		
a) Review and strengthen the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure	Quarter 1, 2021/22: • Review committee structure for implementation in 2021/22 • Review committee terms of reference and operating arrangements with any changes presented to Board for approval in May 2021 • Review committee membership with any changes presented to Board for approval in May 2021 • Fully populate committee workplans, aligned to the Corporate Risk Register and Board Assurance Framework, for Board approval in May 2021	• Board Secretary and Chair/Committee Chairs
b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum (HPF) and the Stakeholder Reference Group (SRG)	Quarters 1-2, 2021/22: • Review Terms of Reference and membership of the Stakeholder Reference Group • 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 Quarters 2-3, 2021/22: • 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	Board Secretary with: • Director of Planning & Performance (SRG) • Clinical Directors (HPF)

Objective	Planned Deliverables	Lead
c) Ensure openness and transparency in the conduct of board and committee business	Quarters 1-4, 2021/22: • Review effectiveness of live streaming board meetings • 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	• Board Secretary • Chair
d) Further improve the quality of information to the Board and its Committees	Quarters 1-4, 2021/22: • Board & Committee report templates to be reviewed to ensure assurance reports are distinguished from reports for management • Report Writing and Presentation Masterclasses to be held for senior management team, via the Management Development Programme	• Board Secretary • Director of Workforce & OD
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	Quarters 1-4, 2021/22: • Board review of effectiveness to be undertaken in April 2021 • Implement a programme of development and a programme of briefings for 2021/22 • Ongoing implementation of an Executive Director Development Programme • Design and implement training and development for Independent Members	• Board Secretary • Chair • Director of Workforce & OD
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required	Quarters 1-4, 2021/22: • Work with Public Bodies Unit to prepare and deliver recruitment campaigns for upcoming vacancies • Implement an Induction Programme for Board Member appointments when required	• Board Secretary • Director of Workforce & OD
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and engagement	Quarters 1-4, 2021/22: • Design and implement a schedule of visits to a range of clinical and non-clinical services and county-wide health board sites	• Board Secretary • Chair • Chief Executive
h) Review and implement arrangements for the development, review, approval and publication of policies delegated by the Board	Quarters 1-2, 2021/22: • Policy Management Framework to be reviewed, confirming policy approval routes • Policies section of intranet/internet to be refreshed • Policy toolkit to be rolled out with awareness raising	• Board Secretary and Executive Director Policy Owners

Objective	Planned Deliverables	Lead
	Quarter 3 and ongoing: • 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.	Quarter 1, 2021/22: • Review delegation of Champion roles to Board Members • Adopt role specifications for Champion roles • Establish reporting arrangements for Champions to Board	• Board Secretary • Chair
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	Quarters 1-2, 2021/22: • Undertake an Annual Review of Risk Management Framework, ensuring alignment with the Board's Assurance Framework Principles • Risk Management Framework to be updated to reflect Risk Appetite Statement • Establish Committee Risk Registers	• Board Secretary
b) Promote a Risk Management Toolkit to support staff in the identification, recording and management of risk	Quarters 1-2, 2021/22: • Publish a Toolkit including the process for escalation and de-escalation, examples of best practice to support moderation and consistency in measurement • Toolkit to be updated in line with review of Risk Management Framework, Risk Appetite Statement and Board Assurance Framework Principles.	• Board Secretary
c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks Patterson,Liz 04/23/2021 12:33:27	Quarters 1-2, 2021/22: • Risk Appetite Statement to be considered by Board in June 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 • Risk Management Framework to be updated to reflect Risk Appetite Statement and communicated with the organisation	• Board Secretary
d) Prepare for implementation of a revised risk register reporting system to ensure it is	Quarters 1-4, 2021/22	• Board Secretary

Objective	Planned Deliverables	Lead
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 • 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	Quarters 1-4, 2021/22: • Undertake an Annual Review of Assurance Framework Principles, ensuring alignment with the Board's Risk Management Framework • Board and committee workplans aligned to Assurance Framework • Assurance Framework updated quarterly, in-line with integrated performance reporting and delivery of audit programmes	• Board Secretary
f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.	Quarters 1-4, 2021/22: • 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 • Gaps in assurance to inform the Board's Assurance Framework	• Board Secretary and all Executive Directors

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 20 July 2020**
Subject:	**COMMITTEE WORK PROGRAMME 2021-22**
Approved and Presented by:	Rani Mallison, Board Secretary
Prepared by:	Caroline Evans, Head of Risk & Assurance
Other Committees and meetings considered at:	n/a

PURPOSE:

The purpose of this paper is to provide the Committee with its draft work programme for 2020-21 (**Appendix A**), ahead of presentation to the Board for approval.

RECOMMENDATION(S):

The Committee is asked to discuss the work programme for 2021-22, as appended to this report, ahead of presentation to Board for approval.

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

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

Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care	1. Staying Healthy	
	2. Safe Care	

Standards:	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Good governance practice dictates that Boards and Committees should be supported by an annual programme of business that sets out a coherent overall programme for meetings. The forward plan is a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that doesn't place an onerous burden on those in executive roles and create unnecessary or bureaucratic governance processes.

The proposed work programme for the Audit, Risk & Assurance Committee for 2021-22 is attached as **Appendix A**.

The work programme has been developed in-line with respective terms of reference, the Board's Assurance Framework and Corporate Risk Register. The work programme will be reviewed routinely at each meeting.

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

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

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

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

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-2022						
		29 April	08 June	12 July	14 Sept	16 Nov	20 Jan	22 March
Governance & Assurance:								
Approach to 2021-22 Annual Accounts	DF&IT							✓
Annual Accountability Report 2020-21	BS	✓	✓					
Annual Accounts 2020-21, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit of COVID-19 Governance Arrangements	BS	✓						
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Charitable Funds Annual Report and Accounts 2020-21	DF&IT					✓		
Losses and Special Payments Annual Report 2020-21	DF&IT		✓					
Losses and Special Payments Update report	DF&IT			✓			✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS				✓			
Review of Standing Orders	BS					✓		
Internal & Capital Audit:								
Head of Internal Audit Opinion 2020-21	HoIA	✓						
Internal Audit Progress Report 2021-22	HoIA	✓	✓	✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2021-22**						
Internal Audit Plan 2022-23	HoIA							✓
External Audit:								
External Audit Annual Report 2021	EAO						✓	

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

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

KEY:

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

IM&T Control and Risk Assessment

Final Internal Audit Report

2020/21

Powys Teaching Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	PTHB-2021-16
Report status:	Final Audit Report
Fieldwork commencement:	12/08/2020
Fieldwork completion:	18/12/2020
Draft report issued:	13/01/2021
Draft report clearance meeting:	13/01/2021
Management response received:	23/02/2021
Final report issued:	23/02/2021
Auditors:	Helen Higgs, Head of Internal Audit Martyn Lewis, Information Management & Technology (IM&T) Audit Manager Kevin Seward, Senior IM&T Auditor
Executive sign off:	Pete Hopgood, Director of Finance and Informatics
Distribution:	Vicki Cooper, Assistant Director (Digital Transformation)
Committee:	Audit, Risk and Assurance Committee ICT Governance Committee

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

ACKNOWLEDGEMENT

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

This baseline review of the arrangements in place for the management and control of Information Governance (IG) and Information Communications Technology (ICT) has been completed in line with the 2020/2021 Internal Audit Plan for Powys Teaching Health Board (the 'health board' or the 'organisation'). The review seeks to provide a baseline picture to the Audit Committee of the processes in place to manage the risks associated with IG the use of ICT.

As this is a baseline review, the assignment has not been allocated an assurance rating, but observations and recommendations have been provided to facilitate change and improvement, and to focus audit work in the future.

The relevant lead for the review was the Director of Finance and Informatics.

2. Scope and Objectives

The objective of the audit was to establish the processes and mechanisms in place for management of IG/ICT within the organisation. The review sought to provide a baseline picture of the organisation's status and provides suggestions for areas of improvement or future development.

The areas considered within the review are:

Information Governance

- The information governance process in place.
- IG policies and procedures in place.

ICT and Security

- ICT responsibilities are clear.
- ICT strategy, linked to organisational strategy.
- The ICT governance process in place.
- The funding / resource available for ICT and its sustainability.
- IT security policies and procedures.
- ICT provision and support arrangements across the organisation.
- IT continuity and disaster recovery processes.
- Compliance against obligations (e.g. GDPR, NIST, PCI DSS etc.)
- The process to track ICT assets.
- IG / ICT risk identification and management.

3. Associated Risks

The potential risks considered in this review are as follows:

- the ICT strategy does not effectively support the Organisation in delivery of its objectives and not supported by effective governance and/or delivery arrangements;
- un-coordinated ICT related financial activities in both the business and IT functions, covering budget, cost and benefit management and prioritisation of spending;
- the ICT services provided do not fully meet the needs of the organisation;
- ICT services are subject to loss of service;
- inappropriate access to systems and data; and
- breach of legal compliance requirements.

OPINION AND KEY FINDINGS

4. Conclusion

As this is a baseline review we have not allocated an assurance rating. Observations and recommendations have been provided to facilitate change and improvement, and to focus audit work in the future.

For this review we used the expected controls derived from the Control Objectives for Information and Related Technologies (COBIT) 2019 framework and we have reported using the subheadings of these control processes for governing organisational IT.

COBIT is an IT management framework developed by the Information Systems Audit and Control Association (ISACA) to help organisations develop, organise and implement strategies around information management and governance.

As part of our assessment we scored the individual controls in place at the health board against the controls we would expect to be in place under each of the headings of the framework. These scores have been represented graphically below to illustrate the strengths and potential for improvement in the organisation's management of IG / ICT.

The scoring reflects the level of compliance with the controls set out within the COBIT framework, and the extent to which they apply across the entire organisation.

The health board scored well under many of the headings, in particular against: Managed IM&T Management Framework; Information Governance; Governance Framework; Managed Operations; Managed Risk and Ensured Risk Optimization.

However, there are opportunities for improvement across some of objectives. The key areas requiring management attention are identified from the scoring. These were: Managed Compliance with External Requirements; Managed Projects and Managed Human Resources. Managed Strategy was also an area that scored low, however it should be noted that this was to be expected given that the organisation has only recently started to develop this area and efforts have been delayed as a result of the pandemic situation.

More detail can be found on these opportunities in section 4 below, and in Appendix A.

The percentage score for each objective is set out in the table below:

Control area	Percentage	No. of Observations/ Recommendations
Information Governance	100%	-
Ensured Governance Framework Setting and Maintenance	83%	-
Managed Compliance with External Requirements	64%	1
Ensured Risk Optimization	100%	-
Managed Risk	82%	1
Managed I&T Management Framework	80%	2
Managed Strategy	39%	2
Managed Budget and Cost	74%	1
Managed Human Resources	53%	2
Managed Security	64%	2
Managed Security Services	80%	-
Managed Assets	76%	1
Managed Operations	94%	-
Managed Continuity	79%	1
Managed Projects	69%	1
Total	**-**	**14**

5. Assurance Summary

Objective 1: Information Governance

Control Area: Information Governance (100%)

There is an established process for Information Governance (IG) at the health board with key strategic responsibilities such as Senior Information Risk Owner (SIRO) and Caldicott guardian assigned to appropriate officers.

There is an IG team to support the organisation, and a suite of IG control documents to support the IG agenda, these are available on the intranet, and form part of induction and organisational training.

IG issues are monitored via the Performance and Resources Committee, and there is an Information Governance Group as the framework for compliance. There are leads and champions which ensures IG is embedded within the organisation.

The health board has a publication scheme in place, along with a disclosure log and an Information Asset Register.

There are no findings/recommendations under this objective.

There are no recommendations under this objective.

Objective 2: ICT and Security

Control area: Ensured Governance Framework Setting and Maintenance (83%)

There is a formal governance structure in place for Informatics and Information Governance with a named Committee and work plans. The structure is underpinned with champions and operational groups feeding up to the Committee.

There is an Internal Audit programme monitored by the Audit Committee which includes Informatics and Information Governance. Reports and findings are also monitored by the joint ICT governance committee.

The terms of reference for the committee and groups which make up the governance structure set out the frequency for review of its effectiveness.

There were no recommendations under this objective.

Control Area: Managed Compliance with External Requirements (64%)

There is evidence of the identification and monitoring of some compliance requirements, in particular the IG items, responsibility to monitor compliance of the health boards IG responsibilities is assigned to the performance and resource committee.

While there is some evidence of the identification of compliance requirements relating to IM&T and the compliance position on some areas such as the GDPR and FOI are well reported, there is no formal register of compliance requirements for IM&T and there is no structured process to identify all the compliance requirements, assessing the compliance status and feeding the position in relation to requirements, status and consequences upwards to committee.

See Observation/Recommendation 1 at Appendix A.

Policies and standard NHS maintenance contracts refer to relevant legislation and standards, and are reviewed in line with their health board approved review period.

The organisation performs some periodical compliance audits for licencing, NIAS and GDPR audits. It also uses external audit organisations such as NWSSP AAS, Audit Wales, Stratia etc. to perform assurance work prioritised by risk, this sometimes looks at compliance issues.

Control Area: Ensured Risk Optimisation (100%)

The risk management process is well established and is consistent with other health organisations we have looked at. It provides key steps to ensure feedback through a monitoring and review process and appropriate communication and consultation.

Risk management processes are in place, are formally defined and include a structure for escalation via committee. Risks are actively monitored with clear escalation from the IT department to committee with the highest risks added to the corporate risk register.

There were no recommendations under this objective.

Control Area: Managed Risk (82%)

There is a process for identification and collation of ICT related risks within a consistent risk register.

As noted above the risk management process works to ensure that executives and independent members are informed of the risks with the

highest score. However, there is no process to formally notify senior management of risks being managed at a lower level which contain a severe or catastrophic worst-case scenario.

See Observation/Recommendation 2 at Appendix A.

There is a link from incident / event reporting whereby information from operational staff is communicated to management to feed the process. The impacts of risks are assessed and actions are defined to manage the risk within accepted tolerance levels.

Control Area: IM&T Management Framework (80%)

The organisation has an appropriate steering structure for ICT and Information Governance. There are operational subgroups in place which feed into the senior team / steering group for operational management.

There are defined I&T related roles and responsibilities for the organisation which delineate responsibilities and accountabilities and appropriate stakeholders are included on the committee and the steering groups.

While there are appropriate stakeholders included on the organisations steering groups for ICT and IG, there is currently no clinical lead for ICT, the existing structure could be strengthened by the appointment of a Chief Clinical Information Officer (CCIO).

A Chief Clinical Informatics Officer provides leadership and management of ICT and information development activity to support the safe and efficient design, implementation and use of informatics solutions to deliver improvements in the quality and outcomes of care. This includes: providing expert clinical informatics advice and guidance; working collaboratively with others to ensure patient and clinical involvement in the planning, development, delivery and evaluation of systems and services; and championing the use of informatics as an enabler of change and quality improvement.

