Audit Risk & Assurance Committee

Tue 07 October 2025, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_ 07Oct2025.pdf (3 pages)

1.1. Welcome and Apologies

Verbal *Chair*

1.2. Declarations of Interest. Board Members Register of Interest

Verbal/Attached *All*

ARA_1.2_Board Members Register of Interests Sept25.pdf (3 pages)

10:00 - 10:00
0 min

2. CONSENT AGENDA BUSINESS

10:00 - 10:00
0 min

3. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

3.1. Minutes of the previous meeting held on the 08 July 2025

Attached *Chair*

ARA_3.1_ARAC Minutes 08JULY2025.pdf (11 pages)

3.2. Committee Action Log

Attached *Chair*

ARA_3.2_ARAC_Action Log 2025-26.pdf (1 pages)

10:00 - 10:00
0 min

4. ESCALATED ITEMS

There are no items for inclusion within this section

10:00 - 10:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Internal Audit Progress Report

Attached *Head of Internal Audit*

ARA_5.1_Internal Audit Progress Report October 25 Cover.pdf (2 pages)
ARA_5.1a_Internal Audit Progress Report October 25.pdf (12 pages)

5.2. Internal Audit Reports: Duty of Candour

Attached *Head of Internal Audit*

ARA_5.2_PTH-2526-22 Duty of Candour Final Internal Audit Report.pdf (13 pages)

5.3. External Audit Progress Report

Attached *External Audit*

ARA_5.3_Audit Wales Update October 2025.pdf (12 pages)

5.4. External Audit Reports: Planned Care

Attached *External Audit*

ARA_5.4_Tackling the Planned Care Challenges Powys.pdf (48 pages)

5.5. Learning from Annual External Audit of Account & Annual Report 2024/2025

Attached *Deputy Chief Executive/Director of Finance, Capital and Support Services*

ARA_5.5_Learning from the Annual External Audit of Accounts and Annual Report 2024-25.pdf (11 pages)

5.6. Counter Fraud Update & Reports

Attached *Counter Fraud*

ARA_5.6_Counter Fraud Update Report.pdf (5 pages)

5.7. Audit Tracker

Attached *Director of Corporate Governance*

ARA_5.7_Audit Recommendations Cover Paper_Sept2025.pdf (13 pages)
ARA_5.7a_Internal Audit Findgings_Completed since the previous report.pdf (3 pages)
ARA_5.7b_Internal Audit Findgings_Not Yet Due.pdf (2 pages)
ARA_5.7c_Internal Audit Findings_that are Overdue.pdf (1 pages)
ARA_5.7d_Internal Audit Findings_with Deadline Revised.pdf (1 pages)
ARA_5.7e_External Audit Findings_Completed since last report.pdf (1 pages)
ARA_5.7f_External Audit Findings_that are Overdue.pdf (1 pages)
ARA_5.7g_External Audit Findings_with Revised Deadlines.pdf (1 pages)

5.8. Financial Controls

Attached *Deputy Chief Executive/Director of Finance, Capital and Support Services*

ARA_5.8_Financial Controls_Oct 2025.pdf (10 pages)

5.9. Risk and Assurance Update

Attached *Director of Corporate Governance*

ARA_5.9_Risk Management and Board Assurance Update_October 2025.pdf (5 pages)
ARA_5.9a_Appendix A - Strategic Risk Register (Board, July 2025).pdf (70 pages)
ARA_5.9b_Appendix B - Board Assurance Framework (BAF) Dashboard (Board, July 2025).pdf (8 pages)
ARA_5.9c_Appendix C - Board Assurance Framework Dashboard - Analysis Principles.pdf (5 pages)

5.10. Information Governance Performance Report

Attached *Director of Corporate Governance*

ARA_5.10_IG Key Performance Report Q1 25-26.pdf (15 pages)

5.11. Digital First Quarterly Monitoring

Attached *Executive Director of Allied Health Professions, Health Science and Digital*

ARA_5.11_Digital First Assurance Report.pdf (60 pages)

5.12. SFI Executive Financial Delegation Limits

Attached *Director of Corporate Governance*

ARA_5.12_SFI Non-pay Executive Delegations.pdf (4 pages)

10:00 - 10:00 ## 6. ITEMS FOR DISCUSSION

0 min

There are no items for inclusion within this section

10:00 - 10:00
0 min

7. CONSENT AGENDA

7.1. Organisational Register of Interests (including budget oversight) Gifts and Hospitality

Attached *Director of Corporate Governance*

ARA_7.1_Declaration of Interests, Gifts & Hospitality Sept 2025.pdf (4 pages)
ARA_7.1a_AppA_Decl of Interests Register 2025-26 Sept25.pdf (5 pages)

7.2. Losses and Special Payments

Attached *Deputy Chief Executive/Director of Finance, Capital and Support Services*

ARA_7.2 Losses and Special Payment interim report October 2025.pdf (7 pages)

7.3. Single Tender Waivers (including extensions to contracts)

Attached *Deputy Chief Executive/Director of Finance, Capital and Support Services*

ARA_7.3_Single Tender Waiver Report.pdf (3 pages)

7.4. Information Governance Toolkit (National Audit replaces Caldicott Principles)

Attached *Executive Medical Director*

ARA_7.4_FINAL IG Toolkit Out-Turn Report and Improvement Plan 25-26.pdf (8 pages)

7.5. Committee Work Programme 2025/26

Attached *Director of Corporate Governance*

ARA_7.5_2025-26_ARA_Committee work plans.pdf (1 pages)

7.6. PTHB Glossary

Attached *Director of Corporate Governance*

ARA_7.6_Powys Teaching Health Board Glossary.pdf (5 pages)

10:00 - 10:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

Verbal *Chair*

8.2. Items to be Brought to the Attention of the Board and Other Committees

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of next meeting: 13 January 2026

8.5. In-Committee

Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interes

AUDIT, RISK AND ASSURANCE COMMITTEE
TUESDAY 07 OCTOBER 2025
10:00-13:15
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT

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

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest • Board Members Register of Interests	Verbal/ Attached	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
	3.1	Minutes of previous meeting held on 08 July 2025	Attached	Chair
	3.2	Committee action log	Attached	Chair
	4	**ESCALATED ITEMS**		
There are no items for inclusion within this section				
	5	**ITEMS FOR ASSURANCE**		
10:10 5mins	5.1	Internal Audit Progress Report 2025/2026	Attached	Head of Internal Audit
10:15 30	5.2	Internal Audit Reports: • Duty of Candour *(Reasonable Assurance)*	Attached	Head of Internal Audit
10:45 5	5.3	External Audit Progress Report	Attached	External Audit
10:50 20	5.4	External Audit Reports • Planned Care	Attached	External Audit
11:10 15	5.5	Learning from Annual External Audit of Accounts & Annual Report 2024/25.	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
11:25 10	5.6	Counter Fraud Update & Reports	Attached	Counter Fraud
11:35	**COMFORT BREAK (10mins)**			
11:45 10	5.7	Audit Tracker	Attached	Director of Corporate Governance
11:55	5.8	Financial Controls	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services

12:10 10	5.9	Risk and Assurance Update	Attached	Director of Corporate Governance
12:20 15	5.10	Information Governance Performance Report	Attached	Director of Corporate Governance
12:35 25	5.11	Digital First Quarterly Monitoring	Attached	Executive Director of Allied Health Professions, Health Science and Digital
13:00	5.12	SFI Executive Financial Delegation Limits	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Organisational Register of Interests (including budget oversight), Gifts and Hospitality	Attached	Director of Corporate Governance
	7.2	Losses and Special Payments	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
	7.3	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
	7.4	Information Governance Toolkit (National Audit replaces Caldicott Principles)	Attached	Executive Medical Director
	7.5	Committee Work Programme 2025/26 (For Information)	Attached	Director of Corporate Governance
	7.6	PTHB Glossary (For Information)	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
13:00	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 13 January 2026 via Microsoft Teams		
8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:				

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
13:00	8.6	Welcome and apologies	Verbal	Chair
	8.7	Declarations of Interest	Verbal	All
15min	8.8	Committee Risk Register	Attached	Director of Corporate Governance

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

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26

Updated: September 2025

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned
INDEPENDENT MEMBERS								
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	**Kirsty Williams**	Non Finanical personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025
		Non Finanical personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsiduary of Cardiff University	None	
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Finanical personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	**Steve Elliot**	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Partner-Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	**Simon Wright**	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	10/06/2025
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	

		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None	
		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL	
Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL	
Independent Member (Capital)	**Michael Giannai**	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
Independent Member	**Ian Thomas**	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	NIL	09/04/2025
EXECUTIVE MEMBERS								
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025
		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery		
Executive Medical Director	**Kate Wright**	Non-Finanical professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025
Executive Director of People and Culture	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated	29/05/2025
			Outside Employment	01-Sep-25	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	NIL	

Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Parnter - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	

AUDIT, RISK AND ASSURANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 08 JULY 2025 AT 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ian Thomas	IT	Independent Member (General)
Kirsty Williams	KWi	Independent Member (PTHB Vice Chair)
Ronnie Alexander	RA	Independent Member (General)
Rhobert Lewis	RL	Independent Member
Mick Giannasi	MG	Independent Member
IN ATTENDANCE		
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Kate Wright	KW	Executive Medical Director
Hywel Pullen	HP	Deputy Director of Finance
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
David Owens	DO	Assistant Director of Digital, Technology and Data Operations
Bethan Hopkins	BH	Audit Wales
Ali Tariq	AT	Audit Wales
Sarah Pritchard	SP	Head of Financial Services
Stella Gwynne	SG	Deputy Board Secretary
Hayley Thomas	HT	Chief Executive Officer
Louisa Steele	LS	Counter Fraud
Ian Virgil	IV	Head of Internal Audit
Matthew Evans	ME	Counter Fraud
Katie Blackburn	KB	Llais
Bethan Powell	BP	Corporate Governance Officer
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	PTHB Chair
Amanda Legge	AL	NWSSP
Kirsten Jones	KJ	Llais

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/039)

The Chair welcomed everyone to the meeting, in particular those members who were in attendance as part of the new Committee Membership. Apologies for absence were received as recorded above.

1.2 DECLARATIONS OF INTEREST (ARA/25/040)

The Chair NOTED the attached Register of Interests and provided an opportunity for the declaration of any further interests pertaining to the meeting agenda.

2. CONSENT AGENDA BUSINESS (ARA/25/041)

No items were requested for inclusion in the main agenda.

3. ITEMS FOR APPROVAL/DECISION/RATIFICATION

3.1 MINUTES OF THE PREVIOUS MEETING HELD ON 17 JUNE 2025 (ARA/25/042)

The minutes of the meeting held on 17 June 2025 were **CONFIRMED** as an accurate record.

Matters Arising

SG confirmed that a PowerPoint summary would be presented at the Health Boards Annual General Meeting (AGM) later in the year to act as an easy read of the Annual Report.

Members suggested the need to explore Artificial Intelligence which may be a beneficial cost-effective resource for administrative tasks. It was confirmed that Corporate Governance are seeking Co-pilot Pro licenses to support this work.

3.2 COMMITTEE ACTION LOG (ARA/25/043)

The Committee **RECEIVED** the action log, and the following updates were provided:

ARA/25/032- Explore MoU arrangements with RPB- Due January 2026.
ARA/25/031 - To clarify the number of PTHB estates buildings occupied by HCRW. It was confirmed that the number was 0, however HCRW did have access to hot desks in the Brecon / Bronllys area, however, do not formally occupy any PTHB buildings.

It was noted that a recent meeting had taken place with the Regional Partnership Board (RPB) where it was recognised that a need for a more structured understanding of hosted agreements between the Health Board and RPB.

Given the use of hot desks across the organisation, were there costs associated with this?
PH explained that there is a hosting agreement in place with Health Care Research Wales (HCRW) relevant to all Health Board premises and facilities to which is under review across ensure appropriate.

4 ESCALATED ITEMS

There were no items for inclusion within this section.

5 ITEMS FOR ASSURANCE

5.1 INTERNAL AUDIT PROGRESS REPORT 2025/2026 (ARA/25/031)

IV provided an overview of the report including the conclusions and assurance ratings for audits finalised in the reporting period. There had been two audits from the 2024/25 plan which had been finalised since the last meeting of the Committee,

Cancer Services (Reasonable Assurance) and Mattresses (Limited Assurance). It was noted that two audits remained work in progress with a further ten at the planning stage.

IV highlighted that the Decontamination Audit Report had been requested to be deferred from Quarter 1 to Quarter 3 due to a change in the Assistant Director and availability of the key management contact. The Head of Internal Audit confirmed the deferment was appropriate.

Independent Members sought assurance by asking the following questions:
Can assurance be provided that Executive and management capacity is considered to enable delivery as Audits are being planned and undertaken?
IV confirmed that the Audit plan and individual audits are developed in collaboration with the Executive and the management lead. There is a consistent and clear dialogue between both parties to ensure management are engaged to ensure the work is facilitated as planned.