See Observation/Recommendation 3 at Appendix A.

The organisation uses standard supervisory practices to ensure that roles and responsibilities are properly exercised and generally to review performance

The model for ICT delivery and support was the result of a formal restructure when the health board entered into the section 33 agreement with PCC, so the organisation is aware of the context and placement of ICT.

The organisation has created and communicated a set of policies which set out control expectations on relevant key topics such as security, privacy, confidentiality, internal and usage of IT assets.

While the health board have a number of IG polices communicated via its intranet site the Information Technology policies are limited to a selection of all wales NHS polices and two others which have recently been adapted from Powys County Council policies for NHS use.

See Observation/Recommendation 4 at Appendix A

Control Area: Managed Strategy (39%)

Currently the Organisation does not have an approved ICT Strategy, the Digital Strategic Framework was due to be drafted 2020/2021, however the Covid situation has impacted the work needed to develop and approve this.

This means that there is no full, current assessment of the external environment in which ICT in the health board operates and no current evaluation of the current position of the health board relating to architecture, applications, culture, challenges. Neither has the full range of stakeholders and the extent to which they should feed into the development of the Strategy been identified.

See Observation/Recommendation 5 at Appendix A.

While ICT strategy development at the health board is in its infancy a high level document setting out the priorities for next 12 months has been developed. An assessment of the current way of working (baseline) was taken and a summary gap analysis completed and referenced in the plan.

The plan explicitly aligns to health board Digital First objectives and workforce futures strategy and stakeholders were involved via a number of workshops and feedback sessions in its development. The plan identifies technology and skills required to deliver the organisations current ICT projects and also identifies where 3rd party may be used for specific skills and deliverables.

Although the IMTP and Divisional plans set out the target services required by the organisation, this is only in terms of the specific systems / applications needed. There is no consideration of wider, supporting items such as validated emerging technology or innovation ideas, reference standards, IM&T capabilities, comparative benchmarks of good practice, and emerging IM&T service provision.

See Observation/Recommendation 6 at Appendix A.

The health board has a number of Champions identified specifically to support the Digital Transformation strategy and engagement is via Exec Boards, Governance Committees and Transformation Programme Boards. The plan was communicated via these stakeholders and groups.

Control Area: Managed Budget and Cost (74%)

Funding for ICT is available and reported under a defined cost centre and identification of spend level for the whole organisation is achievable by the finance department upon request. Standard NHS finance practice ensure all items of ICT spend are identifiable.

There is a standard budget monitoring process which provides the department with a monthly breakdown and includes variance analysis.

While the department has been allocated resources to deliver the ICT goals, the department budget is not based on actual need. Instead it was based previous years with some changes factored in. This means it does not fully cover the financial resource needed to achieve the organisations ambitions and without future investment overspending may occur against budgets.

See Observation/Recommendation 7 at Appendix A.

The organisation uses business cases to rank all IM&T initiatives and budget requests for Development, New build, Information, Information Governance and Programmes.

Control Area: Managed Human Resources (53%)

There is a workforce plan and events are held where staff have the opportunity to share learning across both PCC and PTHB and also identify training gaps. Process documentation exists for some key tasks which could be used in the absence of key staff.

For health board staff, training is recorded and proposed training is identified via the PADR process which then feeds into a single record of training requirements that is prioritised and provided within funding limits. Council staff have a similar process of workforce appraisals.

While the organisation understands its current demands, and work to formulate the ICT strategy has begun, there hasn't yet been a full assessment of what skills and resource would be needed to support the organisational IMTP and implement the ICT Strategy once completed.

Consequently, there has been no identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place ICT may struggle to implement any future ICT strategy.

See Observation/Recommendation 8 at Appendix A.

Through previous audits and through a recent evaluation of priorities carried out by the health board it has been identified that some support requirements such as project management and telephony do not have sufficient resources to deliver the organisations ambitions.

See Observation/Recommendation 9 at Appendix A.

Control Area: Managed Security (64%)

There is a dedicated technical operational lead for cyber security covering both council and health. This Cyber Security Officer draws on available resources in Infrastructure and field Service engineers as required. Additional resource is called in when required and communication streams are opened quickly and remotely using Teams/Skype meetings.

There is a joint health board and council cyber security action plan. There is an appropriate group monitoring the cyber security action plan and the recommended resource required is noted against actions. Additional actions are also included from internal and external Audits. ICT and IG Risks including Cyber Response and Threat are included on the service Risk Register.

There are no formally defined KPIs which feed into the health board's governance structure which track the status of cyber security and the success of the team in managing the issues.

See Observation/Recommendation 10 at Appendix A.

The national logarithm Security Incident and Event Management (SIEM) tool has been implemented and key cyber tasks like patching and monitoring dashboards for our Sophos AV, Force point Web Filtering and Cisco / Fort iGATE Firewalls.

National Cyber Security team meetings (OSSMB) take place virtually every week consisting of a Security representation from each health board in Wales. PTHB has been represented on each weekly meeting and actions and observations are fed back within the relevant teams.

While all health board staff are required to complete the Information Governance mandatory training, Staff are not required to undertake any other Cyber awareness development.

See Observation/Recommendation 11 at Appendix A.

Control Area: Managed Security Services (80%)

Systems for antivirus protection, web and mail filtering have been deployed at the health board. There is collaboration with national cyber groups including the NHS Wales Operational Security Service Management Board (OSSMB). Regular alerts are provided as part of this group which are then assessed and acted upon locally. There is also a security operations centre in place which provides alerts for new threats.

There are firewalls in place at the edge of the health board's network. Changes to the rules require and appropriately approved request and the rules are reviewed periodically.

The network is governed by a standard NHS Wales code of connection. The Code of Connection (CoCo) process is designed to ensure that appropriate levels of assurance are provided for organisations requiring a connection to the NHS Wales Network. In order to provide this assurance the NWIS' Cyber Security Team requires documentation to be completed by any organisation wishing to connect.

There is a process of unique authentication for networked devices to access and be attached to the corporate domain and the network is segmented into different sections in order to increase security.

There is a process for identification and management of security vulnerabilities, the organisation has at its disposal a portfolio of supported technologies, many of these have been procured nationally and funding provided via Health, access to the National Vulnerability scanner is available and intrusion detection systems in place. Penetration testing takes place and vulnerability scans are undertaken locally.

Security incidents are monitored and there is a Major Incident Response Plan in place that sets out how the organisation will react and deal with cyber threats.

There were no recommendations under this objective.

Control Area: Managed Assets (76%)

A register is in place which records all IT equipment. Council End User Services (EUS) are undertaking a review of asset management / recording with a view to consolidating the various inventories into the service desk tool. Going forward this will make it easier to link assets to incident/request reporting and management of the asset lifecycle.

Servers/client devices are purchased with support warranties to cover the planned asset lifecycle. There is a 5-year capital refresh plan that identifies asset lifecycle and refresh requirements.

Assets are maintained by patching and replacement at end of life. Microsoft Endpoint Manager is used to deploy software updates and patches to managed assets. The Network team use Cisco Prime Infrastructure to manage the switch/wireless network including updates.

There is an Asset Disposal procedure in place, this sets out the process to follow for the decommissioning of assets. Disposal certificates are obtained which allow assets to be tracked to disposal.

Currently there is no process for the identification and assessment of assets which are critical for the delivery of the health board's services.

See Observation/Recommendation 12 at Appendix A.

Control Area: Managed Operations (94%)

Threats to service provision are identified such as fire risk and loss of power, and mitigations are in place.

The server rooms have adequate protection based on risk assessment. There is a process in place for monitoring the environment of the server rooms using equipment that ensures warnings are produced in the event of abnormal conditions.

There is a process to ensure server rooms are kept secure, tidy and free from environmental hazards. There is a regular physical check to ensure that the rooms are protected and kept clear with staff taking action when needed.

The designed architecture is resilient through replication across two sites, which minimises the risks associated with the loss of individual servers.

The main site has dual power supplies to ensure continuity. There is an Uninterruptible Power Supply (UPS) in place for the servers. UPS' will self-monitor and log, they are networked and will send reports to Network Team who would undertake failover tests when required.

There were no recommendations under this objective.

Control Area: Managed Continuity (79%)

The health board has documented processes for ICT Major Incidents, Disaster Recovery (DR) and Backup. These are underpinned by several continuity SOPs which are used to support the recovery of key systems in the event of an incident.

Key incident response and process document set out the severity categories and gives examples of critical problems. From the documentation we can

see that RTO and RPO have been set for services. Plans have conditions for invocation.

Recovery procedures are in place so that processing can be re-established, including recovery of missing data. The IT resources required (management and support of incident) to support continuity and recovery are identified in the major incident process document.

Elements of Business Continuity Plans (BCP) are regularly tested, the ICT department Business Continuity (BC) plans are reviewed annually and the BC process for the health board is set out in the Business Continuity Management Policy, it states that The Civil Contingencies Manager will monitor compliance of this policy as part of the annual review of BCPs. The Planning and Strategy Committee will seek assurances that the health board's BCPs and arrangements are adequate, effective and robust. All activities in respect of Business Continuity Management (BCM) are incorporated into the Annual Report on Civil Contingencies Planning, which is subject to approval at Board level.

IT staff are aware of the BCP plans and have used the SOPs to backup and recovery systems in the past, the IT BC Plan is discussed as part of annual Plan review, BCP training for the systems will be the department responsibility and this will take place locally outside of IT area of responsibility.

Backups take place daily which are replicated to offsite storage. Regular backup and restores take place, testing the capabilities regularly.

While the approved recovery procedures and major incident process detail steps to be taken to recover and rebuild in the event of an incident, different continuity options have not been defined and the differing options to deliver these costed.

The extent to which management have approved the current continuity position cannot be considered informed approval without other available options noted and costed.

See Observation/Recommendation 13 at Appendix A.

Control Area: Managed Projects (69%)

There is a record of all ICT projects underway. These projects are run in accordance with PRINCE2 methodology and procedures, guidance and templates for project management are place.

Project Managers employed by the health board are PRINCE2 certified and encouraged to take the Practitioner and ITIL Foundation Certificate in Service Management qualifications.

The health board have identified concerns in the ICT plan in relation to Project/Programme management, there is limited Project Management resource available to deliver the number of planned improvements required to support the organisations ambition, improvements are required to ensure frequent and meaningful reporting on progress of ICT projects within the health board.

See Observation/Recommendation 14 at Appendix A.

6. Summary of Observations and Recommendations

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

Design of Systems/Controls

Our fieldwork has highlighted no observation/recommendations that can be classified as a weakness in the system controls/design.

Operation of System/Controls

Our fieldwork has highlighted fourteen observations/recommendations that can be classified as weaknesses in the operation of the designed system/controls.

Observation 1 – Monitoring compliance (Operation)
There is some evidence of the identification of compliance requirements relating to IM&T, the compliance position on some areas such as the GDPR and FOI are well reported, however there is no formal register of compliance requirements for IM&T and there is no structured process to identify all the compliance requirements, assessing the compliance status and feeding the position in relation to requirements, status and consequences upwards to committee.
Recommendation
The organisation should maintain oversight of the extent to which IM&T satisfies obligations (regulatory, legislation, common law, contractual), internal policies, standards and professional guidelines. A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for reporting status upwards via the appropriate committee.
Management Response, Responsible Officer and Deadline
Agreed – The Informatics team structure has recently been strengthened and this will support the development of a formal register. The Informatics team will work and liaise with the Information Governance team and other departments as needed to identify the best way to implement and maintain. Lead – The Digital Business Manager, accountable to the Assistant Director Digital Transformation & Informatics Target Implementation Date - July 2021

Observation 2 – Communicating managed risks (Operation)
While the department risk register is monitored via the standard health board process and reported via Committee and Board, the process could be improved with monitoring of the risks being managed at a lower level which contain a sever worst case scenario.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Noted and agreed – 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. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics . Target Date – October 2021

Observation 3 – Clinical lead for ICT (Operation)
While there are appropriate stakeholders included on the organisations steering groups for ICT and IG, there is currently no clinical lead for ICT. A Chief Clinical Informatics Officer (CCIO) provides leadership and management of ICT and information development activity to support the safe and efficient design, implementation and use of informatics solutions to deliver improvements in the quality and outcomes of care. This includes: providing expert clinical informatics advice and guidance; working collaboratively with others to ensure patient and clinical involvement in the planning, development, delivery and evaluation of systems and services; and championing the use of informatics as an enabler of change and quality improvement.
Recommendation
The organisation should consider assigning the responsibility of CCIO.
Management Response, Responsible Officer and Deadline
Noted and agreed - 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. Lead – Assistant Director Digital Transformation & Informatics Target Date - October 2021

Observation 4 – Policy publication (Operation)
The organisation has created and communicated set of policies which set out control expectations on relevant key topics such as security, privacy, confidentiality, internal and usage of IT assets. While the health board have a number of IG polices communicated via its intranet site the Information Technology policies are limited to a selection of all wales NHS polices and two others which have recently been adapted from Powys County Council policies for NHS use.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Agreed – 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. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics Target Date - Oct 2021

Observation 5 – ICT Strategy (Operation)
Currently the Organisation does not have an ICT Strategy, the Digital Strategic Framework was due to be drafted 2020/2021, however the Covid situation has impacted the work needed to develop and approve this and the Strategy development in still in its infancy. This means that there is no full, current assessment of the external environment in which ICT in the health board operates and no current evaluation of the current position of the health board relating to architecture, applications, culture, challenges. Neither has the full range of stakeholders and the extent to which they should feed into the development of the Strategy been identified.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Agreed - The Digital Strategic framework will be restarted and is fundamental to our 3-5 year delivery model for Digital Transformation and Informatics.

Lead – Assistant Director Digital Transformation & Informatics Deadline – October 2021

Observation 6 – Strategy Items (Operation)
Although the IMTP and Divisional plans set out the target services required by the organisation, this is only in terms of the specific systems / applications needed. There is no consideration of wider, supporting items such as validated emerging technology or innovation ideas, reference standards, IM&T capabilities, comparative benchmarks of good practice, and emerging IM&T service provision.
Recommendation
The development of the strategy should consider the wider ICT strategy implications and the supporting technical infrastructure.
Management Response, Responsible Officer and Deadline
Noted and agreed, as per response to Observation 5 as clearly linked. Lead – Assistant Director Digital Transformation & Informatics Deadline – October 2021

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Observation 7 – Budget creation (Operation)
While Informatics has been allocated resources to deliver the ICT goals, the department budget is not based on actual need. Instead it was based previous years with some changes factored in. This means it does not fully cover the financial resource needed to achieve the organisations ambitions and without future investment overspending may occur against budgets.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Noted and agreed – 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.

Lead – Assistant Director Digital and Informatics

Target Date – This is an ongoing process so difficult to identify an exact date as will change as BC completed etc. but we will work towards completing within six months of the deadline for Observation 5 – ICT Strategy.

Deadline – April 2022

Observation 8 – ICT Resource Demand (Operation)
While the organisation understands its current demands, and work to formulate the ICT strategy has begun, there hasn't yet been a full assessment of what skills and resource would be needed to support the organisational IMTP and implement the Strategy once completed. Consequently, there has been no identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place ICT may struggle to implement any future ICT strategy.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Noted and agreed, as per response to Observation 6 and 7as clearly linked. Lead – Assistant Director Digital Transformation & Informatics Deadline – October 2021

Observation 9 – Sufficient resources (Operation)
Through previous audits and through a recent evaluation of priorities carried out by the health board it has been identified that some support requirements such as project management and telephony do not have sufficient resources do deliver the organisations ambitions.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Noted and agreed as per Observation 7. Lead – Assistant Director Digital Transformation & Informatics Deadline – October 2021

Observation 10 – Cyber Security KPIs (Operation)
There are no formally defined KPIs that feed into the health board governance structure which track the status of cyber security and the success of the team in managing the issues.
Recommendation
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.
Management Response, Responsible Officer and Deadline
Agreed – Appropriate KPI's are included as part of the work to review the current S33 and is ongoing to ensure that appropriate. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics with PCC colleagues as part of S33. Target Date - Dec 2021

Observation 11 – Cyber training (Operation)
Apart from the section on the Information Governance mandatory training Health Board staff are not required to undertake any other Cyber awareness development.
Recommendation
The health board should encourage appropriate groups of staff to complete the all wales NHS cyber training.
Management Response, Responsible Officer and Deadline
Agreed - This is available on ESR and all staff encouraged to complete, we will continue to explore if this can be made mandatory. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics Target Date - Dec 2021

Observation 12 – Critical IT assets (Operation)
Although IT assets are recorded and tracked, there is no identification of those assets that are critical to the provision of ICT services for the organisation. Accordingly, there is no formal, regular assessment of the risk of failure of these or the need for replacement.
Recommendation
Critical assets should be identified and be subject to enhanced monitoring an assessment for risk / replacement.
Management Response, Responsible Officer and Deadline
Agreed – Action to completed with PCC partners as part of S33 arrangements. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics Target Date - Dec 2021

Observation 13 – Cost of recovery (Operation)
While the approved recovery procedures and major incident process detail steps to be taken to recover and rebuild in the event of an incident, different continuity options have not been defined and the differing options to deliver this assessed/costed. The extent to which management have approved the continuity option / situation cannot be considered informed approval without other available options noted and costed.
Recommendation
In order to ensure best value approach, differing continuity options should be defined and the differing options to deliver this assessed/ costed.
Management Response, Responsible Officer and Deadline
Noted and agreed - The current procedures and process will be reviewed with PCC partners to ensure up to date and different options identified if available. Lead - The Digital Business Manager accountable to the Assistant Director Digital Transformation & Informatics Target Date - April 2022

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Observation 14 – Delivery of planned IM&T improvements (Operation)
There is limited Project Management resource available to deliver the number of planned improvements required to support the organisations ambition, Improvements are required to ensure frequent and meaningful reporting on progress of ICT projects within the health board.
Recommendation
The health board must ensure resource is available to deliver and report upon the ICT programme.
Management Response, Responsible Officer and Deadline
Noted and agreed – 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. Lead – Assistant Director of Digital and Informatics Target Date - October 2021

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a

substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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PROCURING WELL-BEING IN WALES

A Review into how the Well-being of Future Generations Act is informing procurement in Wales.

February 2021

Contents

This work has been completed in partnership with Cardiff University as part of a Memorandum of Understanding, particularly acknowledging the involvement of:

- **Dr Jane Lynch, Reader in Procurement at Cardiff Business School.**
- **Professor Kevin Morgan, Dean of Engagement.**

I would also like to thank the members of the steering group for their contribution:

Catryn Holzinger, Audit Wales.

Vincent Hanley and Cat Griffith-Williams, Constructing Excellence in Wales.

Emma Waldron, Wales Council for Voluntary Action.

Rhian Edwards, Wales Co-op Centre.

Keith Edwards, Foundational Economy Network & Can-Do Toolkit.

The Well-being of Future Generations Act

The Well-being of Future Generations Act (hereby referred to as 'the Act') gives us the ambition, permission and legal obligation to improve our social, cultural, environmental and economic well-being.

The Well-being of Future Generations Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

The Act is unique to Wales attracting interest from countries across the world as it offers a huge opportunity to make a long-lasting, positive change to current and future generations.

To make sure we are all working towards the same purpose, the Act puts in place seven well-being goals.

The Act makes it clear the listed public bodies must work to achieve all of the goals, not just one or two. The Act establishes Public Services Boards in each Local Authority area. They are required to assess the state of well-being locally, set objectives and produce a plan designed to improve economic, social, environmental and cultural well-being in their local area, contributing to the well-being goals.

The Well-being of Future Generations Act defines Sustainable Development in Wales as: "The process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals."

The Act sets out five ways of working needed for public bodies to achieve the seven well-being goals. This approach provides an opportunity for innovative thinking, reflecting the way we live our lives and what we expect of our public services.

Prevention

Involvement

Long-Term

Integration

Collaboration

Sophie Howe is the first Future Generations Commissioner for Wales and her role is to be the guardian of future generations. This means helping public bodies and those who make policy in Wales to think about the long-term impact their decisions have.

Sophie took up post in 2016 and has led high profile interventions around transport planning, education reform and climate change, challenging the Government and others to demonstrate how they are taking account of future generations.

Described by the Big Issue Magazine as one of the UK's leading Changemakers, her interventions have secured fundamental changes to land-use planning policy, major transport schemes and Government policy on housing - ensuring that decisions taken today are fit for the future.

You can find more about our work online at:
www.futuregenerations.wales

01 Introduction

The Act provides us with an opportunity to transform the way procurement is planned and delivered in Wales. By moving from a process-driven approach towards an outcomes-based approach, we can ensure the £6.3 billion spent annually by the public sector in Wales delivers the best outcomes across all four dimensions of well-being (economic, social, environmental, and cultural) for current and future generations.

Procurement is one of the seven corporate areas for change in the Act's statutory guidance (Shared Purpose: Shared Future, SPSF 1: Core Guidance) and it must be a key area of focus for public bodies in meeting their obligations under the Act, including setting, and taking all reasonable steps to meet, their organisational well-being objectives.

If it is accepted (as it should be, as it is set out in the statutory guidance) that the way in which resources are spent through procurement is a reasonable step, then a public body's procurement strategy should be setting out clearly how they are procuring in a way which helps them to meet their organisational well-being objectives, and in turn contributing to the seven national well-being goals. They should also evidence clear alignment with the four dimensions of well-being (cultural, economic, social and environmental) and how they have applied the five ways of working in the Act which are planning for the long term, prevention, integration, collaboration and involvement.

This should be reported through the outcomes that are achieved.

Working in partnership with Cardiff University, we have undertaken research to establish the extent to which the Act has been informing commissioning and procurement decisions across all 44 public bodies in Wales since 2016 (when the Act came into force).

Our work has been undertaken in two stages (i) research and (ii) Section 20 Review.

1.1. Phase 1 - Research

The desk-based research (August 2019-January 2020) consisted of the following approach:

- Preliminary desk-based research on published procurement policies and current guidance
- Requesting evidence from the 44 public bodies and using the information shared to understand the progress that individual public bodies are making in meeting their well-being objectives, the seven national well-being goals and four dimensions of well-being, by using the five ways of working, within their approach to procurement
- Engaging with the wider community of stakeholders at regional events and forums.

The main findings from the first research phase are outlined in the 'Spotlight on Procurement' within the Commissioner's Future Generations Report published in May 2020. The chapter outlines what it could mean if the £6.3 billion a year public bodies spend on procuring a range of goods, services and works was being spent on buying things and improving the economic, social, environmental and cultural well-being of people and communities in Wales. The Act provides an important opportunity to re-think how and where public funds are spent in the interest of current and future generations.

1.2. Phase 2 – Section 20 Review

Building on the research findings from Phase 1, a Section 20 Review was triggered in March 2020 to formally examine the procurement practices of nine public bodies. The purpose of the formal Review was to:
(i) gain a more detailed understanding of how efforts to embed the Act into procurement decisions are helping public bodies to meet (or take steps to meet) their well-being objectives; and
(ii) to further understand how public bodies are taking account of the statutory ways of working, particularly considering long-term impact, within their approach to procurement.

Section 20: Reviews by the Commissioner

(1) The Commissioner may conduct a review into the extent to which a public body is safeguarding the ability of future generations to meet their needs by taking account of the long-term impact of things the body does under Section 3.

(2) In conducting a review, the Commissioner may review

- (a) the steps the body has taken or proposes to take to meet its well-being objectives;
- (b) the extent to which the body is meeting its well-being objectives;
- (c) whether a body has set well-being objectives and taken steps to meet them in accordance with the sustainable development principle.

(3) In conducting a review, the Commissioner must have regard to any examination of the body carried out by the Auditor General for Wales under section 15.

(4) In conducting a review, the Commissioner may make recommendations to the public body about

- (a) the steps the body has taken or proposes to take to meet its well-being objectives;
- (b) how to set well-being objectives and take steps to meet them in accordance with the sustainable development principle.

(5) The Commissioner may conduct a single review of two or more public bodies.

(6) The Commissioner must publish a report of a review (including any recommendations made) and send a copy of it to the Welsh Ministers.

(7) In conducting a review, the Commissioner may require a public body to provide such information as the Commissioner considers relevant to the review.

(8) But a public body is not required to provide information to the Commissioner if the body is prohibited from providing it by virtue of an enactment or any other rule of law.

With the sudden onset of COVID-19, and the additional pressure being placed on public bodies dealing with the impact of the crisis, the Review was paused in March but resumed in October 2020.

Interview discussions with leaders and representatives from each of the nine public bodies (during Autumn 2020) provided an opportunity to discuss the steps they were taking to embed the Act, and establish some of the more deep-rooted challenges faced by public bodies. The discussions helped to identify any gaps in support that may be required going forward.

Who are the Report and recommendations aimed at?

This Report includes findings and recommendations specifically for the nine public bodies who were subject to the Review. The nine organisations have a statutory duty (Section 22(4)) to publish their response to the recommendations made by the Commissioner in this Report. Public bodies are encouraged to do so within 25 working days of the recommendations being published.

Many of the recommendations are equally relevant to all public bodies who should consider them as advice, and we will be following progress as part of the Commissioner's duty to provide advice and assistance and to monitor and assess how public bodies are making progress towards their well-being objectives. The Commissioner and Auditor General for Wales also work closely on their complementary duties, and Audit Wales has contributed to this Review. Going forward, the Commissioner and Auditor General for Wales will be seeking to share relevant information on how public bodies are making progress towards meeting the requirements of the Act.

The findings and recommendations include those which are relevant to all the public bodies subject to the Review and those which are primarily directed at the Welsh Government in its leadership capacity.

The recommendations are specifically aimed at those in senior positions – Ministers, Chief Executives and Directors of Finance.

This Report also includes examples shared by public bodies, illustrating good practice and lessons learned, demonstrating a consideration of specific elements of the Act. However, it was challenging to find examples evidencing consideration of all elements of the Act. When implementing the recommendations from this Report, public bodies should consider how current and future procurement activities can contribute to Wales' seven well-being goals, their organisational well-being objectives and the four dimensions of well-being (cultural, economic, social and environmental), through the application of the five ways of working.

The well-being goals should be placed as the national primary objectives for delivering strategic procurement in Wales. The report explains how this may be achieved, considering the role of procurement professionals, the procurement function and how the procurement process can support delivery of wider organisational priorities and objectives.

02 Section 20 Review

This section outlines the methodology adopted for the Review.

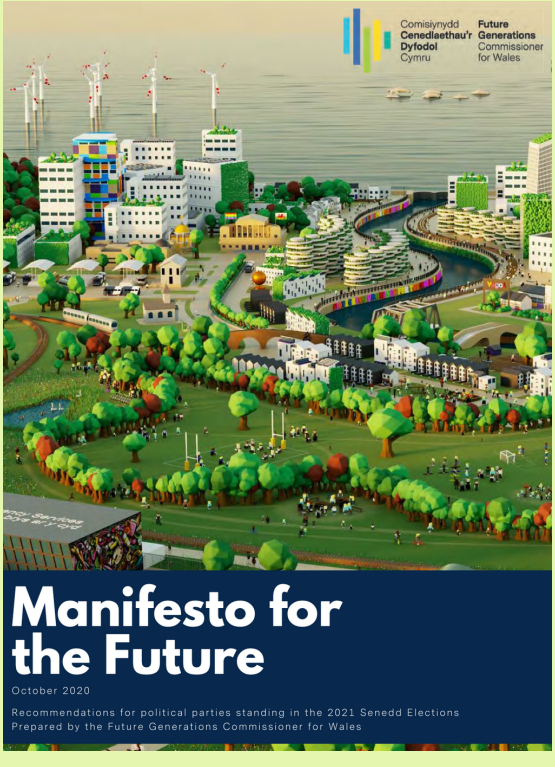
Shortlisted Participants

From the 44 Public Bodies invited to participate in the initial research phase, nine organisations representing a range of national, local authority and health board organisations were selected for the Review:

- Bridgend County Borough Council
- Cardiff and Vale University Health Board
- Denbighshire County Council
- Flintshire County Council
- National Library of Wales
- Velindre NHS Trust (as hosts of NHS Wales Shared Services)
- Wrexham County Council
- Welsh Government
- Ynys Môn / Anglesey Council

The nine public bodies were selected for the Review based on multiple factors including:

- The responses to Phase 1 – the desktop research phase.
- Fair representation of national, local authority and health board. organisations being interviewed
- Evidence of individual procurement strategy development.
- Evidence received outlining the steps being taken to meet the requirements of the Act as part of their procurement process.



03 Findings

The key findings from the research phase were published in May 2020 as part of the Commissioner's Future Generations Report 2020. This is published every four years as part of a statutory duty and provides an assessment of the improvements public bodies have made in relation to meeting their well-being objectives. More than just meeting a 'duty' this Report explains how the Welsh public sector is collectively improving well-being in accordance with the Act. The Commissioner has identified procurement as an important lever for public bodies to achieve their well-being objectives, and it is also one of the seven corporate areas of change identified in Welsh Government's Statutory Guidance on the Act.

Table 1: Summary of key findings and recommendations included in the 'Spotlight on Procurement' (Future Generations 2020 Report, May 2020).