Are there any concerns of the plan not meeting its full delivery and is it anticipated to be delivered as scheduled?
IV explained that Powys has adequate resources in place to deliver the plan at present, recognising that Powys audits are provided by the All Wales Shared Service Auditor provision this provides flexibility to support delivery of plans where required. The team continue to progress audits to completion to ensure deliverability in line with the audit plan.

Would the accounting issues that arose from the 2024/25 Annual Accounts, be considered as part of the Continuing Health Care (CHC) audit?
IV confirmed that the scope of the audit is yet to be finalised and acknowledged the work undertaken by Audit Wales and the accounting issues would be included I requested and agreed by management.

Is the timing change of an audit agreed with the relevant Director?
HT confirmed that any requested change to an audit would need to agree with the relevant Director and would be reviewed by the Executive Committee.

The Committee **NOTED** and **RECEIVED** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.

5.2 INTERNAL AUDIT REPORTS (ARA/25/032)

IV gave an overall view of the assurance obtained from the following Audits:

a) Mattresses *(Limited Assurance)*
b) Cancer Services *(Reasonable Assurance)*

a) Mattresses

IV provided an overview of the report and confirmed a rating of Limited Assurance. Five high priority and two medium priority findings had been found in relation to:

- Lack of awareness and specific training of the Mattress Policy
- No confirmation of compliance in line with the policy
- No periodic review undertaken to check completion of follow up issues
- Monthly mattress audits not completed

- Missing mattress audit information
- No central monitoring and reporting arrangements in place
- No confirmation that actions are taken to address identified issues

Management had agreed to all seven recommendations which would be implemented imminently.

Independent Members sought assurance by asking the following questions:
Was a specific sampling method utilised to undertake this audit?
IV confirmed that the audit of policy and processes is based on establishing areas that should be complied with. A different technique would be utilised across other process-based audits for the Health Board.

Could assurance be provided on the stability of ward staff?
CM explained that ward staff stability was not a concern. As part of the management response, a robust central system would be implemented as part of the monthly monitoring and reporting arrangements.

Was there a read across to Healthcare Associated Infection (HCAI)?
The audit undertaken was triggered from HCAI which had been a driver for review and improvement.

What improvement would be established as a consequence of the Audit?
A Medical Devices meeting had been established to monitor the drivers and areas of concern. CM confirmed that data provided low numbers of incidents but were confirmed as specific.

The field work of the audit states it was undertaken between April and June 2024 and sign off in June 2025, what was the rationale for the delay?
IV confirmed this was an administrative error and should state April and June 2025. This would be amended accordingly.

The proposed target date to deliver staff training is set at the end of July, is this realistic?
CM explained that the deadline to complete staff training was set within a small window given the need to urgently address the issues raised and to ensure compliance had improved. Staff training would be undertaken to familiarise the recording of periodic reviews and follow up would be implemented immediately by ward managers. A centralised monitoring and reporting Business intelligence (BI) dashboard system would be developed and implemented to improve and strengthen reporting mechanisms. However, it was noted that the timeframe would be reviewed.

What interim measures would be put in place, given that the new central digital system will not be implemented until September 2026?
Ward Managers would be responsible for ensuring all staff are aware of the Mattress policy and undertaken specific training to ensure compliance is met. Periodic reviews would be undertaken to check completion of follow up issues and monthly mattress

audits would be established and monitored. The data would be reported to the Medical Devices monthly meeting to provide assurance on the progress undertaken.

Are we confident that this is indicative of a wider cultural issue particular in terms of Infection Prevention Control (IPC)?
HT explained that spot checks would be undertaken across a number of wards following the completion of staff training to ensure that other aspects of compliance are appropriate.

KW noted that the IPC implementation improvement plan is monitored by the Patient Experience, Quality and Safety (PEQS) Committee. All Hospital acquired infections are recorded through the Integrated Quality and Performance report which is consistently reviewed by the PEQS Committee.

The Committee **RECEIVED** and **NOTED** the report.

a) Cancer Services

IV provided an overview of the report and confirmed a rating of Reasonable assurance. The scope of the audit did not include a review of the controls operating within external provider organisations. Although the impact on commissioned services was considered, during the time of the audit. Two medium and one High priority findings had been found in relation to:

- Need to formalise the arrangements of the Cancer group;
- Actions can be overlooked, responsibilities unclear, and progress stalled;
- Fragmented IT infrastructure for national cancer services performance;

Three actions had been identified to take forward in formalising the Cancer Group and development of Terms of Reference, monitoring and recording appropriate actions and target date of completion and copies of communications of meetings that demonstrate continued engagement and advocacy with providers.

HT explained the importance of the IT infrastructure for Cancer services performance which continues to be escalated via Joint Executive Team (JET) meetings. A National Cancer recovery plan for 2025/26 and improvement plan had been recognised as part of the national deliverables. The Health Board recognised the focus on cross border providers of cancer service performance and would ensure it is featured within the revised workplan.

Independent Members sought assurance by asking the following questions:
What work was being progressed to review the accuracy of recording in Primary Care at a point of cancer suspicion?
KW explained that this had been advocated in addition to the single cancer pathway and would need to be addressed nationally. Discussions were ongoing through a number of national forums to ensure this is focused as a key priority.

When audits are completed, are they published publicly or upon request?

IV confirmed that the Audits are available at a point where the Committee papers are published on the PTHB website and through internal mechanisms.

The Committee discussed the management response statement 'The majority of issues are outside the Health Board's control and relate to the national IT infrastructure in place'. Members recognised the need to review the narrative of the management response to identify what work can be undertaken and withdraw focus on elements outside of the Health Board's control.

Committee Members recognised the volume of internal audit reports and the overlap during quarters 3 and 4 and the impact of the internal audit programme given the significant ongoing pressures and demands across the health board.

The Committee **RECEIVED** and **NOTED** the Internal Audit reports.

5.3 CONFIRMATION OF CLINICAL AUDIT PROGRAMME IN PLACE (ARA/25/033)

KW confirmed that a Clinical Audit Programme is in place and provided members with an overview of its content.

Given the complexities and volume of clinical audits undertaken, was the correct emphasis highlighted in the audits, and would it be beneficial to focus on a smaller number?
KW explained that a large number were measurements of recognised fundamentals. There had been dialogue as to holding a number of clinical audits elsewhere, to minimise complexities. It was noted that software had been purchased which stores clinical quality audits and is currently utilised by Nursing staff. As this software matures there may be potential to transfer clinical audit into this platform.

The formation and methodology of the audit plan had significantly improved and strengthened in recent years. It was noted that a mid-year review of clinical audits and thematic assessment was due to be implemented.

The Committee took **ASSURANCE** that the Health Board has a Clinical Audit Plan in place which is overseen by the Patient Experience, Quality and Safety Committee.

5.4 EXTERNAL AUDIT PROGRESS REPORT AND MANAGEMENT RESPONSE (ARA/35/034)

BH provided the committee with an overview of the External Audit progress report and management responses against the following Audits:

- Review of Urgent and Emergency Care – Final report due October 2025
- All-Wales thematic review of Planned Care – The final report would be presented to its next meeting in October 2025;
- Structured Assessment 2024 Deep Dive – review of investment in digital systems – Project brief has been issued, final report due October 2025;
- Core Structured Assessment 2025– final project brief had been published, final report due October 2025;
- Follow up review of Quality Governance arrangements – Project brief issues with final report due October 2025;
- Review of arrangements for managing agency staff at planning stage;

- Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates at planning stage;
- The review of Cancer Services which was at the planning stage.

AT provided the committee with an update against the status of the current accounts audit work. The Accountability Report and Financial statements in respect of the Continuing Health Care (CHC) Accruals were under review. The Health Board was reworking calculations which would then be subject to audit. The final planned completion date was yet to be confirmed, and the significance of delay was recognised against the previous deadline of 27 June 2025. Audit Wales would then seek to publish the revised IS260 based on the outcome of the work undertaken.

The Committee recognised the disappointment felt by the Health Board for not meeting its statutory deadline to sign off the Annual Accounts by 27 June 2025. The Committee discussed the ongoing additional work to ensure the audit was completed appropriately prior to submission to Welsh Government. Following submission, a lessons learned exercise would be undertaken in regard to the errors outlined and presented to the Committee at its next meeting in October.

The Committee **RECEIVED** the External Audit report and Management responses.

5.5 COUNTER FRAUD UPDATE AND REPORTS (ARA/25/035)

ME presented the report and advised that The NHS Counter Fraud Authority had issues guidance in relation to the new Economic Crime and Corporate Transparency Act (ECCTA) 2023. ME explained that the legislation introduces a new offence of failure to prevent fraud and the Health Board would be required to comply. It was noted that the new legislation would come into effect from 01 September 2025.

Powys was rated 'green' status which represented good compliance of Counter Fraud governance. A number of recommendations would be explored followed by a formal risk assessment in line with Counter Fraud national guidance. This would be reported to the Committee in Q4.

Independent Members sought assurance by asking the following questions:
How was the allocation of resources managed?
ME explained the programme was on track to deliver the plan and the team were exploring the use of Viva Engage, an internal social media platform part of the Microsoft 365 package suite, as part of multi-modal means of raising awareness amongst a dispersed workforce.

Are the ECCTA six principles set from a top-down approach or of equal equivalence?
ME explained that the principles are all of equal importance and are mapped to the Health Board Counter Fraud standards. The Counter Fraud Policy is due to be reviewed, and the rewording of the principles would be updated to align legislation.

Is there a general pattern of activity regarding the number of working whilst sick cases?
This activity is monitored through a number of controls and processes in place which follow up any proactive actions to all investigations. A low level of incidents had been reported which was not unusual. The Counter Fraud liaison group share intelligence

of investigations and trends across all NHS organisations which helps manage risks across health boards.

Given the level activity, can Committee Members expect to see outcomes and impact featured in future reports?
ME explained that work is underway to develop a mature reporting process for Counter Fraud with the use of risk assessments to measure performance and outcomes. A Counter Fraud profile would be developed and presented to Committee at its meeting in March 2026.

Given the inaccuracy of the use of formulas, had there been any push back from other organisations of its use?
The use of formulas had been discussed at a national level in NHS Wales. Feedback had been received of the approach being UK based by the Counter Fraud Profession (Public Sector Organisation) with further concerns raised of utilisation of formula. ME confirmed the Health Board was cautious of its use and would keep the Committee informed of any national changes.

The Committee **RECEIVED** the report and took **ASSURANCE** that appropriate counter fraud systems are in place.

5.6 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/25/036)

The Committee received the report, and it was confirmed that there had been no Single Tender Waiver requests made between 01 May 2025 and 30 June 2025.

The Committee **NOTED** the report.

5.7 DIGITAL FIRST QUARTERLY MONITORING (INCLUDING CYBER SECURITY) (ARA/25/037)

CM introduced the report and DO provided the Committee with a comprehensive overview of the progress, challenges and areas for improvements across the Digital infrastructure.

Independent Members sought assurance by asking the following questions:
Do all organisations measure against the same targets and where does Powys benchmark against other health boards?
DO explained that measures are set internally, however they are based on other organisation targets to ensure a balanced comparison.

What is the Health Boards position with using Artificial Intelligence (AI)?
CM explained AI had improved the efficiency in Health Care, however, no national governance structure was available for health boards future direction. A number of teams across the organisation had experimented with copilot to explore this method of AI, it was recognised that this was available on an administrative basis and was limited for clinical use.

Was Powys an outlier with regard to the removal of Windows 10 by October 2025 in comparison with other health boards?

Yes, all health boards are preparing to invest in extended support in Microsoft which is noted as a significant cost. Powys had made good progress to date in comparison to other organisations.

Could clarity be provided that Wi-Fi is available to visitors across the Powys estate?
Powys had always provided a guest Wi-Fi service across the estate, although it was recognised that the usability required improvement. Following implementation of the new Wi-Fi system across the Health Board, patient experience had improved, and positive feedback had been received.

Committee members observed the importance of delivery and the need to explore AI across paediatrics to ensure opportunities are maximised. It was noted that AI had been trailed across clinical services in specialised areas and would be mostly beneficial to those patients across commissioned services. CM explained that Powys would expect to adopt digital AI following trail and testing elsewhere.

Can an update be provided on the Cross-border resources?
It was noted that Powys continue to face technical challenges with regards to the implementation of digital cross-border. Wye Valley Trust remains the sole cross-border organisation to engage to support the integration with resources committed to deliver through a number of escalation mechanisms.

The Committee **RECEIVED** the report and took **ASSURANCE** that work had progressed to deliver against the Digital Strategic Framework.

5.8 INFORMATION GOVERNANCE TOOLKIT (ARA/25/038)

It was noted that the item had been deferred to its next meeting in October 2025.

5.9 ASSURANCE OF RISK MANAGEMENT ARRANGEMENTS: STRATEGIC RISK REGISTER AND BOARD ASSURANCE FRAMEWORK (ARA/25/039)

HB provided an update on the progress made against the development of the Board Assurance Framework (BAF) and Strategic Risks. In March 2025, the Board approved the Risk Management Framework (RMF) and in May 2025 supported the new Risk Descriptors which supports the newly designed Strategic Risk Register.