CHALLENGES AND OPPORTUNITIES FOR CHANGE	WHERE ARE WE NOW?	RECOMMENDATIONS WELSH GOVERNMENT AND PUBLIC BODIES SHOULD:
Develop leadership that supports a strategic approach to procurement, recognising the 'power of purchase'.	There is renewed political commitment towards ensuring procurement is a lever in driving wider ambitions. As yet there is no clear national procurement strategy, process or support to share learning and drive improvement across the public sector in line with the Well-being of Future Generations Act.	Approach all procurement decisions through the lens of the Act – by applying the Five Ways of Working, considering their well-being objectives and/or steps and how to maximise contribution to the seven well-being goals at the very beginning of the process even at pre-procurement stage. Provide clear guidance and leadership to other public bodies, as well as monitoring and assessing how they are considering the Act in their procurement activities.
Procuring well-being: a focus on outcomes and measuring what matters.	The procurement process has improved considerably over the last decade; however, there is still too much focus on process and not outcomes. Measuring 'community benefits' has been in place for many years in Wales, but the reporting and impact of this are not widely shared.	Provide clear evidence for how their procurement activities are supporting the delivery of their well-being objectives. Review their procurement approach and activities to identify opportunities to maximise the social, economic, environmental and cultural impact of spending decisions.

CHALLENGES AND OPPORTUNITIES FOR CHANGE	WHERE ARE WE NOW?	RECOMMENDATIONS WELSH GOVERNMENT AND PUBLIC BODIES SHOULD:
Focusing on longer-term financial planning.	There is too much focus on short-term cost versus delivering wider outcomes.	Explore how they can use budgets to give greater long-term financial certainty to other public and voluntary sector bodies to ease the short-termism challenges faced by procurement. This could include facilitating longer-term (minimum 5 years) contracts with break clauses built in to allow ongoing flexibility.
Promote effective collaboration, with each other and suppliers, to improve sharing, learning, capacity and skills.	Structures for collaboration and learning across Wales are in place but lack national coordination and support especially to facilitate collaboration across different sectors, e.g. local government and health. Opportunities for sharing information and learning appear limited and don't involve a wide cross-section of organisations or partners.	Capture lessons learned based on the outcomes of current frameworks to ensure opportunities to embed the Act are maximised in future.
Build on established frameworks, including legal.	There are opportunities to support innovation that need to be better understood.	Include specific contract clauses linked to well-being objectives/goals in every public sector contract and framework, using social value measures to capture impact.
Promote a can-do mindset and attitude.	There are future generations champions (sometimes frustrated) within our public bodies who are working to deliver positive procurement outcomes often without wider organisational or leadership support. Procurement is sometimes treated as a transactional process, and transformational opportunities are not being maximised.	Involve departments and organisations who are impacted by the procurement process when setting well-being objectives (e.g. commissioning, contract management, suppliers and waste management). This could lead to public bodies understanding the broader benefits and steps they can take to improve all aspects of well-being through procurement.

3.1. Section 20 Review - summary of findings

Evidence gathered in the research and Review phases (for the nine public bodies subject to the Review) included exploration of issues around leadership, embedding the Act, the impact of the Future Generations Report (May 2020) and the impact of Covid-19. In addition, good practice examples are presented throughout the findings.

The following main issues have been identified and each point will be explained in more detail within Section 3.2 and Section 3.3.

Issues directly relating to Welsh Government in their leadership capacity

- Welsh Government has failed to show clear joined up leadership on the role of procurement in delivering Wales' national well-being goals (and public bodies well-being objectives).
- There is poor communication and integration between different Welsh Government priorities, alongside lack of support available for public bodies to ensure these are implemented effectively on the ground.

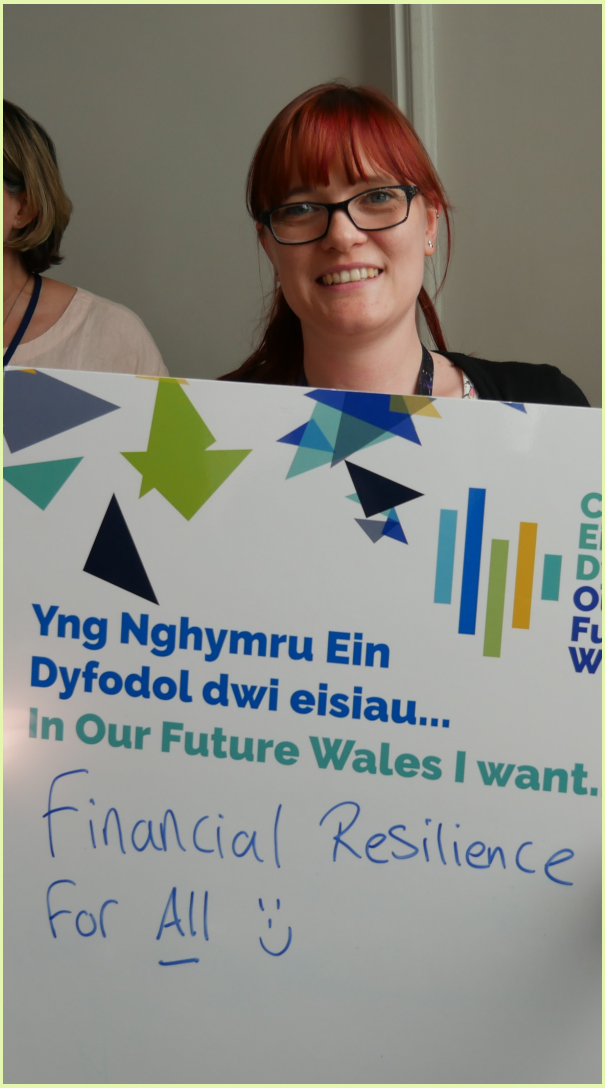
- Opportunities for making spend work harder are being missed due to lack of support for the procurement profession and lack of accountability at a leadership level.
- There is no ongoing monitoring of procurement approaches or outcomes either for the purposes of spotting where things are going wrong, and opportunities are being missed, or for identifying and sharing best practice.

Issues relating to public bodies

- Opportunities to deliver on all four dimensions of well-being are not being maximised, often due to a lack of leadership and strategic approach that recognises the 'power of purchase'.
- The "procurement system" is too often leading to a focus on process and short-term cost rather than delivering wider outcomes over the long-term, and there is no consistent way of measuring the outcomes that can be achieved in line with the Act. There needs to be a shift to considering long term costs holistically, in line with the Act.
- There is no mechanism for promoting effective collaboration for public bodies, particularly cross-sector to improve sharing, learning, capacity and skills.

Although there is evidence across the board that the nine public bodies interviewed are taking steps to apply the Act during the procurement process, the Review has identified a number of challenges and constraints in procuring sustainably including:

- **Organisational buy-in, leadership involvement and engagement – leaders failing to view procurement as an important function or lever in meeting corporate (well-being) objectives.**
- **Insufficient resources and capacity within the procurement function and amongst procurement professionals.**
- **Navigating what has become an increasingly complex landscape.**



3.2. Welsh Government Findings (in their leadership capacity)

The issue: Welsh Government has failed to show clear, joined up leadership on the role of procurement in delivering Wales' national well-being goals (and public bodies' well-being objectives).

The current situation: One of the opportunities for change outlined in the Commissioner's Future Generations Report 2020 is that Welsh Government should develop leadership that supports a strategic approach to procurement, recognising the 'power of purchase'.

During discussions with the public bodies, there was a consensus that Welsh Government should be leading the way when implementing legislation and policy, providing practical support to other public bodies, as well as monitoring and assessing how they, and others, are considering the Act in their procurement activities.

Leadership at the national and local level is inconsistent and current guidance is insufficient in providing the necessary support to embed the Act. Many public bodies are expected to follow the national procurement strategy however, the current Wales Procurement Policy Statement (WPPS) has not been updated since 2015 and does not fully reflect the Act. We are aware that Welsh Government are hoping to publish a revised Statement imminently and the Office of the Future Generations Commissioner (OFGC) has contributed to this process through providing advice.

However, it isn't clear how the current vision in the draft revised Statement aligns to all aspects, or supports the ambitious aims, of the Act:

"Procurement will continue to be a facilitator of change and a conduit to collaboration. Building commercial activities that will foster vibrant Welsh supply markets and support sustainable communities through delivery of citizen centric services within the Welsh Public sector".

The Act requires procurement to adopt a much wider approach to well-being beyond this quite traditional approach.

In March 2020, Welsh Government published "Progress towards the development of a new procurement landscape in Wales" which provides an update on their recent work as well as setting out their new way of working going forwards. Although the Commissioner offered feedback on a draft of this, the Act was not highlighted as a key framework underpinning Welsh Government's approach and is an example of a 'missed opportunity' for showing public bodies how the Act should be the framework for public procurement in Wales, demonstrating clear links between delivering policy and the seven national well-being goals.

Since 2016, when the Act has been in place, Welsh Government has not developed comprehensive guidance or a framework that supports public bodies to apply the Act within their procurement activities.

However there has been some developments in relation to evolving the approach to capturing social value, collaboration in developing a co-ordinated national and regional procurement programme and wider capability and capacity building.

In addition to considering how their own procurement decisions deliver on all elements of the Act, Welsh Government and the National Procurement Service (NPS) has a responsibility to monitor and assess how other public bodies are considering the Act in their procurement activities, particularly through national frameworks.

By working collaboratively, the NPS manages the delivery of all-Wales public sector contracts and frameworks for goods and services. The current NPS pipeline brings together public sector purchasing power of around £0.5 billion for categories of common and repetitive spend. Over 70 public sector organisations in Wales are signed up as NPS members including all local authorities, the NHS, the Welsh Parliament, Welsh Government and Welsh Government Sponsored Bodies (WGSBs), the Police and Fire and Rescue services and Higher and Further Education institutions.

A Welsh Government review in 2018 stated that "NPS will, over time, cease to exist" responding to the views of customers that "they required a different approach which provided greater support to enable delivery of regional and local well-being goals and priorities". It is not clear what progress has been made to establish a "national policy development and delivery support function" as outlined by the Cabinet Secretary for Finance in 2018.

Some public bodies, particularly those with smaller procurement teams, draw on these national frameworks relying on them as the first 'port of call' for managing procurement. They are under the impression that frameworks offer a safety net for capturing social value and assume that they have already considered the Act. During the Review, one national body stated that "we make as much use of well-established local government procurement frameworks as we can and rely on other government agencies to have undertaken the necessary well-being assessments in arriving at the agreed frameworks which are in place".

During the Section 20 Review, Welsh Government representatives emphasised it is the public bodies responsibility to evaluate how using frameworks can contribute to organisational well-being objectives. Therefore, whilst public bodies utilising frameworks to deliver social value is understandable, especially considering the capacity issues they face, the frameworks alone are not ensuring that public bodies are meeting their legal duties to 'take all reasonable steps to meet their well-being objectives.'

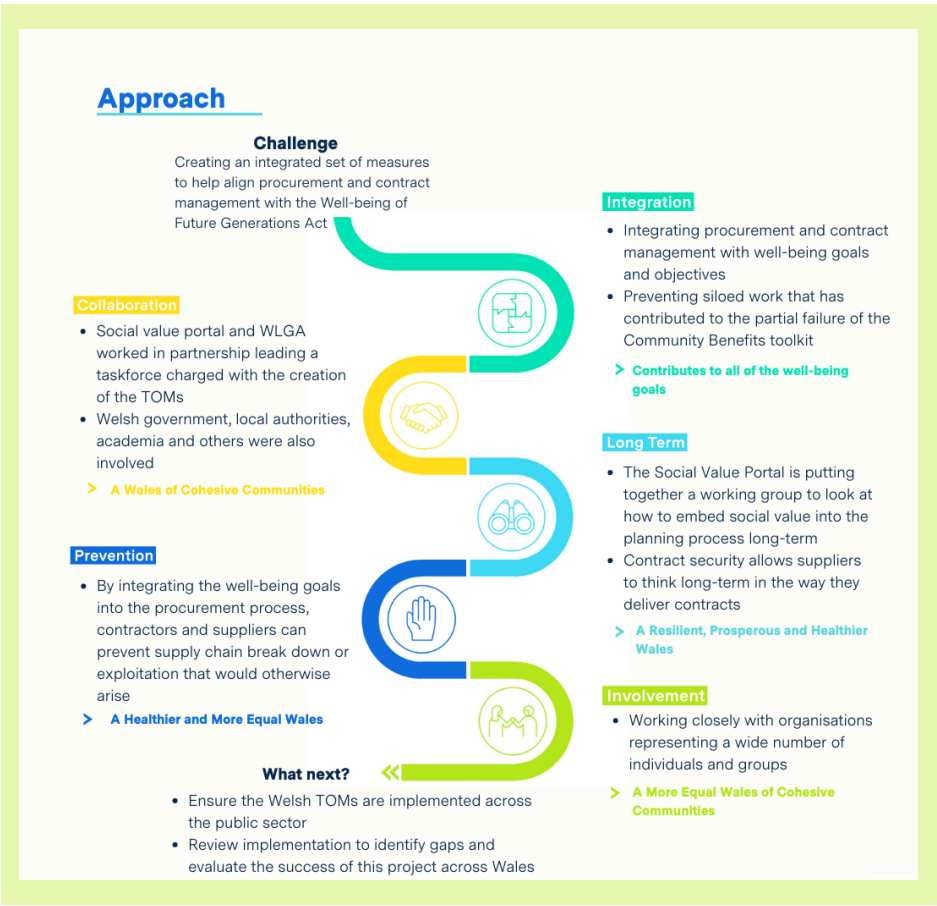
Case Study: Carmarthenshire County Council

Carmarthenshire County Council lead on the tender for the South West Wales Regional Contractors framework (SWWRCF) and was keen to embed opportunities to maximise economic, social, environmental and cultural well-being of people and communities into the core of the Framework. This is a significant regional Framework in South West Wales, with an estimated value of £1 billion worth of construction projects being awarded through it over the 4 year duration. 'Objectives & Aims' based on the Act were produced and included in the Tender to communicate their aspirations to all tenderers and subsequently appointed Contractors. This document has helped to guide opportunities at call-off level, and individual project opportunities can then be built upon further at the next stage.

Case Study: Carmarthenshire County Council (continued)

A commitment to the Act at Framework level, and the application of the five ways of working and seven national goals throughout the procurement process, has led to a more robust and meaningful tender and has created a 'golden thread' where the project aims and objectives are aligned with the Act and reflected in each tender. For example, the themes of innovation, sustainability, collaboration and community benefits form a key part of the quality questions and subsequent scoring criteria that will be asked of tendering contractors. In so doing, Carmarthenshire aims to ensure that sufficient consideration is given to the principles of the Act, together with tangible deliverables such as the delivery of targeted recruitment and training, which will foster involvement and long-term impact, and also opportunities for the community through the provision of services and jobs.

Another example is the forthcoming call-off from the SWWRCF 2020 Framework for Pentre Awel - Zone 1. Funded through City Deal and Council investment, this comprises public, academic, business, health and leisure facilities to boost employment, education, leisure provision, health research and delivery, and skills and training. Due out to tender in February 2021 it is valued at £80 million with a completion date of Summer 2023. Developing the work carried out by the Project Team on embedding the Act from the initial planning phases, they have flowed this vision through to the procurement stage and further aligned the Council's commitment to maximising the well-being goals and their own objectives.



Key Lessons

- They ensure clear communication and transparency on well-being aims and objectives throughout the tender process – “the golden thread”
- The themes of innovation, sustainability, collaboration and community benefits form a key part of the quality questions and subsequent scoring criteria that will be asked of tendering contractors.

Many of the procurement teams who participated in the Section 20 Review highlighted a desire to do things differently but noted that they were unsure how to fully embed the Act in all decision-making without additional support and consistent national guidance. One public body said that their intentions to take additional steps to meet the requirements of the Act, including the recommendations outlined in the Future Generations Report 2020, were ‘meaningless’ without coherent strategic guidance. When developing new initiatives, guidance and toolkits there needs to be clear consideration for how these support procurement activities to deliver against all elements of the Act.

Welsh Government are reviewing the structure and governance of procurement and the transition from NPS and Value Wales to a new structure. Welsh Government accepts that some of the policy implementation toolkits where Wales was once known to excel, such as the Procurement Route Planner, need re-prioritising and updating.

The Commissioner’s Recommendations:

- Welsh Government should establish a Procurement Centre of Excellence for improving coordination, collaboration and providing practical support to public bodies in the exercise of their procurement functions, specifically in relation to the Act. Development of this Centre of Excellence would require a comprehensive review and reform of the existing procurement landscape (structures, networks, partnerships and initiatives) and be resourced to build capacity and support implementation.
- The new Programme for Government should clearly set out how Welsh Government will provide strategic leadership and commitment to supporting and achieving wider outcomes from procurement, using language that is consistent with the Act.
- Welsh Government’s new Procurement Policy Statement should demonstrate how it will support public bodies to deliver the aspirations of the Act in public sector procurement in Wales. This Statement, along with progress to deliver the commitments, should be reviewed and reported annually.
- Welsh Government should ensure all future national procurement frameworks align with, and contribute to, the seven national well-being goals and apply the five ways of working set out in the Act.

The issue: There is poor communication and integration between different Welsh Government priorities, alongside lack of support available for public bodies to ensure these are implemented effectively on the ground.

The current situation: Public procurement operates under a regulatory regime, the Public Contracts regulations, but with growing attention to embedding social value and well-being into procurement, it is perceived by many that the policy landscape has become complex with an extensive set of tools, guidance and priorities coming from Welsh Government. Throughout the duration of the research and Section 20 Procurement Review, Welsh Government has been supporting many initiatives which relate to, and support, progressive procurement including the foundational economy, social partnerships, circular economy, social value, and community wealth building.

There are some innovative approaches being taken to consider the Act, but they appear to be lacking strategic connection. Whilst written guidance from Welsh Government in implementing national initiatives is helpful, when this is not coordinated or explained in the context of the Act, or linked to other relevant policy areas it can cause confusion and makes the already complex landscape even harder for public bodies to navigate.

Examples of relevant national initiatives that would benefit from further integration and coordination include:

- Value Wales and the National Procurement Service – creating new frameworks and managing existing ones whilst transitioning to new arrangements;
- The focus on the Foundational Economy through a new Ministerial Advisory Board, a Foundational Economy Challenge Fund, Community of Practice and expert panel on procurement;
- The partnership with the Centre for Local Economic Strategies (CLES), focusing on community wealth building and supporting Public Service Board clusters to strengthen local supply chains;
- The creation of a Knowledge Hub and refreshing the Welsh Procurement Policy Statement;
- The update of the Community Benefits Toolkit and implementation of the Welsh social value framework (TOMS - Themes Outcomes and Measures);
- Work with the Charted Institute of Procurement & Supply (CIPS) to develop further procurement training;
- Establishing a Critical Equipment Requirements Engineering Team (CERET) during COVID-19;
- Developing a Decarbonisation Dashboard for procurement;
- 'A More Equal Wales: Strengthening Social Partnerships' White Paper which proposes a 'Bill to strengthen our social partnership arrangements', including a requirement for 'specified public bodies to produce a procurement strategy in line with statutory guidance'.

The forthcoming Social Partnerships Bill will need to ensure that the new procurement duty placed on public bodies supports them to deliver outcomes that will help them to achieve their well-being objectives and, in turn, the national well-being goals.

Case Study

Case Study: Foundational Economy Challenge Fund

The foundational economy describes the jobs at the heart of our local communities, across sectors such as care and health services, food, housing, energy, tourism, construction and retail. This part of the economy account for four jobs in every ten and £1 in every £3 spent. Last year Welsh Government invested £4.5 million in a new Foundational Economy Challenge Fund which is currently supporting 52 projects that are testing new and innovative ways of making the everyday economy work better for all communities in Wales. They have recently committed an additional £3 million of funding to enable this work to continue. Funding support has been given to:

- ELITE Paper Solutions, a social enterprise based in Merthyr Tydfil which specialises in document management storage and data shredding. They have been able to develop a fully inclusive workplace, now employing a total of 39 people many of whom might otherwise have been excluded from the labour market, due to disability, health conditions or long-term unemployment. Through winning three large public sector contracts they have increased their revenue by £90,000 and recruited a further six staff members. ELITE is a community benefit arising from, and grown through, the NPS Office Supplies national framework.
- Community Care Collaborative in Wrexham, which is contracted by the local health board to run three GP practices, has developed a new model or primary care based on helping patients access support. They have recruited an emotional well-being team to provide well-being support for patients which has seen a 57% reduction in referrals to other mental health organisations.
- Vale of Glamorgan Council has been able to improve its procurement processes and engage with more than 1,000 businesses since June 2020 to increase the number of local small and medium-sized enterprises delivering Council contracts resulting in more money being retained within the local economy.

Alongside the Challenge Fund the Deputy Minister for the Economy and Transport has established a Ministerial Advisory Board and a package of practical support using experts in the Centre for Local Economic Strategies who are working with Public Services Boards to help them develop their approach to procurement in the foundational economy with a focus on 'community wealth building'. This is welcome practical support but it is currently disconnected from other initiatives in Government. Public sector procurement would benefit from an expanded package of support which integrates all aspects of the Act and related Government programmes.

Case Study

Case Study: Carmarthenshire Public Services Board Food Procurement

Carmarthenshire has a rich history of food production and supply, but it recognised that there is an opportunity for public sector organisations to make a greater contribution to the local supply chain by changing its approach to procurement and doing things differently. Smart public food procurement could provide a 'Double Dividend':

- An economic dividend by securing supply contracts for micro, small and medium sized firms that are locally or regionally based;
- A health dividend by promoting good food for all, especially in schools and colleges, where the citizens of tomorrow are acquiring their skills, habits and tastes today.

©Ungry Young Man

Benefiting from a Foundational Economy Challenge Fund Award, the project will establish a new way of working not just for the food sector but potentially across all other public sector procured goods and services. The Act provides an excellent opportunity to test and challenge, and by using the five ways of working as a guiding framework there is an opportunity to have a significant impact on the social, environmental, economic, and cultural well-being of Carmarthenshire.

Key Lessons

- Welsh Government funded experimentation has accelerated the progress of public bodies taking steps to achieve their well-being objectives.
- A focus on the Foundational Economy is an effective approach for embedding well-being and social value into procurement, but needs to be better connected to other initiatives as well as the Act.

Whilst Welsh Government develops guidance for the public sector, for example on delivering social value and embedding the Act, unless it is integrated with existing guidance it is seen as an additional burden. Feedback from public bodies indicates a need for greater practical support on implementation.

There is also a significant issue around terminology and definitions – a variety of different terms are used, often with ambiguity over their meanings and their application, such as consistency with implementing collaboration and understanding social value, with general lack of coordination and connection back to the Act.

This results in a lack of clarity for procurement practitioners on how these different initiatives are connected. This lack of coordination has been highlighted at procurement forums by professionals unable to see how the outcomes are meaningful or impactful. In the absence of Welsh Government providing clarity and join-up between these activities, procurement professionals are having to communicate the connections between, and the outcomes of, these different initiatives.

This complex landscape is also perpetuating the competing priorities procurement teams are already managing, and the lack of guidance leaves public bodies unsure about which actions to prioritise. An example of this is that during the Section 20 Review discussion with one public body, they outlined clear decarbonisation aspirations but did not know how to prioritise this with limited resources.

Procuring in a Climate Emergency

Work undertaken by Natural Resources Wales and the NHS Wales Shared Services Partnership to calculate the carbon footprint of their activities has shown that procurement contributes nearly 60% and 49% respectively of their overall emissions, greater than emissions created by energy use in buildings and transport. The Welsh Government has set an ambition for the public sector to be carbon neutral by 2030, which is commendable, and the latest UK Committee on Climate Change advice has suggested ambitious emission reduction targets for Wales to be Net Zero by 2050. However, it is not clear how procurement is currently being used to meet our climate change targets. Although Welsh Government has recently developed guidance for the public sector on decarbonisation as a helpful resource - a Decarbonisation Dashboard Procurement Advice Note which enables public bodies to analyse the carbon intensity of their expenditure - it adds to the plethora of existing guidance and if not integrated with other requirements can be seen as an additional burden.

The 21st-century schools programme provides an opportunity for public bodies to deliver outcomes linked to the Act. Through our research, we have seen evidence from some public bodies delivering outcomes aligned to the Act, such as low/zero carbon schools. One local authority shared a case study on the construction of a school commissioned for £7 million, with a requirement for this project to achieve Passivhaus certification.

They provided evidence that they have considered each of the five ways of working and an explanation for how the project is meeting ten out of their 15 well-being objectives (including looking after the environment now and for the future, promoting Welsh language and culture and helping children live healthy lifestyles). I also welcome £5m of capital funding in the 2021-22 draft budget to take forward a Carbon Zero Pilot Project to decarbonise schools and colleges in Wales. Llancarfan Primary School in the Vale of Glamorgan, will be completed later this year and will be Wales' first Net Zero Carbon School.

However, this good practice isn't happening consistently, and we are still seeing disparity in the approach being taken by public bodies. Feedback from the construction sector has highlighted projects, including new schools, that are not seeking opportunities to contribute to all national well-being goals. Welsh Government needs to provide a clear commitment, through their Mutual Investment Model and other significant infrastructure programmes, to ensure that all publicly funded buildings will be zero carbon in future and maximise their contribution to all seven well-being goals, rather than just considering energy use or community benefits, and ensure that the 'pilot' being supported becomes normal practice across Wales.

Case Study: Collaborative Project to Develop a Warrantied Design System for the Delivery of Zero Carbon Homes from Timber, at Scale

At its second meeting on the 2nd October 2020, members of the Council Housing Development Forum Wales, gave their backing for a collaborative working proposal to commence work on the development of a pattern book of zero carbon timber frame house designs and work together to establish a procurement club to purchase the homes direct from manufacturers. The Innovation Partnership project requires that 11 participating local authorities advertise and let a contract to develop the system with designers and manufacturers. Following the conclusion of the Innovation Partnership, the Councils will let a contract to deliver the zero carbon homes for a period of five years. It is recommended that a five-year contract is let to provide suppliers with order book certainty, enabling them to invest in new plant and equipment generating economies of scale, which should enable the price of the homes to reduce over the lifetime of the contract.

The Commissioner's Recommendations:

- Welsh Government should review all guidance and toolkits that are currently in place to support sustainable procurement and measure/monitor community benefits and/or social value, and publish a clear plan outlining how these will be revised and consolidated to enable a consistent approach for public bodies to report on the well-being outcomes being achieved.
- In order to meet carbon emission targets, every public body should set out how they have considered the carbon impact of their procurement decisions and in the case of construction or infrastructure contracts should require schemes to be net zero carbon over their lifetime.

The issue: Opportunities for making spend work harder are being missed due to lack of support for the procurement profession and lack of accountability at a leadership level.

The current situation: Procuring sustainably throughout the public sector in Wales requires leadership support: senior champions who will set a strategic vision, commit to effecting change, take ownership over targets and drive good practice throughout their organisations. The Act provides an opportunity to deliver innovative procurement; procurement that is focused on long-term value and achieving better outcomes for Wales. Evidence that this is happening is patchy, and there is no structure or mechanism in place to monitor or report on the outcomes that are being achieved from the £6.3 billion spend.

Getting buy in from senior organisational leadership is noted as challenging due to 'so many other competing priorities' and 'budgeting issues.' This situation is compounded by the initial reactive and fragmented response to the Covid-19 crisis and the impending Brexit transition. During one interview, a Director of Finance commented that their priority is to add value from a governance and audit perspective, with a focus on delivering 'value for money,' rather than sustainability, further stating "it is the role of the procurement team to manage relationships and carry out groundwork." Without the Act being recognised as a strategic issue, and prioritised, at a senior level within public bodies and in Welsh Government, any initiatives to fully embed the Act in procurement activities will be unsuccessful, including the recommendations outlined in this report.

One public body stated that "as 'stewards of money,' cost must be the factor that drives procurement outcomes." Some public bodies perceive that it is cheaper to procure goods outside of Wales and justifying the additional spend of local sourcing is not an option. However, there is evidence of other public bodies being willing to prioritise spending in the local economy as it results in wider benefits. The focus on short-term cost and 'value for money' as opposed to wider benefits that could be achieved limits opportunities for public money to contribute towards Wales' seven well-being goals illustrating that without support from senior leadership, procurement cannot be realised as a lever that delivers best outcomes for current and future generations.

The Review has also shown that examples that demonstrate procurement's contribution to each of Wales' seven well-being goals, are rarely widely shared. Equally, not enough of these examples exist that focus on delivering the best outcomes across all four dimensions of well-being (economic, social, environmental, and cultural) because achieving 'value for money' or the 'most economically advantageous tender' is often prioritised. However, some organisations have progressed the 'Community benefits' agenda and we are beginning to see examples of contracts placing greater emphasis on social value through the application of the new Themes, Outcomes and Measures (TOMs) framework. There needs to be further senior leadership support that empowers the procurement profession to drive and share good practice.

The Commissioner's Recommendations:

- The Procurement Centre of Excellence should review and reform structures for national accountability and establish an appropriate mechanism to scrutinise progress on implementation. Welsh Government should report annually on how overall national public spend is contributing to the national well-being goals.
- In addition, their annual report (on progress with the Act) should clearly set out how all of their own procurement spend, and grant spend, is contributing to meeting their well-being objectives, and in turn the seven national well-being goals.

The issue: There is no ongoing monitoring of procurement approaches or outcomes either for the purposes of spotting where things are going wrong, and opportunities are being missed, or for identifying and sharing best practice.

The current situation: Public bodies are no longer gaining the necessary support from Welsh Government required to maximise opportunities to deliver community benefits, social value and wider procurement outcomes that support the ambitions within the Act.

During discussions with public bodies a barrier to implementing the Act that was consistently identified was the numerous reporting tools used, with little feedback from Welsh Government about the outcomes that are delivered as a result. One example of this is the Community Benefits toolkit (first published in 2011 and currently on its ninth iteration), which is designed to help public sector bodies in Wales to identify community benefit objectives that can be delivered as part of their contracts, and to show how these economic and social outcomes support delivery of the Act. Public bodies submit this information to Welsh Government but do not receive any feedback; "it goes into a black hole".