It was noted that following the decision to transfer 'Digital' reporting from the Finance and Performance Committee into the Audit, Risk and Assurance Committee remit, a Strategic Risk Register would now be presented from the next meeting in October which focuses on Digital and Cyber Security. It was explained that it is the Committees responsibility to fully review and monitor this risk as part of the Committee's remit going forwards.

Significant progress had been made to develop the BAF, which displays a newly formed dashboard based on the Strategic Risk Register. The BAF Dashboard was noted as under development and would support the Board's SRR and would 'close the loop' of the risk management process.

The dashboard would focus on providing assurance in relation to the adequacy and effectiveness of the controls currently deployed by the Health Board to manage its strategic risks and will demonstrate a summary of the findings of associated available assurance.

Committee members proposed the potential benefit of a risk summary which indicates the significant changes to risk, including the risk owner and trend analysis. HB confirmed this would be considered as part of the development work.

Members discussed the need to consider an operating manual to support the Board Assurance Framework to help the assessment for consistency and the adequacy of assurance, controls and actions. Further work would be developed around risk prevention and how this is moderated across all aspects of risk management. This would be considered as part of the BAF and SRR development prior to the Board in July.

The Committee **NOTED** that the Strategic Risk Register (SRR) is currently under development and **RECEIVED** an overview of the risks due for allocation to this Committee. Members **RECEIVED** and **DISCUSSED** the proposed templates developed for the Board Assurance Framework Dashboard from July 2025.

5.10 ANNUAL CORPORATE GOVERNANCE DEVELOPMENT PLAN (ARA/25/040)

HB provided the Committee with an overview of the plan for continuous development, based upon the matters identified for actions within the 2024-25 annual review of Committee effectiveness. The plan comprises of a cross-Committee Action Plan and those significant actions which are specific to the Audit, Risk and Assurance Committee.

The Committee **RECEIVED** the Audit, Risk and Assurance Continuous Development Plan 2025-26 and **TOOK ASSURANCE** that the implementation of continuous improvement actions will be monitored throughout the year as a key principle of good corporate governance.

6. ITEMS FOR DISCUSSION

There were no items for inclusion in this section

7. CONSENT AGENDA

There were no items for inclusion in this section

8.OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (ARA/25/041)

No other urgent business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/25/042)

There were no items raised.

8.3 COMMITTEE REFLECTIONS (ARA/25/043)

The following feedback was noted:

- Helpful pre meeting prior to ARAC
- Robust discussion and appropriate challenge
- Bleeding across other Committee meetings

- Difficult issues discussed sensitively
- Emphasised discussion on Cyber – Evolved as a key issue regarding some members concerns.
- Planning needed ahead of the October ARAC meeting given length of items scheduled to ensure adequate time allocated.

8.4 DATE OF NEXT MEETING

The date of the next meeting is scheduled on 07 October 2025 at 10:00 via Microsoft Teams.

Meeting closed at 12:53

Beth Powell

Audit and Risk Assurance Committee								
RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer needed	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							

Audit and Risk Assurance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW- (NONE)								
OPEN ACTIONS - NOT YET DUE (07 OCTOBER 2025)								
17-Jun-25	ARA/25/032	Director of Corporate Governance	Structured Assessment Report 2024	To explore a MoU arrnagement with RPB to strengthen governance and processes of responding to the health board	**01.07.2025 update:** the action will be progressed in line with the target date	Jan-26		On track
ACTIONS RECOMMENDED FOR CLOSURE (NONE)								

Agenda Item: 5.1

Audit, Risk and Assurance Committee	07 October 2025

Subject:	**Internal Audit Progress Report**
Approved and presented by:	Director of Corporate Governance / Board Secretary Head of Internal Audit
Prepared by:	Head of Internal Audit
Other Committees and meetings considered at:	N/A

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Note** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit report.
- **Approve** the proposed adjustments to the 2025/26 plan.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

The progress report highlights the conclusions and assurance ratings for audits finalised in the current period.

The following audit report has been finalised since the July 25 meeting of the Committee:

- Duty of Candour (Reasonable Assurance)

The full copy of the report is also included as a separate item within the agenda.

The progress report also includes details of proposed adjustments to the 2025/26 plan.

Progress with the delivery of the 2025/26 plan is also detailed within Appendix A of the progress report.

BACKGROUND AND ASSESSMENT:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to Powys Teaching Health Board.

The work undertaken by Internal Audit is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the engagement process established with the Health Board.

The 2025/26 plan was formally approved by the Audit, Risk and Assurance Committee at its March 25 meeting.

The progress report provides the committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including commentary as to progress with the delivery of assignments.

NEXT STEPS:

A progress report will be submitted to each meeting of the the Audit, Risk and Assurance Committee.

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
October 2025

NWSSP Audit and Assurance Services

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2025/26 Internal Audit plan.

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

The plan for 2025/26 was agreed by the Audit, Risk & Assurance Committee in March 2025 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

The assignments noted in the table below are those which had been planned to be reported to the October meeting but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Digital Systems Uptake	Draft Report	Limited	Delay in completion of fieldwork due to waiting for identification of key contacts and provision of information.
Continuing Healthcare	Draft Report	Reasonable	Pause in commencing the audit due to considerations over potential duplication with the external support work.
MH and LD Triage and Assessment Process	Work in Progress		Delay in agreeing audit brief and then availability of internal audit resource to commence fieldwork.
Community Care	Planning		Further discussions required with the Executive lead to agree the scope of the audit.
Follow-up: DoLS	Planning		Management request to postpone from Q2 to Q4.

3. Outcomes from Completed Audit Reviews

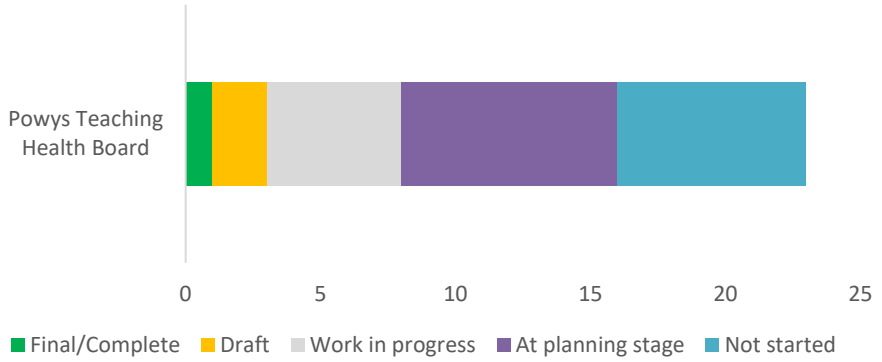
One assignment from the 2025/26 plan has been finalised since the previous meeting of the committee and is highlighted in the table below along with the allocated assurance rating.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Duty of Candour	Reasonable	

4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 23 reviews included within the 2025/26 Internal Audit Plan (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that one audit from the 2025/26 plan has been finalised so far this year and two others have reached the draft report stage.

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

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

Appendix A also includes details of one further audit from the 2024/25 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2024/25. The outcome from that audit will feed into the 2025/26 Opinion.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators (KPI).

5. Changes to the 2025/26 Plan

- Route Map to Sustainability & Strategic Commissioning – Identified for removal from the plan due to duplication of the scopes with the coverage of the external support being procured by the Health Board. Removal has been agreed with the respective Executive leads and the Director of Corporate Governance.
- Follow-up DoLS – The Director of Nursing has requested that the timing of this audit is moved from Quarter 2 to Quarter 4 due to delays in appointing to some positions, including the DoLS coordinator.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2024/25 Plan								
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.		Primary, Community Care and Mental Health	3				March
2025/26 Plan								
Duty of Candour	To consider the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.	22	Nursing, Quality, Women & Family Health	2		Final Report	Reasonable	October
Digital Systems Uptake	To review the level of uptake and utilisation of digital systems once they have been introduced.	20	Allied Health Professions, Health Sciences & Digital	1		Draft Report	Limited	January
Continuing Healthcare	To review recent changes / future plans within the Health Board around addressing the current level of cases and costs associated with CHC, including a focus on the placement review process.	10	Primary, Community Care & Mental Health	2		Draft Report	Reasonable	January
MH and LD Triage and Assessment Process	Review of the new Single Point of Access Triage and Assessment Model for Mental Health Services in PTHB. Linked to anticipated reduction in need for agency staff and impact on variable pay.	11	Primary, Community Care & Mental Health	1		Work in Progress		January
Community Care	Review of how different teams within the community are working together for care of the patient.	12	Primary, Community Care & Mental Health	2		Planning		January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Staff Development Programmes	Review of the processes for developing and delivering staff development programmes, linked into Management Charter / Compassionate Leadership.	16	People, Culture & Transformation	2		Work in Progress		January
Clinical Supervision	Establish the level of compliance with the Health Board's Clinical Supervision Policy across staffing groups. Focus on frequency / quality of supervision and quality of recording.	18	Allied Health Professions, Health Sciences & Digital	2		Work in Progress		January
Core Financials	Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management / Accounts Receivable / Capital Asset Management.	04	Finance, Capital & Support Services	3		Work in Progress		January
Estates Assurance Asbestos Management	To evaluate the controls and practices in place to ensure that the key asbestos regulatory requirements are adequately addressed, and appropriate management arrangements were embedded within the organisation.	05	Finance, Capital & Support Services	3		Planning – Final brief issued		January
Decontamination	Review of the Health Board's structures and processes for decontamination of equipment, to ensure compliance with standards and legal requirements.	23	Nursing, Quality, Women & Family Health	~~1~~	3	Work in Progress		January
Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	02	Corporate Governance / Board Secretary	3		Planning		March
Budget Setting	To review how the Health Board sets delegated budgets to meet its agreed financial plan.	03	Finance, Capital & Support Services	3		Planning		March
Systems – Discretionary Capital	To obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated discretionary capital funds.	06	Finance, Capital & Support Services	3		Planning		March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
North Powys Integrated Wellbeing Hub	To evaluate the processes and procedures put in place by to support the management and control arrangements applied to deliver the project through to the Submission of the FBC.	07	Finance, Capital & Support Services / People, Culture & Transformation	3				March
Catering Services	Review of processes and controls in place to ensure compliance with Environmental Health Office Standards / hygiene ratings.	09	Finance, Capital & Support Services	3				March
Primary Care Clusters – Project Management	How are the project management processes working to enable implementation of developments.	13	Primary, Community Care & Mental Health	3		Planning		March
Digital Operating Model & Strategy	Review of the Health Board's new Digital Operating Model following previous Section 33 arrangements being brought in-house.	20	Allied Health Professions, Health Sciences & Digital	3		Planning		March
Mortality Reviews	Review of processes for dealing with deaths that are referred back to the Health Board by the medical examiner for further review.	24	Medical	3				March
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	08	Finance, Capital & Support Services	4				March
Follow-up DoLS	Follow-up of 2024/25 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	21	Nursing, Quality, Women & Family Health	~~2~~	4	Planning – Final brief issued		March
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance / Board Secretary	4				May
Strategic Equality Plan	Review of delivery against the Health Board's Anti Racism Plan.	17	People, Culture & Transformation	4				May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Vaccine Storage	Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.	25	Public Health	4				May
Reviews removed from the plan								
Route Map to Sustainability	Advisory review of the plans and processes in place for the development of the Health Board's Route Map to Sustainability.	15	People, Culture & Transformation	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board. To be agreed by October ARAC				
Strategic Commissioning	Review of the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.	14	Planning, Performance & Commissioning	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board. To be agreed by October ARAC				

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Duty of Candour	Reasonable	Final	12/09/25	03/10/25	26/09/25	26/09/25	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	May 2025	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	R	20% 1 from 5	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 3 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	100% 1 from 1	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 1 from 1	80%	v>20%	10%<v< 20%	v<10%

Assurance Opinions

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Duty of Candour

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-22
Fieldwork	June – August 2025
Executive Sign Off	September 2025
Audit Committee	October 2025
Executive Lead	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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

Executive Summary

Purpose

Our audit review in relation to the Duty of Candour arrangements was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

Legislation in relation to the Duty of Candour was introduced in April 2023 as part of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 along with the Duty of Quality.

Duty of Candour means that NHS organisations have a duty to be open and honest with the service users they are providing healthcare for. If things go wrong, and harm has occurred, they must recognise this and communicate with the service user. This builds upon the principles of the 'Putting Things Right Regulations' already in place within NHS Wales, with an overall objective of ensuring that when a person receives healthcare services, that they are dealt with in an open an honest way by their care provider. The Duty ensures that NHS organisations are clear about avoiding any potential culture of blame and supports those where mistakes and errors have been made.

Where Duty of Candour incidents are identified they should be investigated by the relevant NHS organisation within the required timeframes to understand what happened, to provide the service user with truthful information and an apology, and to identify areas for improvement and lessons to be learnt.

The relevant lead for this review is the Executive Director of Nursing, Quality, Women and Family Health.