They expressed frustration at the lack of feedback as it meant that potential missed opportunities to deliver community benefits, as well as examples of good practice, are not being shared. The interview with Welsh Government civil servants highlighted that they do not have the resources or capacity to monitor and assess the steps public bodies are taking to deliver community benefits using the toolkit, or indeed any other steps they are taking to embed the Act.

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As already highlighted Welsh Government has, over many years, supported many initiatives designed to support the delivery of sustainable and progressive procurement (Community Wealth Building, Foundational Economy, and TOMs led by the Welsh Local Government Association) however the range of reporting tools available to capture procurement outcomes, combined with the lack of feedback on their application from Welsh Government and a lack of opportunity to share and learn, has resulted in an inconsistent approach to applying the Act and also uncertainty of what good practice looks like. All public bodies that participated in the Section 20 Review highlighted a need for a mechanism to share real-life examples and lessons learned when taking steps to consider the requirements of the Act during commissioning, procurement, and contract management.

Procurement professionals also felt a reticence in sharing lessons learned from ineffective attempts to embed the Act in the procurement process with procurement networks and/or forums. One such example is where two public bodies wanted to procure drinking fountains in public spaces, as an example of what is possible when procuring in collaboration, considering outcomes through the lens of the Act. However, there were insurmountable legal obstacles, preventing the procurement from going ahead. This example emphasises how difficult it can be to achieve long-term positive outcomes when all departments involved with the procurement process have not adopted a 'can do mindset'. Innovative approaches to embed the Act should be commended, public bodies should be encouraged to take risks, and further support needs to be provided by Welsh Government to maximise opportunities to deliver community benefits, social value and wider benefits that align with the Act.

The Commissioner's Recommendations:

- The Procurement Centre of Excellence should develop a mechanism or tool to assist public bodies to monitor and report consistently on the Act (possibly building on the work being done on social value and the new TOMS framework) demonstrating how their procurement spend is meeting the well-being goals and objectives.
- Welsh Government should monitor progress by public bodies in Wales. This must be reported within the annual reports on delivery of their well-being objectives for both Welsh Government, in respect of the overall outcomes being delivered across Wales, and by individual public bodies.

3.3. Public Body Findings

Whilst the issues identified in the above section focusses on Welsh Government, many are also relevant to public bodies including the need for a strategic approach with senior leadership support and commitment that recognises the role procurement can play in supporting the achievement of wider outcomes. We acknowledge that the issues identified at a national level do not always make it easy for public bodies to procure in line with the Act, however each public body has a role to play in identifying and delivering these wider outcomes to ensure that their procurement spend contributes to the achievement of their well-being objectives and the seven national well-being goals.

As well as an array of uncoordinated Welsh Government initiatives, there is also currently an agreed lack of clarity on the following areas which add to the complex landscape procurement teams are trying to navigate.

- Data analysis – access to accurate and timely data is challenging in organisations where resource and analytical skills are constrained. Internal communication is also reported as a key factor here.
- Training for non-procurement staff - some of the richer interview discussions were with public bodies that involved other departments wider than just procurement. In some public bodies, resources were so limited that having a standalone procurement function is not feasible.
- Tension between process and outcomes – it is challenging for procurement professionals to focus on delivering long-term positive outcomes, in line with the Act, when public bodies have limited capacity and / or where procurement and commissioning do not collaborate effectively.
- Perception of procurement – the lack of acknowledgement from organisational leadership, as well as other departments, of the strategic role the procurement process has in taking steps to meet the requirements of the Act present numerous barriers. This means that procuring goods and services more sustainably becomes harder and more time consuming.

The issues that are specific to public bodies:

The issue: Opportunities to deliver on all four dimensions of well-being are not being maximised, often due to lack of leadership and strategic approach that recognises the 'power of purchase'.

All public bodies evidenced some steps being taken to consider economic, environmental, social, or cultural well-being. Most public bodies who actively embed the principles of the Act focus on delivering the well-being goals and only one public body focused on maximising their contribution through applying the ways of working.

The interview discussions revealed examples where public bodies are taking steps to consider the Act in procurement decisions, and others where embedding the Act has plateaued due to the Covid-19 crisis period, lack of understanding, feeling overwhelmed, resource constraints and general lack of central support.

Many public bodies were able to show how they had considered issues such as waste reduction, carbon emissions and local employment, but few public bodies recognised the importance of close alignment with their own individual well-being objectives. Hardly any of the public bodies that participated in the Section 20 Review were able to explain how their approach to procurement was helping them to meet wider long-term objectives, for example how they might procure a particular product which has less carbon impact, supports the growth of jobs and skills in the local economy which in turn supports objectives around tackling poverty and improving health. Nor were any able to show how they had involved citizens in the process.

There still needs to be further work across the public bodies in fully embedding all elements of the Act and aligning their procurement outcomes with their organisational well-being objectives.

For example, one public body demonstrated they are taking steps to meet the spirit of the Act, through sharing what they consider 'quick wins' including the procurement of compostable cutlery and cups. Whilst the steps they are taking to promote sustainability are welcome, they also need to be showing how they have considered procuring in a way which helps them to deliver their well-being objective to be "an exemplar organisation driving a culture that promotes well-being, equality, and sustainability". This finding indicates there may be missed opportunities to drive progress on achieving organisational objectives through procurement decisions.

Case Study – Cardiff Council

Based on the Act, and other policy drivers, Cardiff Council outlines their six procurement priorities and how they will be delivered through their Socially Responsible Procurement Policy, illustrating the important role of procurement in supporting how a public body can take steps to meet the requirements of the Act. An example of this is their priority "to protect the environment, minimise waste, reduce energy consumption and use other resources efficiently" supporting their well-being objective "Cardiff Grows in a Resilient Way".

Case Study – Caerphilly Council

As an example of good practice, Caerphilly County Borough Council has published their 'Programme for Procurement 2018-2023' which clearly outlines the steps they have taken, and plan to take, to achieve each of their 17 strategic goals. The strategy demonstrates clear consideration for each of the four dimensions of well-being, along with an understanding of how success will be measured, as shown below. Each strategic goal is accompanied by the steps already taken towards achieving it, what success looks like, how this will be achieved and a timescale for when it will be achieved. There is also an acknowledgement that progress will be measured through their service improvement plan.

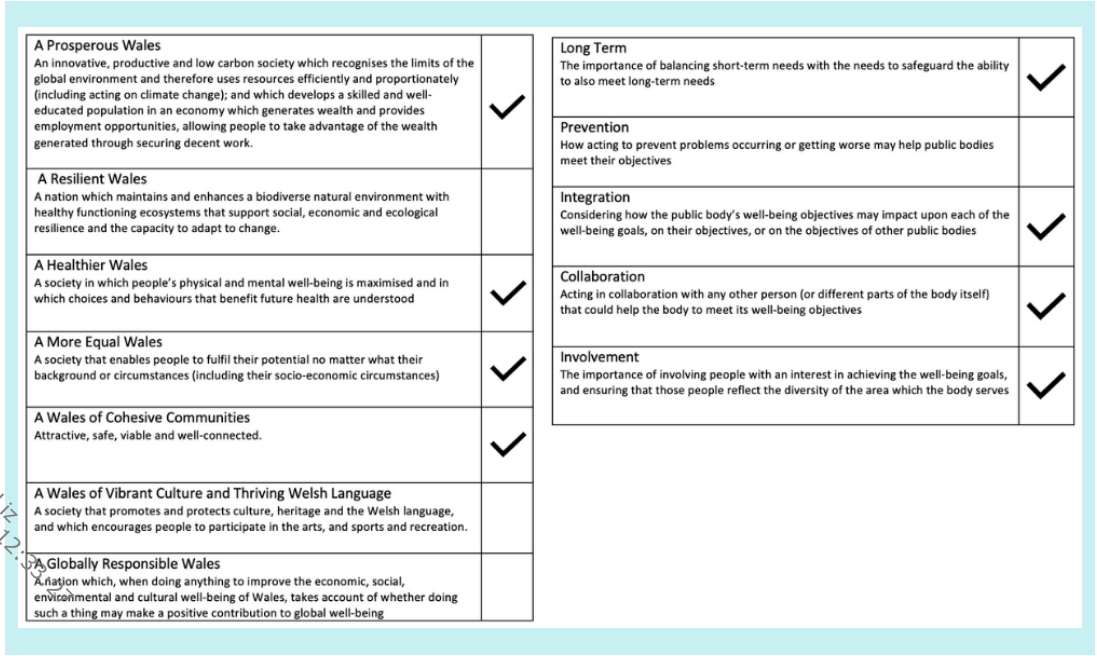
Case Study – Caerphilly Council (continued)

THEME	STRATEGIC GOAL	MOST RELEVANT WELL-BEING OBJECTIVES	ONE ASPECT OF SUCCESS
Environment	Responsible business through procurement activity that works to help and not hinder the duty of care incumbent on us to be fair and considerate in all aspects of our business activities	Objective three - Address the availability, condition and sustainability of homes throughout the county borough and provide advice, assistance or support to help improve people's well-being. Objective four - Promote a modern, integrated and sustainable transport system that increases opportunity, promotes prosperity and minimises the adverse impacts on the environment.	Tangible evidence that procurement activity is supportive of The Well-being and Future Generations (Wales) Act.'

Many Health Boards use the 'Well-being of Future Generations Act Checklist,' developed by the NHS Wales Shared Services Partnership and evidenced within the 'Procurement Services case study template', to demonstrate which of Wales' seven well-being goals and sometimes the five ways of working they consider relevant.

This example of how the 'Well-being of Future Generations Act checklist' has been applied, shows that five of Wales' seven well-being goals and all the five ways of working are considered relevant to this project. This illustrates consideration for how procurement outcomes can deliver some aspects of the Act which is positive, however the implementation of the Act is not being considered holistically as each element of the Act is being considered in isolation.

Also, the checklist does not provide space to explain how the goals are being considered and there is no consideration of the organisational well-being objectives or the four dimensions of well-being (cultural, economic, environmental, and social). Senior leadership should be considering how opportunities to deliver all elements of the Act are considered through procurement activities, utilising the Commissioner's existing tools and guidance to support this.



A Prosperous Wales An innovative, productive and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change); and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work.	✓
A Resilient Wales A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change.	
A Healthier Wales A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood	✓
A More Equal Wales A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic circumstances)	✓
A Wales of Cohesive Communities Attractive, safe, viable and well-connected.	✓
A Wales of Vibrant Culture and Thriving Welsh Language A society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.	
A Globally Responsible Wales A nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being	

Long Term The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs	✓
Prevention How acting to prevent problems occurring or getting worse may help public bodies meet their objectives	
Integration Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies	✓
Collaboration Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives	✓
Involvement The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves	✓

In 2019, Cardiff and Vale University Health Board were the first Health Board to announce a climate emergency and have taken measures to introduce sustainable operating theatres. This highlights how procurement can be used to support the delivery of their strategic outcomes and supports the delivery of their well-being objective to 'reduce harm, waste and variation sustainably, making best use of the resources available to us'.

The Commissioner has already given advice to public bodies (Chapter 2, Future Generations 2020 report), as set out below:

- Clearly align financial planning and decisions across the seven corporate areas of change to the achievement of their well-being objectives. The vision provided by well-being objectives should provide a longer-term plan of funding and corporate plans/well-being statements should set out how spending plans will seek to finance their steps.

- Provide evidence in their well-being statements/plans/corporate plans and annual reports on how applying the Act to the corporate areas of change is informing the steps they are taking to maximise their contribution to the goals.

The Commissioner's Recommendations:

- Senior leadership should review their procurement approach and activities to identify opportunities to maximise the social, economic, environmental and cultural impact of spending decisions, setting clear steps that show how procurement is supporting the delivery of their organisational well-being objectives.

The issue: The "procurement system" is too often leading to a focus on process and short-term cost rather than delivering wider outcomes over the long-term, and there is no consistent way of measuring the outcomes that can be achieved in line with the Act. There needs to be a shift to considering long term costs holistically, in line with the Act.

Although the procurement process has improved considerably over the last decade, there is still too much focus on process and not outcomes. The Act requires public bodies to focus on procuring well-being with a greater focus on outcomes and measuring what matters.

Another key barrier to sustainable procurement has been that it can cost more at least in the short-term, especially when whole-life costing is not considered, even if it does offer long-term savings and wider 'value'.

Generating community benefits is a long-established concept in the Welsh procurement landscape; an innovative approach when launched that has supported public sector bodies to consider additional economic and social benefits that can be achieved when tendering large contracts. Throughout the research and formal Section 20 Review, public bodies have shared examples of how they are delivering community benefits through procurement. Public sector organisations, particularly within the housing sector, use the Community Benefits Toolkit to report economic and social outcomes. These outcomes are reported to Welsh Government but the impact of these is often slow to be analysed and is not shared or reported more widely.

Case Study – Denbighshire County Council

In June 2019, Denbighshire County Council established a Community Benefits Hub, designed to provide support and enabling council services to include community benefits in contracts at the earliest opportunity. There is a clear understanding by the Local Authority on how using an outcomes approach to procurement contributes towards their corporate objectives and priorities: i.e., young people, connected communities, environment, and resilient communities. This is a positive example of developing a suitable platform for sharing knowledge and best practice.

The community benefits approach has achieved positive outcomes over many years; however the landscape has changed, and the Act now requires public bodies to move beyond community benefits, which have particularly focused on delivering outcomes that contribute to A Prosperous Wales, A Healthier Wales and A More Equal Wales, and less on areas such as nature and decarbonisation. The Community Benefits Toolkit does not clearly include consideration of the four dimensions of well-being (cultural, economic, social and environmental), organisational well-being objectives, or the application of the five ways of working. The Act requires us to move to spending more strategically to meet a wide set of organisational well-being objectives and in turn the long-term well-being goals for Wales.

Case Study – Flintshire County Council

Flintshire County Council has developed a Social Value Strategy, Social Value Procurement Policy and appointed a Social Value Officer to help them take steps to achieve strategic objectives outlined in their well-being Plan, and embed well-being and wider social value into commissioning and procurement. Their approach is summarised by stating that "Social value looks beyond the financial cost of a service and considers what wider additional benefits to the community can be generated. Implementing the Social Value Strategy will be a key element in delivering the Well-being of Future Generations Act and enable the Council and partners to create new resources for priority work streams". This is an encouraging step which should assist the Council to better meet their objectives although, both in this case and in the development of the 'Social Measurement Framework for Wales', there are opportunities to further reinforce links to the Act by using the language of well-being and sustainability rather than 'social value' which could be construed as relating predominantly to 'social well-being' rather than embedding social, economic, environmental and cultural well-being as the Act requires.

In their efforts to do this and consider wider social value, focusing on contribution to all the well-being goals, the interviews with many public bodies revealed that commissioning and procurement teams are moving away from the community benefits approach.

This builds on the work that has been led by the Welsh Local Government Association (WLGA) over the last 15 months, working with local authorities to develop a new social value measurement framework for Wales. The Welsh National Themes, Outcomes and Measures (TOMs), led by the WLGA was launched in November 2020 and provides organisations with a social value measurement and management framework which is aligned to the seven national well-being goals and allows them to consider how their procurement decisions also contribute to their own well-being objectives.

We welcome the development of a framework that takes a more holistic approach to measuring social value and well-being, aligned to the Act. It is not however currently clear whether this approach should be, or will be, adopted consistently across Wales and there is currently a lack of national guidance on this. Any framework that is put in place will need to ensure sufficient resource and skills for managing contracts to ensure that efforts to embed the Act into procurement is followed through and measured; many public bodies expressed concern that this currently is not the case.

Welsh Government reported that they are focused on achieving consistency with measuring social value and the Act, however, there remains no mechanism in place to do this, and no consistent approach for clearly monitoring and reporting how procurement spend is meeting public body well-being objectives or the seven well-being goals.

This requires long-term cultural change across public bodies. Most interview participants (procurement professionals, finance, and respective team members) emphasised the need for, and a desire to, work towards achieving this cultural change to deliver wider social value and outcomes aligned to the Act.

The Commissioner's Recommendations:

Once a mechanism or tool is developed and adopted by Welsh Government (as recommended above), each public body should be using it to clearly monitor and report on its activities, both in individual procurement exercises and overall, how their procurement spend is meeting their well-being goals and objectives.

- This should be reported within the annual reports on delivery of their well-being objectives.
- In order to avoid confusion of language, and link clearly to the statutory requirements of the Act, the terminology should be revised to mirror the language of the Act.

The issue: There is no mechanism for promoting effective collaboration for public bodies, particularly cross-sector to improve sharing, learning, capacity and skills.

There are some structures for peer-to-peer support, collaboration and learning across Wales, such as the local government Heads of Procurement network, Welsh Government Sponsored Bodies Procurement group and NHS Wales Shared Services forum, but they lack national coordination and support especially to facilitate collaboration across different sectors, e.g. local government and health. Representatives from the public bodies, who participated in the Section 20 Review, consistently acknowledged there needs to be better alignment and opportunities for communication and closer collaboration across the Welsh public sector. This builds on the phase 1 research findings published in the 'Spotlight on Procurement' chapter of the Future Generations Report 2020.

Collaborative arrangements seem to be in flux since the changes announced to the NPS (in 2018). This lack of coordinated and practical support for collaboration means that:

- Opportunities for sharing information and learning are limited and don't involve a wide cross-section of organisations or partners
- Examples of innovation and good practice are not shared, or encouraged to be adopted, as widely as they could.

Evidence from public bodies shows that there are many frustrated champions, who believe in the wider power of procurement working to deliver positive procurement outcomes, often without wider organisational or leadership support.

However, lessons from these outcomes are not always being applied throughout frameworks and collaborative procurement, leading to a gap between the potential and actual outcomes being achieved.

There was a consensus that communication and agreement between Welsh Government Ministers and commissioning on high level priorities is key. For example, if austerity drives the need for 'lowest cost' as a priority this will restrict the ability (and mindset) to source locally and more sustainably and consider more innovative approaches. When there is a clear motivation for more local sourcing and sustainable outcomes it forces the organisation, not just the procurement profession, to think differently about the end-to-end procurement process. In other words, the extent to which the Welsh Government sets the narrative and shows leadership from Ministers, to the individual actions of departmental officials in this area, is critically important. It is not clear how this is communicated, understood or monitored consistently across Welsh Government and there are examples of where direction from Welsh Government has been counterproductive in encouraging other public bodies to take steps towards sustainable procurement.

There is a wide perception that communication on decision-making between UK Government and the Welsh public sector is poor. For example, there remains uncertainty over major political milestones such as Brexit and Wylfa leaving little time to budget and plan appropriately - these require significant investment and upfront planning which affects spend categories such as schools, housing, infrastructure, and food.

Some participants felt that further funding is required to implement "FG requirements" – i.e, a 'sustainability budget'. Some public bodies felt they struggle to identify where opportunities to consider the Act are missed and do not know which type of resources are needed to support this (this was similar to a finding noted in the research phase published in the Future Generations Report 2020 recommendations).

However, whilst I agree that there needs to be a clear and consistent narrative from Welsh Government which emphasises the new requirements to consider long-term 'well-being spend,' alongside appropriate recognition of this in funding allocations and requirements that are placed on public bodies, I do not agree that the answer is sustainability budgets. What is required is longer-term cultural change towards well-being budgeting rather than short-term one-off allocations which have the result of working against a fundamental shift in attitudes towards how we spend public money in Wales.

Case Study – Wrexham County Borough Council

Wrexham County Borough Council are currently collaborating with Glyndwr University on systems leadership to improve the joining-up between services, resulting in a 'can do mindset' being established. However, during discussions, the local authority expressed that the Act is sometimes perceived as an additional 'statutory thing' rather than a strategic framework to achieve cultural change.

Throughout the interviews with public bodies there have been some good examples of innovative thinking and how collaborative procurement has helped to combat the pressures with individual budget constraints and further demonstrate consideration for the Act.

To take steps to meet the requirements of the Act, procurement teams have been working collaboratively with other departments, sectors, and organisations across regions. For example:

Case Study – Powys County Council

Over the last 3 years, the Home Grown Homes project, led by Powys County Council has worked to identify and test interventions that, if applied, could have a transformative impact on the Welsh timber construction supply chain in particular, and on the delivery of low carbon social housing in general. The project is funded by Welsh Government and the EU Rural Development Programme and delivered by Wood Knowledge Wales with Cardiff Metropolitan University, Coed Cymru and BM TRADA. The project report states that "now is the time for implementation at scale and in a manner that addresses the economic shock of Covid-19 to deliver meaningful green manufacturing, construction and forestry jobs together with Net Zero Housing at scale and supplied from Welsh manufacturing and forest industries."

Case Study – Flintshire County Council and Denbighshire County Council

Flintshire County Council and Denbighshire County Council have a long-standing collaborative procurement service. Representatives from Flintshire County Council explained that this was originally established due to procurement roles not being filled in either Local Authorities, and the organisations collaborated to deliver their joint vision which is to:

- Implement a shared, skilled and excellent corporate procurement service that ensures the required support for the two organisations and individual services in delivering corporate and service objectives and efficiency targets;
- Maximise procurement savings for the benefit of the residents and businesses of Denbighshire and Flintshire;
- Develop professional capacity and resilience to create a top performing procurement team, delivering organisational benefit and personal professional development for the team.

The discussion with Flintshire County Council highlighted that the agreement promotes a 'Can Do mindset' due to the scope of activities included in (day-to-day management, policy, advice, compliance and liaison). But maintaining the relationship is not without challenges, primarily due to the different priorities in each Local Authority. This collaborative working is to be commended but trying to align the two organisations' priorities may result in missed opportunities for procurement outcomes to contribute to their individual organisational well-being objectives.

Case Study – Cardiff and Vale University Health Board

Cardiff and Vale University Health Board has developed a good example of long-term planning, effective communication and sustainable sourcing - a Memorandum of Understanding (MoU) has been organised through the Public Service Boards to help formalise relationships between the Health Board and the third sector. One such initiative taken to implement this MoU specific to procurement, to protect and grow the £7 million annual spend on contracts in the third sector, was to provide training for third sector organisations on the Light Touch Regime in procurement. The Health Board currently has 35 contracts in place with third sector organisations, over four years, which has led to creating new jobs and expansion of welsh suppliers to support their service provision.

These examples highlight the need to involve other departments, organisations, sectors and suppliers at a pre-procurement stage to deliver outcomes that maximise contribution to organisational well-being objectives, and the seven well-being goals through applying the five ways of working.

Case Study – InFuSe – Innovation of Future Public Services

InFuSe is a research led collaboration between Cardiff Capital Region (with Monmouthshire leading), Y Lab (Nesta) and Cardiff University. The Wales European Funding Office project aims to help public sector workers develop skills that can better support communities and accelerate decarbonisation in the Cardiff Capital Region. The programme will target new capacity for innovation around experimentation, better use of data for decision-making, and targeted procurement to solve shared regional challenges, primarily across the region's ten local authorities. The three core workstreams for the programme are:

- The Adaption Lab - supporting officers to design and deliver experiments that test potentially scalable solutions to regionwide problems.
- The Procurement Lab – supporting officers to learn, develop and test new processes and methods for procuring innovative products and services that produce better outcomes for people who use and deliver services against the two thematic areas.
- The Data Lab – supporting officers to better collect, manage, analyse, understand and make more effective use of data in decision making.

The Commissioner's Recommendations:

- The Procurement Centre of Excellence established by Welsh Government will act as a central portal to support cross-sector collaboration and implementation. In collaboration with others Welsh Government should review existing groups and networks to better coordinate activity across local government, health, PSBs and regions, along with the third sector and private sector.
- Public Services Boards should prioritise how they can collaborate and use spend to maximise social value, contribute to their well-being objectives, and improve well-being on a local level.

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3.4. The Impact of Covid-19 – Challenges and Opportunities

There is no doubt that the impact of Covid-19 has been significant on all public bodies and led to both positive and negative developments in procurement. Whilst there have been some examples of innovation and good practice, linked specifically to procuring during the pandemic, as a whole the steps public bodies are taking to meet the requirements of the Act has plateaued during the Covid-19 crisis period often due to ongoing challenges being exacerbated. Generally, this has been due to reduced capacity, lack of understanding, resource challenges and constraints, and a general lack of central support, the latter being consider essential by participants when considering the recovery phase.

Some of the main issues and challenges reported by public bodies during discussions were:

COVID-19 Challenges

Resource and Capacity Challenges

Resource and capacity have become even more of an issue during the crisis period affecting procurement and especially contract management and capacity to ensure the procurement process and contract management system captures all potential areas of social value.

Some public bodies reported high levels of staff on sick leave during this period and smaller public organisations appear to have faced greater negative impact due to the proportion of resource taken away from the day job when responding to the Covid-19 crisis. For example, one local authority reported that responding to Covid-19, meant that 10 from a team of 16 employees were diverted from daily tasks. This has meant that some [innovative] projects have been paused and, in some cases the additional burden on staff to manage both normal daily activity and Covid-19 related activity means that significant pressures have been placed on staff – with a fear of 'burn out'.

Time pressured procurement

The urgent need to re-think approaches to procurement to centralise and urgently scale up the supply of products and services required for Covid-19 sometimes meant that internal communication and consultation has been impacted. This has slowed down some procurement and shortened procurement pipelines, leaving less time for suppliers to prepare.

Public bodies reported that the urgency for supply and some relaxation of some procurement regulation meant that they were better able to prioritise local spend and support local communities, while others struggled with establishing supply chain voids and knowing how to reach out the local market quickly. This varied dependent on the type of product or service being procured. This point also relates back to the issue on capacity and resource.

Public bodies with lower spend and high-level uncertainty (power to purchase) found that they do not offer sufficient investment to convince suppliers to have a strategic change of direction, i.e, they were not able to offer suppliers a higher sense of longer-term security.

Embedding well-being and social value

The response to the Covid-19 crisis has brought contrasting results when it comes to achieving social value. As a whole, prioritisation of the Act has reduced during Covid-19; procurement teams have had to contend with supply voids, short timescales and staff sickness. However, there have been some examples where Section 20 Review participants felt well prepared and didn't feel they needed to compromise on considering well-being objectives or delivery on the Act.

Projects Paused

Some public bodies reported that procurement spend has been reduced during the crisis with many new and innovative projects being put on hold leaving less opportunity to embed social value. But there have been examples of good practice where local suppliers have been deliberately sourced to provide goods and services necessary for the crisis period. This is especially relevant in the procurement of medical equipment (PPE, hand sanitiser).

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Case Study - National Library of Wales

During the Covid-19 pandemic, the National Library of Wales decided to cancel the procurement of a £4million project to build a storage facility as part of the national broadcasting archive. The funding for this is being invested in things that deliver community engagement with culture and heritage through digitalisation. This approach has been welcomed by the Heritage Lottery and contributes to their well-being objective to "deliver new ways of interpreting our collections to a wide range of audiences". In addition, this procurement outcome reflects the changing needs of Welsh citizens in response to Covid-19 where loneliness during periods of self-isolation has had a negative impact of people's mental health.

COVID-19 Lessons Learned & Opportunities

Although there has been little time, if any, to capture lessons learned during the crisis, it is important to consider how we can learn from the positive action during this period and take these lessons forward over the long-term. The Covid-19 learning project has been underway by Audit Wales' Good Practice Exchange and the Institute of Welsh Affairs (IWA) is seeking to learn from this period.

Some initial feedback to highlight includes:

Embedding well-being and Social Value

Some participants felt well prepared and did not feel they needed to compromise on well-being objectives or delivery on the Act because of Covid.

Strategically Elevating Procurement

There is a widely held view that the perception of procurement within the organisation has improved since Covid-19; procurement has been a critical function in terms of how public bodies have had to respond with opportunities to demonstrate how it can support delivery of key outcomes. Greater focus on outcomes over process is illustrated by Velindre NHS Trust who reported a higher drive towards achieving more value-based healthcare recognising the impact of procurement decisions from the patients' point of view with end users being more involved in product design.

Accelerating Innovation

Dearth in the supply market for PPE and other emergency products, has meant that Covid-19 has provided an opportunity for innovation in procurement with more focus on outcomes than process.

For example, building on the success and lessons learned from initiatives such as “Better jobs closer to home”, the Foundational Economy Challenge Fund has enabled experiments in the more challenging aspects of procurement such as through social care with lessons being shared through a Community of Practice (CoP) forum with the aim of developing and scaling-up similar projects across Wales. One important message that has become clear during the pandemic is the need to support Welsh small and medium-sized enterprises to be more resilient, able to scale up quickly, to diversify and to grow.

Sector Engagement

Discussions with the public bodies during the Section 20 Review showed that opportunities for more local sourcing has meant there has been greater motivation for public bodies to engage with third sector partners who have historically been perceived as weaker links around the table. But since Covid-19, their unique position and closeness to serving local communities has changed the dynamic and attitude.

Workforce Mobility

The pandemic period has demonstrated that most procurement work can be managed electronically without the need to travel, with the same objectives within reach. This could offer opportunities for a more agile approach to collaborative procurement that have yet to be explored.

Budget Silos

[Outside of procurement] the crisis has accelerated the need for public organisations to better understand ‘what is value?’. Increased costs of sourcing locally may represent long-term better value for money as it is important to weigh up other factors such as logistics costs, whole life cost, and to factor in whether a higher cost product achieves wider or more longer-term benefits to the local economy. Local suppliers are also closer to understanding local needs.