Overview

We have concluded reasonable assurance on this area. The key matters requiring management attention include:

- The Integrated Management Framework does not state responsibility, accountability and reporting structures in respect of Duty of Candour.
- There is a lack of awareness of Duty of Candour training which is not being monitored, and the Duty of Candour SharePoint page is not being promoted effectively.
- There is inconsistent recording and supporting documentation of changes made to Duty of Candour incident assessment severity levels and Rapid Review Meetings being undertaken.
- There is inconsistent recording within Duty of Candour Datix case files of 'in person' notification dates and retention of 'written notification' letters.
- There is an absence of regular Duty of Candour reports to Clinical Service Group management and Governance Leads to support local scrutiny and oversight of Duty of Candour case activity.

Full details of matters arising are within the Findings & Agreed Action Plan. We also identified the following opportunities for enhancement that do not impact the overall opinion and are highlighted for management information:

- The Integrated Management Framework and the Datix User Guide, which details case recording and management, are currently not available on the Duty of Candour SharePoint page.

Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.	1	**Reasonable**
2	Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.	2	**Reasonable**
3	Cases are consistently managed in accordance with the defined procedures to ensure that the Health Board complies with the Duty of Candour.	3,4	**Reasonable**
4	Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.	5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.	Reasonable

Overview / Summary of Observations

Duty of Candour (DoC) procedures are incorporated within the Health Board Incident Management Framework (IMF), rather than detailed in a separate DoC Policy and Procedure. The IMF document is current in content; however, it does not indicate which Health Board management group or Committee is responsible for its sign off.

Our formal comparison of the Welsh Government Guidance and the IMF found that both documents align regarding the key requirements and processes in respect of Duty of Candour. Both also highlight the significance of honesty, reporting, and internal review when addressing incidents of this type. The Health Board has a dedicated DoC page on the Quality and Safety SharePoint pages. However, the Incident Management Framework and the Welsh Government Guidance is not currently available on this site and as such there is a risk of limited management and staff awareness of its existence and statutory content as a result.

We also note that the Health Board's Duty of Candour processes are available via the Feedback and Concerns pages of the Health Board's internet site for the public to access.

Key Findings		Risk & Impact	Agreed Management Action
1	Incident Management Framework We note that whilst the Incident Management Framework (IMF) is current, it does not state which Health Board Group/Committee is responsible for its sign off. The IMF provides a high level overview of key staff and their responsibilities for the operation and management of Duty of Candour but does not specify which roles within the Health Board are accountable for this. In the absence of a dedicated Duty of Candour policy, it may be important to define clear responsibilities for relevant roles. Furthermore, the Framework lacks detail regarding lines of accountability within the Health Board and does not outline a formal organisational structure for the monitoring or reporting of Duty of Candour at the Clinical Service Group, Committee, and Board levels. We also identified discrepancies within the IMF regarding the specified timeframes for conducting Rapid Incident Review Meetings (RIRM) as references are made to both 72-hour and 48-hour intervals.	Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.	**Agreed Action:** The Incident Management Framework will define and document the specific Health Board / Committee responsible for the sign-off of the IMF. This will be included in the document to ensure accountability and clarity. The IMF will define and document clear responsibilities for relevant roles within the Health Board for identifying, investigating, and monitoring Duty of Candour cases. A detailed organisational structure will be developed and included within the Framework that outlines the lines of accountability for monitoring and reporting Duty of Candour. This will specify the roles and responsibilities at the Clinical Service Group, Committee, and Board levels. The IMF will be amended to show the correct timeframe for conducting the RIRMs. **Expected Evidence of Implementation:** The IMF is in the final phases of a review, where all recommendations have been implemented in the new version

			and once ratified will be published on the Q&S SharePoint and cascaded through the Health Board.
		High Priority	**Officer: Heidi Sinclair**
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date: 31/10/2025**

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06/10/2025 11:52:35

Objective 2: Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.	Reasonable

Overview / Summary of Observations

The Duty of Candour (DoC) page on the Quality and Safety SharePoint page offers training resources, including a Datix reporting video, staff leaflets explaining Duty of Candour, and an ESR e-Learning package that comprises three training modules.

Despite being in place since March 2023, the SharePoint page has seen minimal visits and there have been no recent awareness campaigns in respect of DoC. Uptake of both the ESR e-Learning package and the Datix Manager training remains low across clinical and nursing departments. Additionally, there has been no monitoring of training participation to fully assess and address gaps in uptake.

The Quality and Safety management team has noted the value of collaborating with the Clinical Education department to compare current ESR training with future face-to-face or Teams-based Duty of Candour training for staff. Staff are also able to access one-to-one Datix coaching on Duty of Candour cases on an ad hoc or request basis. The review and possible enhancement of training materials was discussed at the Quality & Safety team meeting in August 2025; however, information regarding the outcome and the timeline for implementing changes is not currently available.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>Absence of Duty of Candour Awareness Exercises</u> At the time of our review, the Duty of Candour SharePoint page had been viewed 452 times since its launch in March 2023. Additionally, no recent awareness exercises to promote Duty of Candour as a statutory requirement and also that of the SharePoint site have been undertaken within the Health Board during April 2024 to July 2025. <u>Duty of Candour Training</u> The Duty of Candour E-Learning course can be accessed through the ESR system. From March 2023 to July 2025, only 285 Health Board staff had completed the training. Additionally, we reviewed the attendance log for Health Board managers who completed Datix training, which covers Duty of Candour incident management. In 2024/25, only 44 managers attended including: • 29 from Nursing or Midwifery • 7 were Admin & Clerical • 5 Allied Health Professionals	Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.	**Agreed Action:** Periodic exercises will be introduced to increase awareness and promotion of the Duty of Candour process and also signposting of the Duty of Candour SharePoint site. The Quality and Safety team will work with Clinical Education to review and enhance Duty of Candour training. Additional exercises may be implemented so all relevant staff gain the required statutory knowledge and understand reporting and investigation processes. The team will also identify staff who would benefit from this training. <u>Monitoring of Duty of Candour training uptake within the Health Board</u> Processes will be put in place to track and address gaps in Duty of Candour training across all Clinical Service Groups.

	• 3 Other • 0 from medical staff. Since clinical and nursing managers are responsible for these duties, such low participation poses a risk to effective management of Duty of Candour. <u>Monitoring of Duty of Candour training uptake within the Health Board</u> There is currently no monitoring of Duty of Candour training gaps within the Health Board, though discussions with Clinical Education are planned.		**Expected Evidence of Implementation:** Q&S team have implemented a tracker to support services with completion of DOC investigations within KPI time frames. [Completed] Q&S will be working with Clinical Education and the Communications Team to develop a series of online tutorials to support services through the completion of DOC investigations and the final response letter. The People's Experience Lead and Head of Quality and Safety have implemented training for DoC into internal training, including: Health Board Induction, Preceptorship and the Aspire training courses. Signposting to the online DOC ESR training will be frequently shared via SharePoint and the Health Board intranet newsfeed.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 30/11/2025**
	Theme: Training & Development	Control Operation	

Objective 3: Cases are consistently managed in accordance with the defined procedures to ensure that the Health Board complies with the Duty of Candour.	Reasonable

Overview / Summary of Observations

All staff are responsible for reporting incidents within the Datix system as they occur, including recording an initial assessment of the level of harm. We were informed that it is the responsibility of the Governance Leads to review incidents daily and ensure appropriate investigators are assigned. Within the Health Board, these three Governance Leads, are also responsible for adjusting the harm level according to their assessments, coordinating and leading the Rapid Incident Review Meeting (RIRM) for incidents classified as moderate or higher within 72 hours and ensuring that meeting minutes are accurately documented and uploaded to Datix.

A DoC incident is triggered when harm is classified as moderate or higher and the Health Board is identified as a contributor. The Health Board must notify the service user or their representative in person (by phone, video call, or face-to-face) then follow up with a written letter within 5 working days confirming the details of the notification.

We conducted sample testing to verify that cases are managed consistently with established procedures, and that the Health Board meets the Duty of Candour requirements. A Datix DoC activity report was provided, outlining incidents during 2024/2025 that led to adverse outcomes. This analysis focused on cases where the Health Board was not identified as a contributing factor, therefore not initiating the Duty of Candour procedures. Eight cases were found, and for the four cases reviewed, all decisions were appropriately ratified, managed, and documented in Datix as required.

Further testing was undertaken to examine incidents that triggered a Duty of Candour over a six-month period from January to June 2025. During this time, 1,775 incidents were reported. Of these, 521 were classified as 'low' harm and 814 as 'none' during the Manager's Interim harm assessment, resulting in a total of 1,335 cases (the remaining 440 cases were either left blank (401) or categorised as Moderate or above (39)). At the Post Investigation stage, 92% (1,224 cases) maintained the same harm level. From the other 111 cases, 110 remained under investigation, and one was reclassified from low to moderate harm. These findings suggest that managers' initial harm assessments are generally consistent and accurate.

Using the same Datix report we reviewed 9 out of 27 cases that triggered a DoC and found existing processes for updating harm levels were generally followed. However, key information from RIRM is not routinely recorded in DoC files. We also identified inconsistences in documenting trigger dates, 'in person' notifications and evidence of issuing written notification within 5 working days.

	Key Findings	Risk & Impact	Agreed Management Action
3	<u>Changes to level of harm and Duty of Candour Rapid Review Meetings: Recording and retention of information on Datix</u> A sample of 9 out of 27 DoC cases between January and June 2025 were selected. Our testing identified that: • All nine sampled cases had their severity ratings changed in Datix by appropriate staff; two were downgraded however during the final investigation stage with no documented justification or narrative. <u>Rapid Incident Review Meeting (RIRM)</u> Eight out of nine sampled cases had no documentary evidence retained within Datix to support the RIRM meetings. A questionnaire was distributed to CSG Governance Leads. The Mental Health CSG reported that rapid reviews are not routinely completed for all DoC incidents; however, they are conducted in cases involving a death. The Community CSG has implemented a process flow chart, which indicates that a RIRM should occur within 5 working days, though this is not consistent with the IMF timeframe. For Women and Children, a patient safety huddle may be convened between the governance lead, HoM, DoM, and Quality and Safety team as required. This indicates inconsistencies in the application of RIRM across all CSGs.	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.	**Agreed Action:** Any changes to assessment severity levels will be recorded in Datix with an accompanying narrative explaining the reason for the change to the harm level. This documentation will be maintained for each phase. A copy of the Rapid Incident Review Meeting (RIRM) TOR will be distributed to relevant staff to emphasise the importance of conducting RIRM meetings within 72 hours of the initial report for incidents classified as moderate harm or above. Additionally, the TOR will be revised to highlight the requirement for documenting and recording of these meetings, ensuring that supporting evidence is maintained in Datix to confirm their completion.
			Expected Evidence of Implementation: Recommendations have been built into the IMF. The HOQ&S will meet with the Governance Leads of the Care Service Groups and emphasis the necessity to document changes to the assessment of severity levels during the RIRM and investigation process. They will also be reminded to use the TOR during the process. The TOR will be shared again on the Q&S SharePoint page.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 30/11/2025**
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
4	<u>Recording of Duty of Candour Communication on Datix</u> A Datix report was requested to incorporate the five working day key performance indicators, which showed that there had been 102 DOC-triggered incidents since its introduction in April 2023. The report found six cases with missing 'in person' notification dates in Datix with three dating back to 2024. Additionally, five cases all prior to 2025 had incident notification dates preceding their DoC trigger dates. Further detailed analysis was performed by selecting ten current DoC cases to assess the key processes in the Health Board's	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.	**Agreed Action:** Key staff will be reminded of the importance of ensuring that • All 'in person' notification dates are recorded promptly in Datix. • All cases have documented narratives within the progress notes confirming the 'in person' initial date. • Copies of all 'written notification' letters are retained in the documents section of Datix. A review of the IMF will also be carried out to ensure that these requirements are documented within it for transparency.

	IMF. One case however had to be removed from our sample due to it being under external investigation and not subject to Duty of Candour requirements. Our findings highlighted: • All nine cases showed evidence that the service user/respondent was kept updated on the issue's progress. • The 'written notification' letter was not retained in Datix for three of the nine cases. (One respondent requested not to receive this correspondence or updates). • Although all nine cases had an initial date entered in the DoC section of Datix, five lacked documented narratives in the progress notes.		Periodic audits will be undertaken to verify compliance with these key stages and feedback will be provided to staff of any non-compliance. **Expected Evidence of Implementation:** Updated IMF to include documentation requirements. KPI reports will now be run in line with the Integrated Quality Report and a selection of DOC cases will be audited for monitoring to include documentations requirements.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 31/10/202**
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 4: Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.	Reasonable

Overview / Summary of Observations

We were informed that weekly updates on moderate and above incidents were previously distributed to Clinical Service Group Management, Directors, and Executives. However, this practice discontinued as of June 2025. Governance leads and heads of service currently have access to dashboards within Datix for monitoring concerns, incidents, and duty of candour cases, although the frequency of dashboard usage remains unclear. As stated in Key Finding 1, it is essential that clear monitoring and reporting arrangements are embedded within the reporting structure to support ongoing oversight and continuous improvement.

It was indicated that Clinical Service Groups conduct quality and assurance meetings to address concerns, incidents, and nationally reportable events, with escalation to the Executive Committee as necessary. However, this process could not be substantiated during the course of the audit.

Duty of candour activity data and associated lessons learned outcomes are included in the Integrated Quality Report (IQR), which is submitted bi-monthly to the Patient Experience and Quality Safety (PEQS) Group. Additionally, the PEQS Committee Chair provides a quarterly copy of the IQR to the Board. In addition, any significant Duty of Candour issues that require escalation are reported to the Board on an exception basis.

A review of Board Papers and relevant PEQS Committee Chair Highlight Reports from March to July 2025 found no Duty of Candour issues reported. Duty of Candour activities, lessons learned, and improvement outcomes are referenced in the Health Board's Annual Report for 2024/25, as well as in the annual Duty of Quality Report for 2024/25 which is submitted to the Welsh Government.

	Key Findings	Risk & Impact	Agreed Management Action
5	<u>Monitoring and reporting arrangements</u> Weekly Datix DoC reports were historically sent to CSG Service Managers and Governance Leads for review within quality meetings covering concerns, incidents, and NRIs. These reports detailed cases under review, investigation, and closure. However, distribution of the weekly reports ceased in mid-June 2025 due to uncertainty over their value, and also whether the data provided to CSG management teams was having any direct effect. Governance leads and heads of service have access to dashboards within Datix for monitoring concerns, incidents, and duty of candour cases; however, the frequency with which these dashboards are used has not been determined. A questionnaire was distributed to CSG Governance Leads, which indicated that Mental Health and Women & Children's CSGs conduct weekly safety or PTR meetings and provide monthly reports to their Quality Assurance (QA) Group or Senior	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt	**Agreed Action:** Meetings will be scheduled with CSG management teams, and their Governance Leads to determine whether the weekly DoC reports are necessary. If required, these discussions will also establish the specific data types to be included to ensure the reports provide meaningful information. Additional analysis will also be conducted to identify current users of the Datix DoC dashboard and determine whether it is being used to support case incident review and decision-making. A standardised review process will be established to manage cases designated as 'blank,' ensuring that all cases are evaluated within the prescribed timeframes. These steps will be included into the reporting structure that has been discussed under Key Finding 1.

	Management Team (SMT); however, this information could not be independently verified during the audit. Based on the testing conducted under objective 3, it was identified that interim harm assessments by managers were 'blank' in 401 out of 1,775 incidents, including: • Seven classified as Severe; • 15 as Moderate; and • Two as Catastrophic. These incidents should have undergone assessment with the corresponding harm levels confirmed. The Quality & Safety team meets with CSGs every two weeks to review DoC and NRI cases but cannot address unresolved cases due to limited capacity. This suggests that CSG's case monitoring needs a thorough review and that checks on 'blank' cases have been insufficient.		**Expected Evidence of Implementation:** Meeting minutes from Governance Lead meeting in October. This will discuss dashboard access and usage and management under DOC KPIs. Audit to include review process
	Theme: Reporting	**Medium Priority** Control Design	**Officer: Heidi Sinclair** **Target Implementation Date: 31/10/2025**

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

Disclaimer

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

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Archwilio Cymru
Audit Wales

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

Date issued: September 2025

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

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

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

Audit, Risk and Assurance Committee Update

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board (the Health Board). We presented our most recent Audit Plan to the committee in March 2025.

2 We also provide additional information on:

- other relevant examinations and studies published by the Audit General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date of completion
Audit of the 2024-25 Accountability Report and Financial Statements	Executive Director of Finance, Capital & Support Services	Statutory audit of the financial statements to inform the audit opinion.	Audit has been completed and final accounts submitted.	Final accounts were submitted on 1 August 2025.
Audit of the 2024-25 Charitable Funds Financial Statements	Executive Director of Finance, Capital & Support Services	Audit of the financial statements to inform the audit opinion.	Exact timing of audit to be confirmed. We will ensure deadline of 31 January 2026 is met.	January 2026

Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Executive Director of Primary Community Care and Mental Health	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Final Report	October 2025 (missed off July agenda)
Structured Assessment 2025 - Core	Director of Corporate Governance/Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of	Report drafting underway	January 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		resources. Our 2025 Structured Assessment will review: • Board transparency, effectiveness and cohesion • Corporate systems of assurance • Corporate approach to planning • Corporate financial planning, financial management and financial performance; and • Progress in meeting outstanding recommendations		
Review of Urgent and Emergency Care	Executive Medical Director	This work will examine different aspects of the urgent and emergency care system and will include analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing urgent and emergency care demand by helping patients access	Blog and data tool published in April 2022 Part 1 - Report drafting underway. Part 2 – Report drafting underway	 January 2026 January 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		services which are most appropriate for their care needs (Part 2).		
Follow Up - Review of Quality Governance Arrangements	Executive Director of Nursing, Quality, Women and Family Health	This work will follow up on the recommendations made in our 2021 audit. Our previous audit examined whether the health board's governance arrangements support delivery of high quality, safe and effective services.	Report drafting underway	January 2026
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Executive Director of Finance, Capital & Support Services	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork underway	March 2026
Local work 2024 – review of arrangements for managing agency staff	Executive Director of Primary, Community Care and Mental Health	This work will review the Health Board's arrangements to manage agency staff use within mental health and learning disability settings. The exact scope of the work is still to be developed.	Fieldwork underway	March 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates	To be confirmed	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. When undertaking this work, we will take into account the local work already underway examining the Health Board's arrangements for managing capital prioritisation.	Planning	TBC
Review of cancer services	-	This work will follow on from the review of national leadership arrangements for cancer services, and will focus on : • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services. In discussion with the Health Board, we have agreed that the scope is not applicable to Powys and have therefore agreed to refund this element of the audit fee.	Cancelled	N/a

Other relevant publications

6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Wales Finances Data Tool	September 2025
Temporary Accommodation, long-term crisis?	July 2025
Cost Savings Arrangements – A checklist for NHS Board Members	June 2025
The Wales Infrastructure Investment Strategy	May 2025
No time to lose: Lessons from our work under the Well-being of Future Generations Act	April 2025

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. The links to the reports on our website are provided.

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
Welsh Language Report 2024-25	September 2025
Annual Report and Accounts 2024-25	June 2025

8 There are currently no relevant Audit Wales consultations underway.

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

Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Powys Teaching Health Board

Date issued: May 2025

Document reference: 4667A2025

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

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

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

Contents

Summary report

About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Powys Teaching Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023[3]**);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on "Tackling the Planned Care Backlog in Wales" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between August 2024 and February 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 In November 2024, the Welsh Government escalated the Health Board to (Level 4) for finance, strategy and planning on its NHS Wales escalation and oversight framework. The financial position has a direct bearing on the financial sustainability of planned care services, and in particular its ability to commission externally provided services to meet rising demand.

Key facts[4]

£25.4m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

27,578** the overall size of the waiting list at December 2024 (combined Welsh and English providers).

344* the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has reduced by 57% since April 2022.

197** the number of patient pathways waiting more than 2 years for treatment at December 2024 against a national target of zero waiting.

89%* the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. This is an 18% reduction of 'over 8 weeks' diagnostic waits since April 2022.

99.9%* the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 96% reduction of 'over 14 week' therapy waits since April 2022.

2,749** the number waiting more than one year for treatment at December 2024 against a national target of zero for most specialties by Spring 2025.

* This data is for Powys residents waiting in Welsh NHS Providers only. Therefore, this excludes Powys residents waiting/treated in England.

** This data is for all Powys healthcare providers. It includes Powys residents waiting for treatment in Powys and Powys residents waiting for treatment in Welsh health boards and English trusts.

[4] The data source for Welsh residence and provider waiting times data is Welsh Government's Stats Wales website. NHS England waiting times data was sourced from the Health Board's January Integrated Quality and Performance Board report.

Key findings

8 Overall, **we found following some early success, performance against some ministerial priorities has plateaued and the overall number of patients waiting has continued to rise. The Health Board's service demand is increasing. It needs a plan to meet current and future service needs, which considers its strategic commissioning environment and maximises local service efficiencies.**

Action that the Health Board is taking to tackle the planned care challenge

- Whilst the Health Board has set out clear plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to balance capacity/resources with demand to secure more sustainable improvements to planned care services.
- The Health Board is spending its additional Welsh Government planned care allocation in line with its plans. However, it has been unsuccessful in obtaining additional transformation funding which has contributed, in part, to a limited focus on service transformation.
- The Health Board has started to deliver a greater level of efficiencies but there remain further opportunities. Work is underway to improve theatre utilisation as currently there are opportunities for greater efficiency and the Health Board needs to take action to reduce the number of cancelled operations.
- The Health Board is managing its complex commissioning environment well and effectively holding its commissioned bodies to account for outsourced planned care services. However, its insourcing arrangements are vulnerable because 'in-reach' consultants who travel to work in Powys to provide in-county treatment are not always available.
- The Health Board is making progress implementing the Welsh Government's Promote, Prevent and Prepare policy, but current arrangements do not cover Powys residents waiting for out of county treatment. The arrangements for monitoring and reporting incidence of harm associated with planned care waits for require strengthening.

Waiting list performance – is the action taken resulting in improvement?

- The Health Board has continued to see a rise in its waiting list (the number of open patient pathways). As of December 2024, there were 27,578 open pathways.
- It is making mixed progress against the Welsh Government aims:
  - Despite early progress in reducing the number of people waiting longer than one year in most specialties by Spring 2025, performance has plateaued.
  - While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year and has struggled to maintain its early improvements.
  - Although the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024, it has made good progress overall reducing the level of waits from around 699 in May 2022 to around 197 in December 2024.
  - The Health Board is currently meeting the target for therapy waits. However, its diagnostic services performance is more of a challenge, but based on the current performance it looks likely that the Health Board will meet the target during 2025.

Barriers to improvement

- There are a number of barriers to further planned care improvement. These include financial pressures in the Health Board, growing service demand, reliance on commissioned bodies' capacity, fragility of some in-reach services, under-utilisation of theatres and limited staff resources in some areas.
- The Health Board recognises these challenges and is introducing a range of actions to help address these issues. These actions are at their early stages and more needs to be done to implement and embed them at pace.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 4**.

Exhibit 1: recommendations

Recommendations
Longer term planning and costing R1 Over and above the commitments signalled in the Integrated Plan 2024-29 and Annual Plan 2024-25, the Health Board should develop a Planned Care improvement plan which aims to both design and deliver financially sustainable local services and affordable commissioning approaches in the medium to longer term. The plan should be costed, with realistic but challenging milestones within it (**Exhibit 2**).
Demand and capacity planning R2 The Health Board should ensure that its demand and capacity modelling approach informs short-term service capacity planning and longer-term service design. This should fully consider continued growth or expected changes in population demand for planned care services **(Exhibit 2)**.
Efficiency and productivity R3 To further improve efficiency and productivity, the Health Board should: 3.1 Produce a progress report providing an update on the completion of recommendations arising from the Getting It Right First Time (GIRFT) reviews to be presented at Board. (**Exhibit 6**). 3.2 Reduce the numbers of short notice surgical cancellations due to clinician unavailability (**Exhibit 6**). 3.3 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% (**Exhibit 6**).
Managing clinical risks associated with long waits R4 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks resulting from long waits.

Recommendations

4.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties (Exhibit 7).

4.2 Routinely report harm resulting from delays in access to treatment to the Quality and Safety Committee. This should include data for all Powys residents i.e. whether they are treated in Powys or receiving care commissioned by the Health Board (Exhibit 7).

Action that the Health Board is taking to tackle the planned care challenge

10 We considered whether the Health Board has taken appropriate action to tackle the planned care challenge. This included reviewing its plans, programme delivery arrangements and oversight, utilisation of additional Welsh Government funding and the operational management of planned care.

11 We found **that the Health Board has a good, but short-term focus on planned care service recovery, supported by a clear programme delivery and oversight arrangements. However, it is facing financial pressures, and it needs to develop a clear plan for financially sustainable and efficient planned care services. It also needs to expand its 'Promote, Prevent and Prepare' arrangements and strengthen its reporting of harm associated with long waits.**

Planned care improvement plans and the programme to deliver them

12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

13 We found that **the Health Board has set its direction for planned care, however its delivery plan is uncosted and focused on short term solutions. The plan is also not informed by analysis and modelling of capacity and demand.**

14 The findings that underpin this conclusion are summarised in **Exhibit 2**.

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	**Partially**	The Health Board has set its direction for planned care within its Integrated Plan 2024-29 and Annual Plan 2024-25. Delivery of this is through the Planned Care Pathways Plan 2024-25, but the plan is too short-term and there needs to be far greater clarity on longer-term goals. The plan also needs to set out financially sustainable local service models and commissioning approaches **(Recommendation 1).**
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Planned Care Pathways Plan 2024-25 does not contain clear costings for activities and initiatives and it is unclear whether the plan is affordable **(**see **Recommendation 1)**. Given the Health Board's current planned care model and commissioning approach, there is a direct trade-off between its financial position and its ability to commission the capacity needed to secure a material reduction in waits. This suggests the current model may be increasingly unaffordable as planned care demand rises (See **Exhibit 16**, page 37).
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Health Board's Integrated Plan 2024-29 and Annual Plan 2024-25 are sufficiently aligned to the ministerial measures and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan.
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	**Partially**	The Health Board has developed improvement trajectories aligned to the Ministerial priorities. However, plans lack longer-term planned care ambitions and milestones.