Legacy Building

Covid-19 has demonstrated that a lot can be achieved in a short space of time which has prompted procurement professionals to work with others in the organisation to review how to procure differently, to understand the impact of the scale and scope of change when interventions are possible. Legacy building and understanding tools and techniques for capturing value is key going forward; participants quoted examples (e.g., face coverings) to understand what can be done when cost is not a priority driver.

Procurement of personal protective equipment (PPE)

There have been examples of Welsh manufactures adapting their capabilities to develop local supply chains for PPE and other emergency products during the pandemic.

- One of the first examples in Wales was the Royal Mint, a producer of coins, who adapted their manufacturing capabilities and created a medical visor, gaining mass production approval within 48 hours. The medical visors are being supplied to hospitals in Wales.
- Local gin producers Hensol Castle Distillery adapted their manufacturing capability in response to Covid-19 and supplied the health board with hand sanitiser.

The Auditor General for Wales stated that "although the bulk of PPE came from international suppliers, the Welsh Government and NHS worked with Welsh manufacturers to develop local supply chains. Welsh Government officials told us that this involved collaborative working within the Welsh Government, NHS and Industry Wales through the critical equipment requirements engineering team (CERET)." This collaborative approach during the crisis is welcome and should be built on over the long-term as we look to recover from the pandemic.

COVID-19 Concluding Statement

Due to the pervasive nature of the pandemic, and the significant role of procurement, it has been important to understand the opportunities and challenges experienced by public bodies when considering the Act during the procurement process.

The response to Covid-19 has demonstrated that procurement can deliver ambitious and innovative outcomes, in a time-pressured environment, sometimes with reduced capacity. Looking towards a Covid-19 recovery, it is important for this good practice is scaled up, reflecting upon the lessons learned.

Equally, the impact of Covid-19 has drawn attention to the existing barriers to delivering procurement outcomes in line with the requirements of the Act, including an absence of organisational buy-in, leadership involvement and engagement (both with the Act and with procurement), having insufficient resources and capacity, along with the challenges navigating what has become an increasingly complex landscape.

The lessons learned from Covid-19 appear to have accelerated change with special attention to working digitally and working from home leading to greater environmental benefits. In procurement there has been improved collaboration horizontally across public bodies and vertically between public bodies and the local supply market. It was noted by some public bodies that while they are keen to continue with the changes made, there is a fear that business will revert to normal pre-covid times.

As we emerge from the pandemic and meet head on the economic and social fallout, it is critical that we do not lose sight of the advancements made and that procurement continues to develop. There is more of an imperative than ever for the Welsh Government to address the barriers to implementing sustainable procurement, to ensure that public money is spent in a way which drives wider benefits towards those further from the labour market, towards meeting our decarbonisation targets and towards the regeneration of communities worst hit by the crisis.

04 RECOMMENDATIONS FOR WELSH GOVERNMENT

These Recommendations are designed to promote and sustain positive change, but to have maximum effect they need to be considered expeditiously. The Recommendations were put together on the basis they can, and ought to be achieved, within the next 12 months, i.e before end March 2022.

Issue highlighted:

Welsh Government has failed to show clear joined up leadership on the role of procurement in delivering Wales' national well-being goals (and public bodies well-being objectives).

Recommendations to Welsh Government

- Welsh Government should establish a Procurement Centre of Excellence for improving coordination, collaboration and providing practical support to public bodies in the exercise of their procurement functions, specifically in relation to the Act. Development of this Centre of Excellence would require a comprehensive review and reform of the existing procurement landscape (structures, networks, partnerships and initiatives) and be resourced to build capacity and support implementation.
- The new Programme for Government should clearly set out how Welsh Government will provide strategic leadership and commitment to supporting and achieving wider outcomes from procurement, using language that is consistent with the Act.
- Welsh Government's new Procurement Policy Statement should clearly demonstrate how it will support public bodies to deliver the aspirations of the Act in public sector procurement in Wales. This Statement, along with progress to deliver the commitments, should be reviewed and reported annually.
- Welsh Government should ensure all future national procurement frameworks align with, and contribute to, the seven national well-being goals and apply the five ways of working set out in the Act.

Further advice on how this could be achieved:

We would strongly advise that this Centre of Excellence is not developed by civil servants alone, but should be done in collaboration with the wider procurement community and external experts, with Ministerial oversight. Welsh Government should involve a holistic range of organisations who bring knowledge and expertise of each of the national well-being goals as well as relevant professions. This structure could have oversight from the Office of the Future Generations Commissioner but as a minimum should have a clear link.

The Centre of Excellence will:

- Act as a central portal to coordinate and support cross-sector collaboration and implementation.
- Report outcomes delivered through procurement on a regular basis.
- Provide feedback to public bodies on good and bad practice.
- Support and enable shared learning amongst public bodies that drives improvement in line with the Act.
- Provide on the ground practical support for the procurement profession.
- Raise the profile of procurement, giving agency and authority to procurement professionals supported by senior-level commitment.

Welsh Government should establish the Centre and set clear outcomes (in agreement with others), reporting annually on how these are being delivered.

Welsh Government's Centre of Digital Service is an example of a 'mechanism' designed to provide guidance, training, standards, collaborative networking and hands-on practical help to the Welsh public services. A similar approach could be taken for procurement.

The Foundational Economy Challenge Fund, Centre for Local Economic Strategies (CLES) work and the development of Welsh National TOMs highlighted in this report are a good starting point. However, there needs to be better integration and more join up between these projects, as well as the provision of additional coordinated practical support for public bodies.

Welsh Government should provide practical guidance, supporting public bodies using national and/or regional frameworks to contribute to the seven national well-being goals and apply the five ways of working set out in the Act.

Issue highlighted:

There is poor communication and integration between different Welsh Government priorities, alongside lack of support available for public bodies to ensure these are implemented effectively on the ground.

Recommendations to Welsh Government

- Welsh Government should review all guidance and toolkits that are currently in place to support sustainable procurement and measure/monitor community benefits and/or social value, and publish a clear plan outlining how these will be revised and consolidated to enable a consistent approach for public bodies to report on the well-being outcomes being achieved.
- In order to meet carbon emission targets every public body should set out clearly how they have considered the carbon impact of their procurement decisions and in the case of construction or infrastructure contracts should clearly require schemes to be net zero carbon over their lifetime.

Further advice on how this could be achieved:

The forthcoming Social Partnerships Bill will need to ensure that the new procurement duty placed on public bodies supports them to deliver outcomes that will help them to achieve their well-being objectives and, in turn, the national well-being goals.

A recent Wales Co-operative Centre report provides a useful summary of how existing legislation, policy and guidance supports delivery of social value within the social care sector.

Issue highlighted:

Opportunities for making spend work harder are being missed due to lack of support for the procurement profession and lack of accountability at a leadership level.

Recommendations to Welsh Government

- The Procurement Centre of Excellence should review and reform structures for national accountability and establish an appropriate mechanism to scrutinise progress on implementation. Welsh Government should report annually on how overall national public spend is contributing to the national well-being goals.
- In addition, their annual report (on progress with the Act) should clearly set out how all of their own procurement spend, and grant spend, is contributing to meeting their well-being objectives, and in turn the seven national well-being goals.

Further advice on how this could be achieved:

This Centre of Excellence will be connected to key decision-makers including Ministers and public sector leaders, and supported by external advisers with knowledge and expertise of each of the national well-being goals as well as relevant professions. The Centre will have a specific remit to highlight where overall spend across Wales is not aligning or making slow progress to meeting the well-being goals and directing national action to address this.

Issue highlighted:

There is no ongoing monitoring of procurement approaches or outcomes either for the purposes of spotting where things are going wrong, and opportunities are being missed, or for identifying and sharing best practice.

Recommendations to Welsh Government

- The Procurement Centre of Excellence should develop a mechanism or tool to assist public bodies to monitor and report consistently on the Act (possibly building on the work being done on social value and the new TOMS framework) demonstrating how their procurement spend is meeting the well-being goals and objectives.
- Welsh Government should monitor progress by public bodies in Wales. This must be reported within the annual reports on delivery of their well-being objectives for both Welsh Government in respect of the overall outcomes being delivered across Wales and by individual public bodies.

Further advice on how this could be achieved:

Welsh Government should commit to providing support to public bodies (specifically the procurement function) on achieving this.

This could include establishing a Community of Practice for sharing and learning what works.

05 RECOMMENDATIONS FOR PUBLIC BODIES, INCLUDING WELSH GOVERNMENT

Again, these Recommendations are designed with a 12-month (before end March 2022) timeframe in mind, unless stated otherwise.

Issue highlighted:

Opportunities to deliver on all four dimensions of well-being are not being maximised, often due to lack of leadership and strategic approach that recognises the 'power of purchase'.

Recommendations to Public Bodies

Senior leadership should review their procurement approach and activities to identify opportunities to maximise the social, economic, environmental and cultural impact of spending decisions, setting clear steps that show how procurement is supporting the delivery of their organisational well-being objectives.

Further advice on how this could be achieved:

Procurement needs to be 'at the top table'. Public bodies should involve departments and organisations who are involved in, and impacted by, the procurement process when setting well-being objectives (e.g. commissioning, contract management, suppliers and waste management). This could lead to public bodies understanding the broader benefits and steps they can take to improve all aspects of well-being through procurement.

Issue highlighted:

The "procurement system" is too often leading to a focus on process and short-term cost rather than delivering wider outcomes over the long-term, and there is no consistent way of measuring the outcomes that can be achieved in line with the Act. There needs to be a shift to considering long term costs holistically, in line with the Act.

Recommendations to Public Bodies

Once a mechanism or tool is developed and adopted by Welsh Government (as recommended above), each public body should be using it to clearly monitor and report on its activities, both in individual procurement exercises and overall, how their procurement spend is meeting the well-being goals and objectives.

- This should be reported within the annual reports on delivery of their well-being objectives.
- In order to avoid confusion of language, and link clearly to the statutory requirements of the Act, the terminology should be revised to mirror the language of the Act.

Further advice on how this could be achieved:

As a minimum, all contracts above £1 million (same as Community Benefits Toolkit) should include an assessment of the outcomes being delivered against the four dimensions of well-being (cultural, economic, social and environmental) or the seven well-being goals and their own well-being objectives.

Public bodies should proactively participate in the Community of Practice for sharing and learning what works.

Public bodies should use the resources published by the Future Generations Commissioner and other organisations.

- Chapter 2 in the Future Generations Report 2020 'A spotlight on Procurement' outlines a vision for public section procurement in Wales with recommendations for all public bodies (including Welsh Government).
- Chapter 4 of the Future Generations Report 2020 focuses on 'Setting good well-being objectives'.
- Art of the Possible 'journeys' for each of the seven well-being goals provide guidance for public bodies on the actions they should be taking. Fair and local procurement is a theme within a Journey to a Prosperous Wales, and ethical consumption and procurement is a theme within a Journey to a Globally Responsible Wales.

Issue highlighted:

There is no mechanism for promoting effective collaboration for public bodies, particularly cross-sector to improve sharing, learning, capacity and skills.

Recommendations to Public Bodies

The Procurement Centre of Excellence established by Welsh Government will act as a central portal to support cross-sector collaboration and implementation. In collaboration with others Welsh Government should review existing groups and networks to better coordinate activity across local government, health, PSBs and regions, along with the third sector and private sector.

Public Services Boards should prioritise how they can collaborate and use spend to maximise social value, contribute to their well-being objectives, and improve well-being on a local level.

Further advice on how this could be achieved:

Review the impact of existing initiatives and mechanisms (e.g. Knowledge Hub, Foundational Economy Community of Practice, national and regional networks).

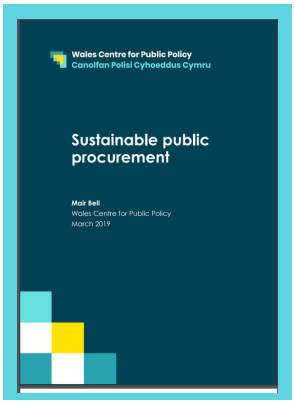
Greater peer-to-peer support to harness good practice and drive change across sectors.

The Centre for Local Economic Strategy (CLES) is currently working with five clusters of Public Services Boards in Wales to explore opportunities around procurement, local spend and community wealth building. There should be support to scale this work up across Wales.

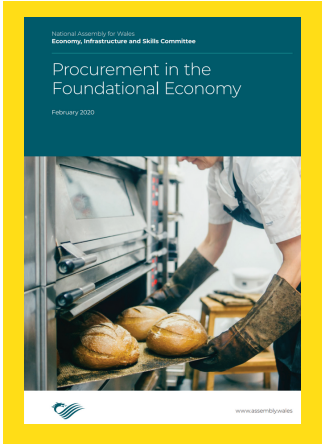
Useful resources and tools, which can help you follow these recommendations:

The Future Generations Report 2020 - This report sets out the Commissioner's assessment of progress made in implementing the Act within the reporting period.

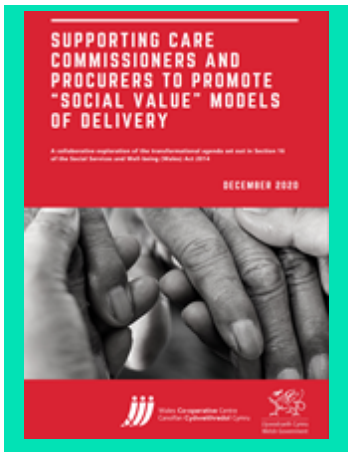
The Manifesto for the Future - This document aims to amplify the voices of young people as we approach the Senedd election in 2021. It sets out the key recommendations that the Commissioner wants to see the next Welsh Government commit to. The Commissioner has called on all political parties to consider these recommendations within their manifesto work.



The Wales Centre for Public Policy 'Sustainable Public Procurement' 2019 Report - Outlines how to implement sustainable procurement practices.



Procurement in the Foundational Economy - This report highlights the Welsh Government's ambitions for the role of procurement in Wales, the current role of procurement, and best practice examples.



Supporting Care Commissioners and Procurers to Promote 'Social Value' Models of Delivery - This document is the outcome of work commissioned from the Wales Co-operative Centre by the Welsh Government in mid-2019. The intention was for the work to "influence commissioners and procurers to promote co-operatives and other social value models".

The National TOMs Wales - A framework for social value measurement and management that allows for an unlocking of social value through its integration into procurement and project management. It incorporates all of the requirements of the Community Benefits Toolkit and has been designed to allow organisations to assess their social value contribution to the Well-being of Future Generations Act.

Useful contacts to support you with following these recommendations:

Wrap Cymru

National Social Value Taskforce

National Procurement Service

Constructing Excellence in Wales

Natural Resources Wales

Welsh Local Government Association

Atebion Solutions

Procurement & Supply Chain Knowledge - CIPS

Sustainable Procurement - CIPS

Institute for Collaborative Working

Making Wales a Deforestation Free Nation – Size of Wales