Audit question	Yes / No / Partially	Comments
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**No**	The Health Board has developed a demand and capacity modelling approach; however, this has not yet been implemented **(Recommendation 2).**
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**Partially**	The Integrated Plan 2024-29, and the Health and Care Strategy for Powys "A Vision to 2027 and beyond" provide a future vision for Healthcare in Powys. However, it does not sufficiently set out the approach in enough depth to enable the introduction and development of sustainable clinical service models.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP, and plans for workforce, digital and estates?	**Partially**	The Annual Plan 2024-25 refers to high-level enablers including, workforce, estates and digital services, with some alignment to planned care improvement aims. Until there are clear longer-term plans for planned care services, it will not be possible to accurately determine digital, workforce or estates requirements.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

15 We found that **the Health Board has clear planned care programme delivery arrangements in place, with appropriate resources and there is appropriate oversight from the Health Board and its committees.**

16 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

Exhibit 3: the Health Board's approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	**Yes**	The Health Board's Diagnostics, Ambulatory and Planned Care Programme Board is driving delivery of the Planned Care Pathways Plan 2024-25 and is appropriately resourced.
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**Yes**	There is clear operational accountability and clinical leadership for planned care. The Executive Director of Primary Care, Community and Mental Health has executive responsibility for planned care, supported by the Assistant Director of Community Services, and the senior manager for planned care. Recent appointments have also furthered strengthened this capacity including: • Clinical Lead for the Promote, Prevent and Prepare for planned care[5] programme; • Assistant Medical Director for Planned Care; • Director for Improvement and Transformation.
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Yes**	The Health Board has a planned care risk register which is presented routinely at the Diagnostics, Ambulatory and Planned Care Programme Board. The Health Board appropriately and routinely analyses, tracks and categorises the risks to the delivery of planned care improvement. In addition, the Planned Care Quality and Safety group also reviews the planned care risk register. The Health Board also monitors risks to planned care delivery at commissioned bodies through its Commissioning, Quality and Performance meetings.

[5] Welsh Government's Promote, Prevent and Prepare for Planned care policy aims to ensure that patients are supported and informed while waiting for planned care..

Audit question	Yes / No / Partially	Comments
Is performance on planned care recovery routinely reported to the appropriate committee and to the board?	**Yes**	The Board and committees effectively oversee planned care performance and improvement. Board performance reports track and monitor planned care targets, including the ministerial targets. The Health Board has also held a Board awareness session with a specific focus on planned care and sharing good practice.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

18 We found that **since 2023-23 the Health Board has received a total of £25.4 million in additional Welsh Government planned care funding. It is focusing the funding on short term improvements with limited investments in service transformation to help make planned care services financially sustainable in the long term.**

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £25.4 million between 2022-22 and 2024-25 (**Exhibit 4**).

20 We reviewed the use of funding in 2023-24 in greater detail. This shows that the Health Board has spent all the additional funding it received on planned care services, as Welsh Government intended (**Exhibit 5**). This funding has been used to support additional commissioning of activity and insourcing of in-reach consultants to deliver additional activity. However, the Health Board has introduced multidisciplinary teams in ophthalmology, ear, nose and throat, and orthopaedics services which has reduced the need for in-reach consultant appointments.

Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	7.9
2023-24	6.9
2024-25	5.6
Additional in-year allocation in 2024-25[6]	5.0
Total allocated	25.4

Source: Health Board financial self-assessment returns

Exhibit 5: Use of the 2023-24 £6.9 million Welsh Government additional financial allocation, Powys teaching Health Board

	Performance improvement funding (£m)	Transformation funding (£m)
Outpatient transformation		0.44
Promote, Prevent and Prepare programme		0.17
Planned care recovery monies	5.3	
Planned care supporting additional capacity into NHSE to reduce waiting times	0.8	
Additional sessions – Powys provided services		
• Endoscopy services	0.04	
• General surgery - outpatients	0.06	
• Oral and maxillofacial	0.01	
• Orthopaedics	0.09	
Total allocated	**6.30**	**0.61**

Source: Health Board financial self-assessment returns

[6] In December 2024, the Welsh Government allocated an additional £5 million in year funding for reducing length of waits for Powys residents treated in England.

22 For 2024-25, the Health Board continues to invest its routine additional allocation on planned care. In December 2024, the Welsh Government allocated a further £5 million, which in the allocation letter was intended to support and increase commissioning of planned care services from NHS England.

23 The Welsh Government allocates additional funding to health boards to support planned care transformation. The Health Board submitted nine bids to Welsh Government for additional funding from the Planned Care Transformation Fund in March 2024. All were unsuccessful.

Monitoring impact of additional funding

24 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. We found **that despite reasonable arrangements to oversee the use of the additional Welsh Government planned care financial allocation, we have not seen evidence of monitoring of impact of the funding.**

25 The Executive Committee receive routine planned care update reports which include the monitoring of planned care monies and the financial implications of funding allocations. The Diagnostics, Ambulatory and Planned Care Programme Board also review and receive regular updates on funding and spend on planned care. The Health Board does not formally assess or report on the impact of additional funding, albeit much of the funding directly corresponds to increased levels of commissioned acute care.

Operational management of planned care

26 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to secure sufficient planned care capacity through service commissioning.

Maximising the use of existing resources

27 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found that **the Health Board has started to implement the Getting It Right First Time recommendations, but it needs to make greater progress and there remains significant opportunity to improve efficiency.**

28 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	The Health Board has made a mixed progress in responding to GIRFT reviews. While it has made some good progress in several service areas, including outpatients and diagnostics, there remain key areas for improvement including improving theatre efficiency and increasing the overall utilisation of the theatres estate by increasing the numbers of day case procedures. At the time of fieldwork, it was difficult to assess the level of progress achieved with GIRFT recommendations **(Recommendation 3.1).**
Arrangements for improving the productivity of services	The Health Board is focusing on improving productivity of its services. These include: • The monthly Integrated Quality, Planning and Delivery meetings focus on productivity and elective pathways in relation to national improvement requirements. • Updates on the Planned Care Pathways Plan 2024-25 provided to the Diagnostics, Ambulatory and Planned Care Programme Board also include updates on productivity and efficiencies based upon national improvement requirements, including outpatient and day case productivity and theatre efficiencies. • The establishment of a Theatre Transformation Programme, theatre efficiency programme and theatre clinical workforce review to drive improvements in theatre efficiency.
Reducing non-attendance at outpatient appointments and managing referrals	**Exhibit 18,** page 38 shows that the Health Board is managing outpatient appointment non-attendance well. Its Did Not Attend (DNA) rates represented 3.8% of total outpatient clinic activity in the last 12 months. The Health Board is focused on reducing DNA rates and has taken several steps to improve its booking system, contacting patients prior to appointments and supporting patients with additional needs. However, a 3.8% DNA rate still equates to a loss of approximately 2,110 outpatient appointments a year. If the Health Board could further reduce its outpatient DNA rate by 20% (i.e. to 3%), it would provide around 420 additional outpatient appointments and avoid wasting the equivalent of approximately £63,000 of NHS resources each year.
Making use of "virtual" outpatient appointments	Virtual appointments can have a positive impact in reducing the need for travel and the risk of picking up healthcare acquired infections. For the period April 2024 to February 2025, 22.2% of all the Health Board's appointments were virtual (**Exhibit 19**, page 39). The Health Board has set an ambitious target for new virtual outpatients' appointments of 35% and 50% for follow

Opportunity area	Audit findings
	ups. This is being driven through increasing telephone consultations and virtual clinics through its Attend Anywhere[7] scheme.
Reducing the number of cancelled operations	The Health Board has increased its focus on reducing cancelled operations. For the period March 2024 to February 2025, 11% of its operations were cancelled at short notice. The most common reason being unavailability of clinical staff (**Exhibits 20 and 21,** pages 40 and 41). The Health Board is focussing on reducing patient cancellations, through its Waiting Well service, calling patients to ensure that they are ready for their procedure and by strengthening its pre-operative assessment processes. However, it needs to do more to reduce cancellations that occur because of clinician unavailability **(Recommendation 3.2).**
Improving operating theatre utilisation	Operating theatres in Powys are substantially underused, often running at around 30% utilisation[8]. In May 2024, the Health Board established its theatre clinical workforce review and a theatre efficiency programme as part of its Theatre Transformation Programme. The Health Board has set a target of improving theatre capacity by reducing the number of fallow lists by 25% by the end of September 2025. The Health Board has sought to utilise its theatre estate with regional partners offered via national meetings, but at the time of this review, no formal arrangements had been agreed. The Health Board needs to make a step-change in operating theatre efficiency and ensure that its Theatre Transformation Programme delivers tangible improvement with the aim of reaching 85% utilisation **(Recommendation 3.3).**

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

[7] Attend Anywhere is a scheme where the Health Board can offer some appointments by video, with patients able to use their computer, tablet or smartphone to do access the appointment with a healthcare professional.

[8] Data reported by the Health Board in July 2024 shows that between 2021-2024, utilisation across its four theatres has declined in most cases. For example, utilisation of its Brecon Theatre was at 31.9% in 2021-22 but by 2023-24 this had fallen to 28.3%. Furthermore, the utilisation of its Llandrindod Treatment Room was only at 3.1% during 2023-24.

Ensuring sufficient planned care capacity through external commissioning

29 We examined the actions the Health Board is taking to secure sufficient planned care service capacity from external commissioned bodies through outsourcing and insourcing.

30 We found that **the Health Board is appropriately managing and holding its commissioned bodies to account. However, there is inequity in waits across the county, challenges securing 'in-reach' services from external providers and an ongoing trade-off between securing the commissioned activity required and the strategic financial position of the Health Board**.

31 Commissioning activity accounted for £169 million of the Health Board's total expenditure in 2023-24. This includes the commissioning of planned care services from other health bodies in Wales and NHS providers in England. The Health Board has longstanding arrangements for managing this through a complex range of Service Level and Long-Term Agreements. The Health Board manages and oversees planned care commissioning activity with its commissioned bodies through its Commissioning Assurance Framework and its routine Contract Quality and Performance Review meetings. Despite its strategic ability to commission additional services from a range of providers, the Health Board is facing a position where there is a trade-off between materially reducing waits and the overall financial position of the Health Board.

32 To help the Health Board provide care closer to home, it also commissions 'in-reach' services where consultants travel to Powys to provide treatments. In 2023-24 the Health Board spent £3.7 million on in-reach services. However, its in-reach services are fragile because other health bodies are not always able to release staff owing to pressures in their own services. This affects the capacity and efficiency of in-county services and results in clinic and surgical cancellations. The Health Board is managing this by setting up alternative insourcing contracts with a private provider. However, cardiology and colonoscopy services remain fragile.

33 The Health Board's complex commissioning environment means that where a resident lives in Powys will have a direct bearing on which outsourced provider treats them. The Health Board's different providers all face their own performance challenges, and therefore patients across Powys experience different waiting times. English providers were quicker recovering from the impact of COVID-19, and waiting times are generally shorter. The Health Board has indicated that there is inequity of waits across the County. It was planning to take action to address its 'Treat in Turn' rates, to reduce the variation in the timeliness of access to care. This action was dependent on planned care transformation funding bids, but as highlighted earlier **(paragraph 23)**, these were not successful. It remains unclear if the Health Board will be able to improve its equity of provision.

Managing clinical risk and harm associated with long planned care waits

34 Long patient waits increases the risk of preventable and often irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

35 We found **that the Health Board has made some progress to implement Welsh Government's Promote, Prevent and Prepare policy, but needs to extend the service to cover all patients regardless of their place of treatment, and strengthen reporting on actual harm resulting from long planned care waits.**

36 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy?	**Partially**	The Health Board, with leadership from the Clinical Services Manager, has implemented the first phase of Welsh Government's Promote, Prevent and Prepare policy. The Health Board is aiming to ensure that support and information is easily accessible for those who are waiting for secondary care treatment. It provides online patient information, and a contact number and email for patients.
Is the Health Board assessing the risk to patients waiting the longest?	**Partially**	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. However, there is no consistent mechanism throughout specialties to assess risk and inform reporting, with only Ophthalmology using a prescribed prioritisation scale to assess risk and harm (**Recommendation 4.1**).

Audit question	Yes / No / Partially	Comments
Is the Health Board routinely capturing and reporting evidence of harm resulting from waiting list delays and is it reporting on it to the Quality and Safety Committee?	**No**	The Health Board does not routinely report harm associated with waiting list delays across specialties or for residents for whom it commissions external services for, to its Patient Experience, Quality and Safety Committee (**Recommendation 4.2**).
Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical risks in its approach to prioritising patients?	**Partially**	The Health Board is generally striking a balance between eliminating long waits and managing clinical risks. Clinicians undertake regular reviews considering a range of factors including patient acuity/urgency, length of wait, age and home personal circumstances. The Health Board also reviews waiting lists at commissioned bodies at its Commissioning, Quality and Performance Reporting meetings. However, despite having a 'Treat in Turn' Policy, there is variation in waiting times dependent on the location of treatment and at present, there is only limited scope to influence or remedy variation in other health bodies.
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	**No**	The Health Board has acknowledged that some patients will seek private treatment outside of the NHS due to the long waits that they have experienced. Currently these patients are not recorded on the Patient Administration for Wales System (WPAS), and there is no other evidence of consistent monitoring and reporting of these numbers.

Source: Audit Wales fieldwork

Waiting list performance – is the action taken resulting in improvement?

37 We analysed current ‘Referral to Treatment’[9] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall size of its waiting list; and
- meeting specific Ministerial priorities and Welsh Government national targets for planned care

38 We found **mixed progress on delivery of the Welsh Government targets which are due to date and the waiting list is continuing to grow, signalling future challenges.**

The scale of the waiting list

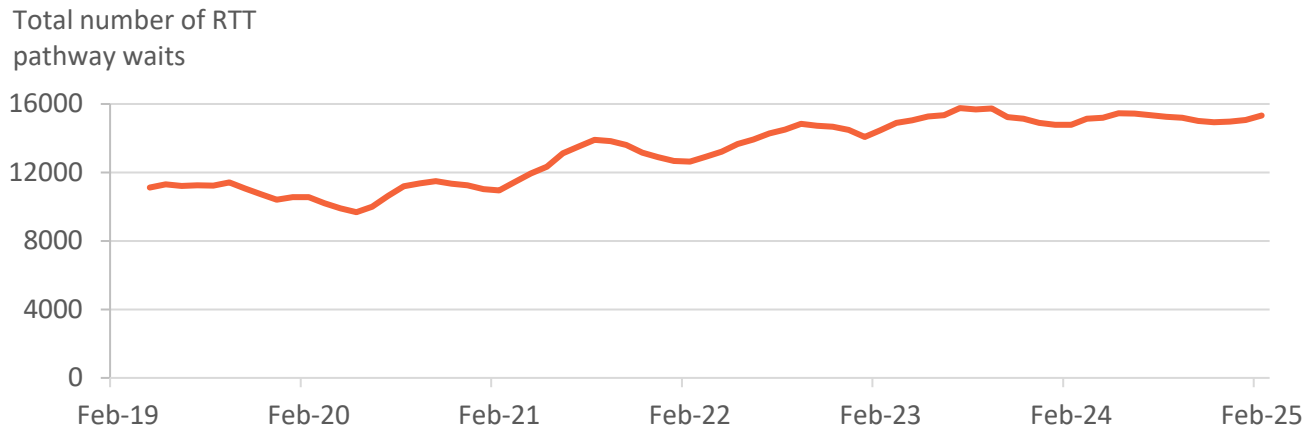
39 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the Health Board’s waiting list. We have also considered the volume of waits for diagnostics and therapy services and trends in referral rates. We found that **compared with other Health Boards the total number of waits is low, however the size of the waiting list remains higher than pre-pandemic levels.**

40 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019 for those patients treated in Wales[10]. Between April 2019 and February 2025, the Health Board’s waiting list increased from 11,115 to 15,330. The action that the Health Board is taking to reduce the overall numbers of people waiting is not resulting in reduced numbers of waits.

[9] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

[10] Exhibit 8 data is sourced from Welsh Government and only includes Powys patients who are waiting for treatment in Wales. We do not have comparable NHS England trend data for patients residing in Powys and waiting for treatment in England.

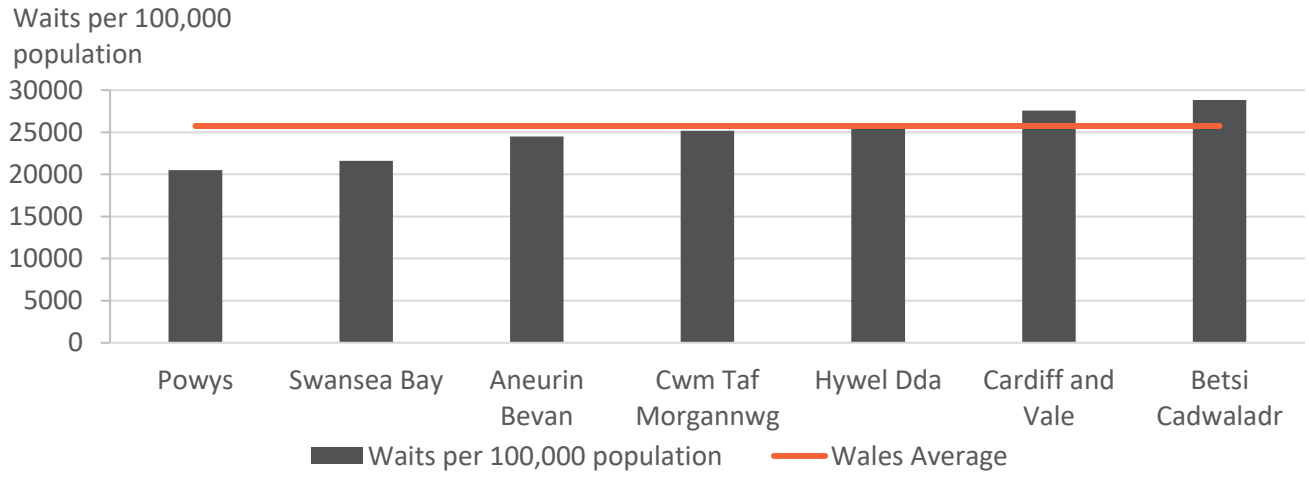
Exhibit 8: planned care waiting list size: Powys Teaching Health Board residents waiting for treatment in all Welsh providers (Excluding NHS England providers)



Source: The Welsh Government, Stats Wales

41 **Exhibit 9** provides a comparative picture of the volume of waits across Wales and it shows that the Health Board proportionately has the fewest waits[11].

Exhibit 9: Waits per 100,000 population, by health board of residence, December 2024. Exhibit 9 data includes Powys residents waiting for treatment (both in Wales and England)



Source: The Welsh Government, Stats Wales. Mid-year 2023 mid-year population estimates used in calculation. Powys's NHS England waits data sourced from Health Board performance reports.

[11] Our figures are based on NHS Wales's 'open' referral to treatment measure. This counts the number of open pathways, rather than unique numbers of people.

Performance against national targets/priorities

42 We looked at the progress that the Health Board is making against the Welsh Government's aims[12]. These are:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023[13]**).
- Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**).
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

43 We found **that performance against the ministerial priorities is mixed, whilst there has been good progress in eliminating waits over 2 years and reducing waits for therapy and diagnostics, initial progress on the 52-week outpatient target and reducing the number of people waiting longer than a year has not been sustained.**

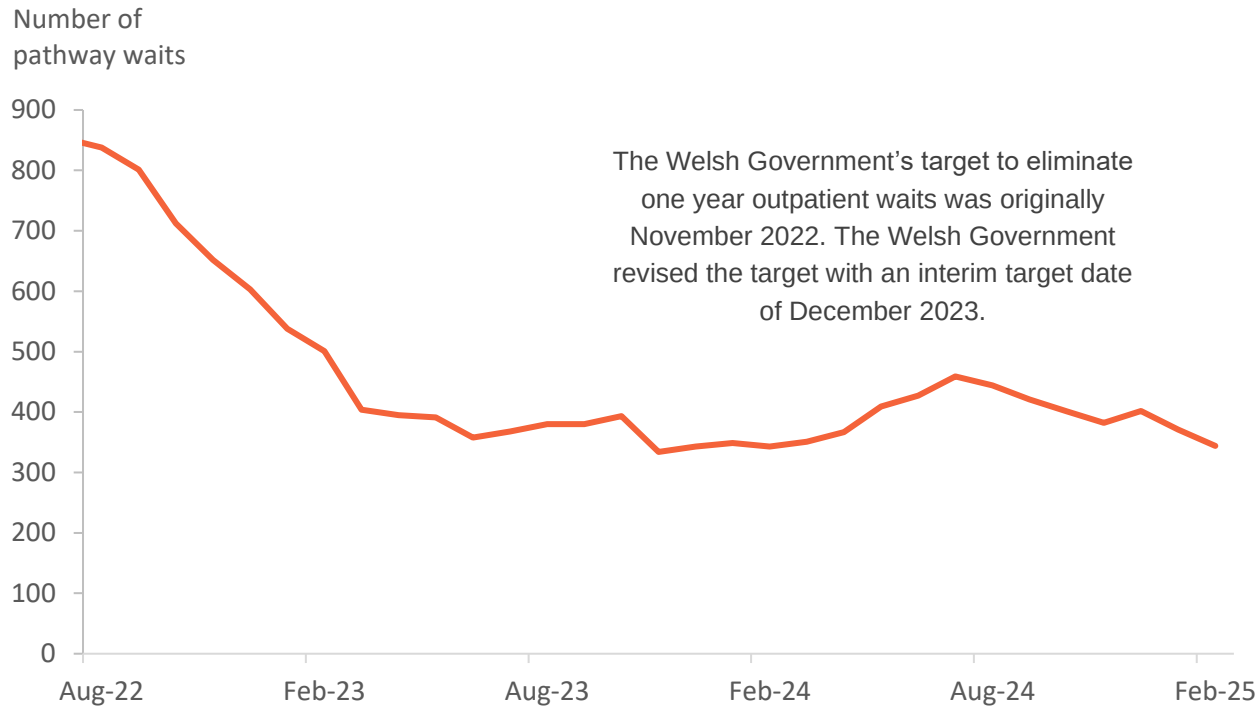
No one waiting longer than a year for their first outpatient appointment

44 **Exhibit 10** shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no residents waited more than a year for their new outpatient appointments. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year and has struggled to maintain its early improvements.

[12] We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

[13] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, by Health Board of residence, Powys Teaching Health Board – (Excludes NHS England providers)

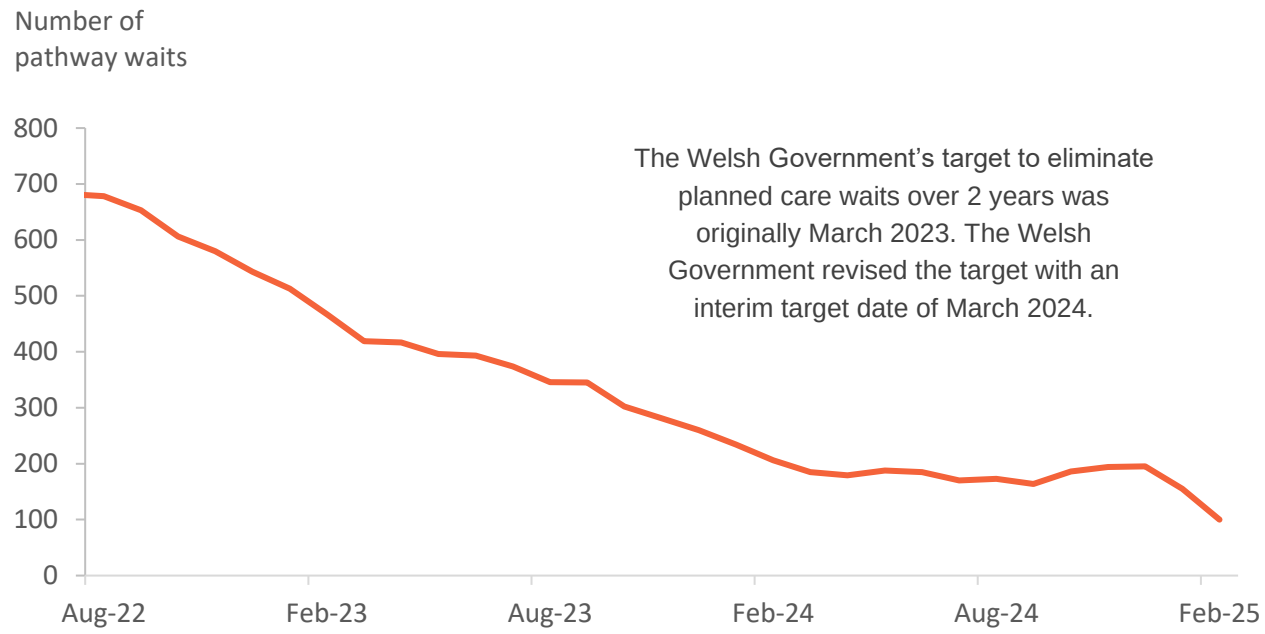


Source: The Welsh Government, Stats Wales

Eliminate the number of pathways longer than two years in most specialties by March 2023

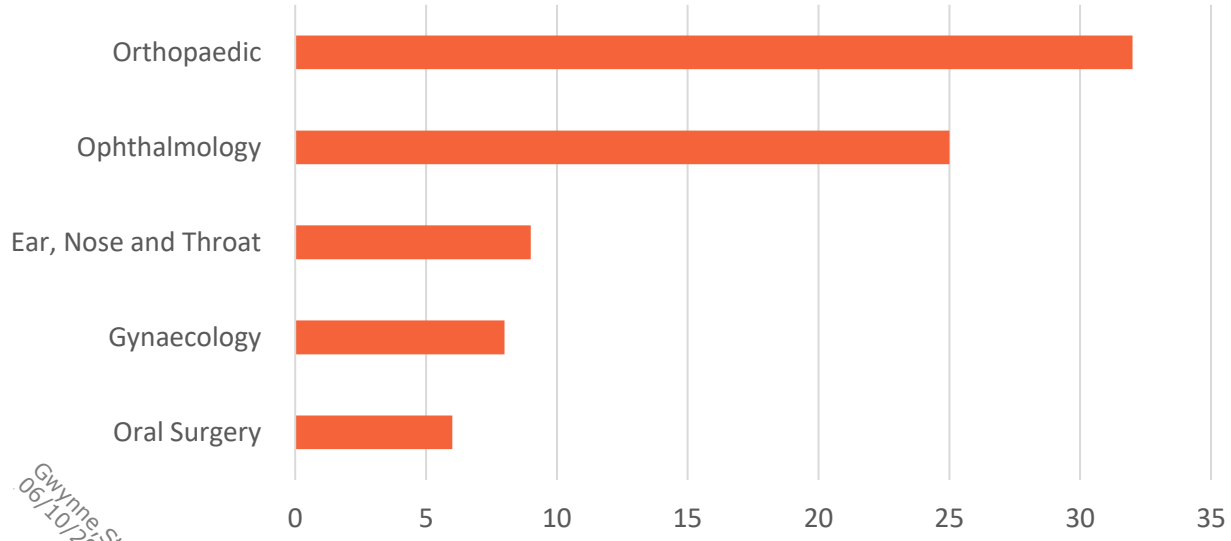
45 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024, but it has made good progress overall. Of those waits currently over 2 years, **Exhibit 12** shows that the most extreme waits are in a small number of specialties. Orthopaedics is clearly a challenge but longer waits in other specialties may also present an elevated risk of harm resulting from treatment delays.

Exhibit 11: the number of planned care waits over 2 years, by Health Board of residence, Powys Teaching Health Board (Excludes NHS England providers)



Source: The Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, by Health Board of residence, Powys Teaching Health Board (Excludes NHS England providers)

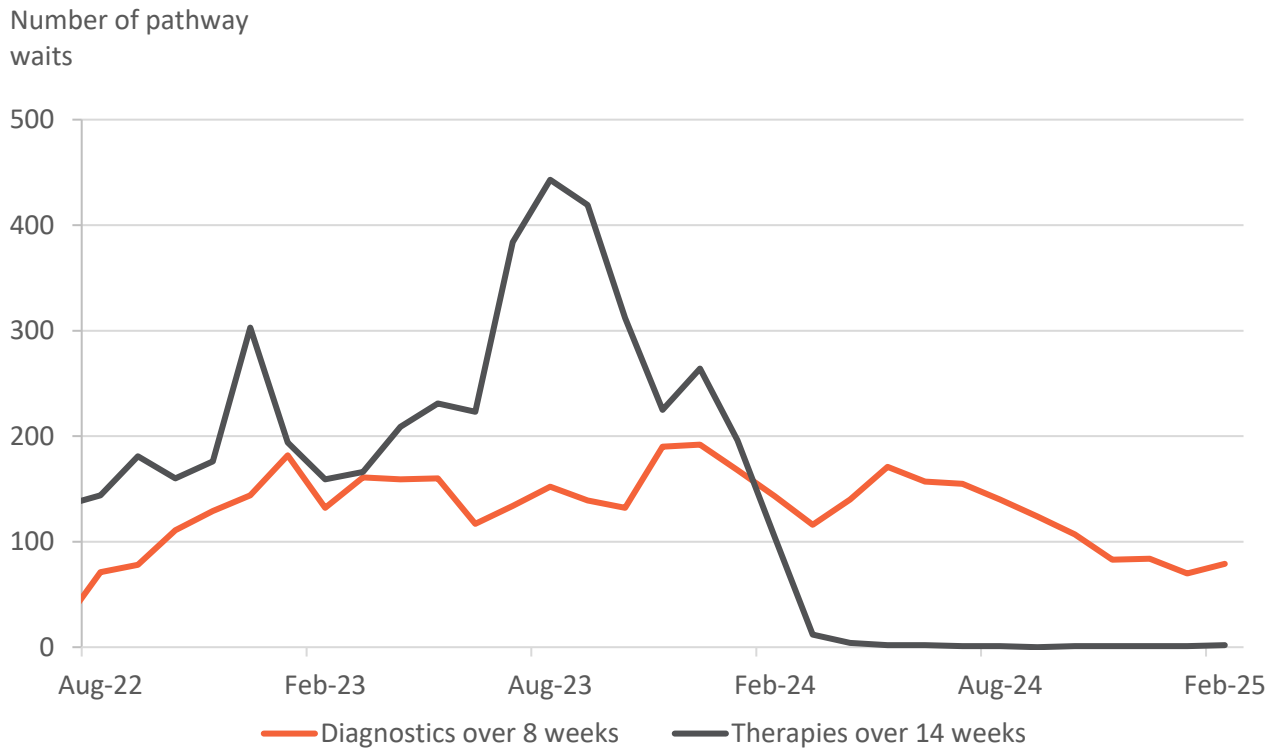


Source: The Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

46 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. The Health Board is currently meeting the target for therapy waits. Based on the current diagnostic performance it looks likely that the Health Board will also meet the diagnostic target in 2025 (**Exhibit 13**). Of its diagnostic services, cardiology diagnostics is of greatest concern because of the level of long waits.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14-week target), Powys Teaching Health Board (excludes NHS England providers)

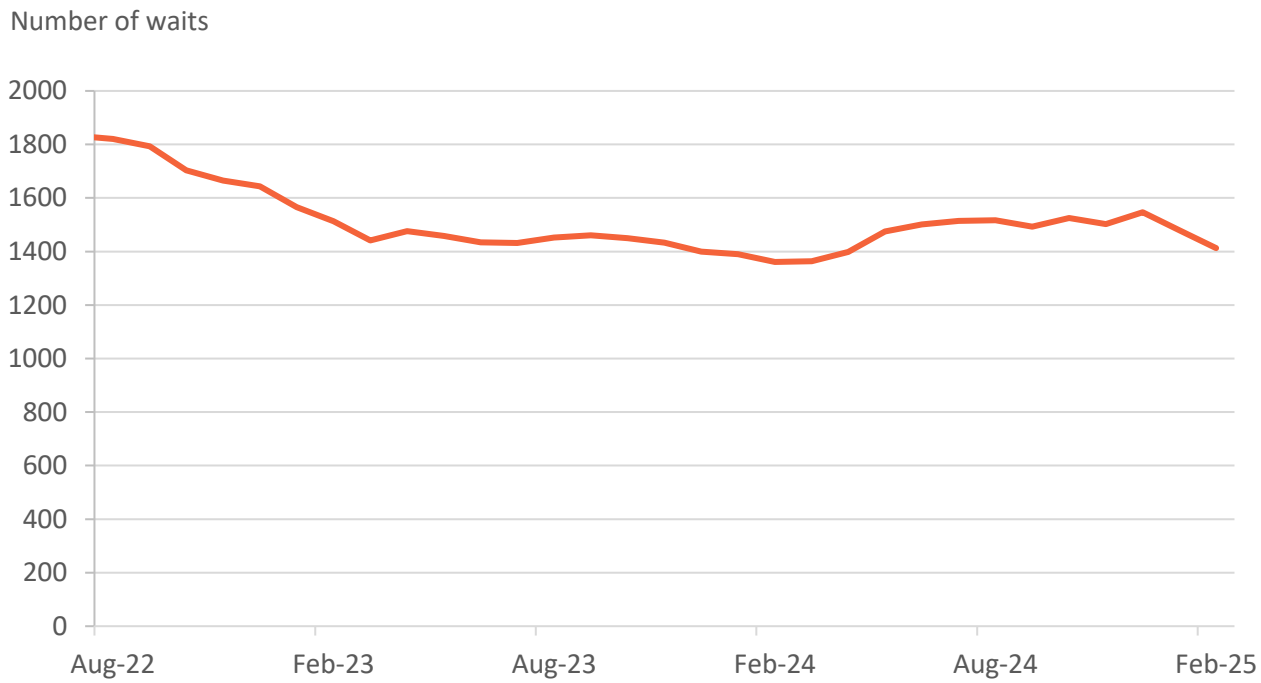


Source: The Welsh Government, Stats Wales

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

47 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** showed some improvement since 2022; however, performance improvements have since plateaued.

Exhibit 14: the number of pathway waits that are over a year, by Health Board of residence, Powys Teaching Health Board (Excludes NHS England providers)



Source: The Welsh Government, Stats Wales

Barriers to further improvement

48 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

49 We found that **the Health Board recognises its barriers to planned care recovery but will need to address a number of challenges if it is to secure sustainable planned care improvements.**

50 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is increasing demand for planned care services which we expect to grow further. While the Health Board is reducing the number of long waits, the overall numbers of patients on the waiting list continues to grow. Since April 2022, the overall waiting list has grown by nearly 40 percent. The Health Board's referral levels (excluding the atypical pandemic period), shows a long-term trend of increasing demand (**Exhibit 16, Page 37**) which if it continued, will present an ongoing operational and financial challenge.
- **Financial pressures** - The Health Board is experiencing significant financial pressures and is currently in Level 4 Targeted Intervention (Level 4) for finance, strategy and planning. This has resulted in the organisation facing challenging decisions on the extent that it can afford to fund planned care to the levels needed. This is likely to slow the pace of recovery.
- **Fragility of locally provided services** – Our capacity analysis of the Health Board's locally provided elective admissions indicates that its surgical activity levels are lower than 2019 levels (**Exhibit 17, Page 37**). We understand that this is affected by challenges recruiting to key roles, particularly those within clinical leadership, staff unavailability and staff turnover.
- **Complex commissioning environment** – As highlighted earlier, external staffing of in-reach services is becoming increasingly problematic. This is resulting in fragility in outpatients, general surgery, echo-cardiogram procedures, diagnostic endoscopy, ENT and day case activity.
- **Complexity of contractual arrangements** - The Health Board identified that the complexity of the contracting approach in Wales is a challenge. It indicated that historical Long-Term Agreements, a lack of standardisation across contracts and inconsistencies within the payment system have caused inefficiencies.

51 The Health Board is taking action to address some of these barriers. It has strengthened transformation programme leadership through the appointment of a Director of Improvement and Transformation. To address issues with theatre capacity, it has created a new theatre transformation programme, theatre efficiency programme and is undertaking a theatre clinical workforce review as described in **Exhibit 6**.

52 To address the fragility of services, the Health Board is introducing increased ‘daily’ contact with operational teams across commissioned bodies, as well as the creation of an operational fragile services log. Where there are issues, it can now escalate services through its contract quality and performance review meetings. The Health Board is also considering insourcing further private provision to mitigate gaps within commissioned capacity, as well as weekend clinics and theatre sessions.

53 Several of these improvement actions are at their early stages and the Health Board will need to review and monitor progress to ensure positive results. Service transformation needs to be embedded in the Health Board’s long-term plans for improvement, with appropriate resource in place to drive the changes. The Health Board needs to continue to embed these arrangements, and review and monitor progress to ensure positive results and value for money.

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Annual Delivery Plan 2024-25 • Powys THB Integrated Plan 2024-2029 • Integrated Medium-Term Plan (IMTP) 2022-25 • The Health and Care Strategy for Powys, A Vision to 2027 and Beyond (2017-2027) • Planned Care Pathways Plan 24/25 • Designing a sustainable approach for Powys. Better Together. November 2023 • Powys THB Integrated Quality & Performance Framework • Powys THB Incident Management Framework • Planned Care & Diagnostics programme initiation document • Getting It Right First Time reviews • Planned Care Transformation Fund bid forms • Diagnostics, Ambulatory and Planned Care meeting papers • Delivery & Performance Committee papers • Patient Experience, Quality & Safety Committee papers • Public Board meeting papers • Planned Care performance update reports • Risk registers
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Assistant Director of Community Services

Element of audit methods	Description
	• Senior Planned Care Manager • Interim Assistant Medical Director for Planned Care • Senior Clinician Theatres/Endoscopy, Q & S Lead for Planned Care • Deputy Director of Therapies and Healthcare Science • Senior Nurse Outpatients Development • Assistant Director of Finance • Assistant Director of Performance and Commissioning
Observations	We observed the Performance and Business Meeting and the Delivery and Performance Committee in August and the Diagnostics, Ambulatory and Planned Care Programme Board in September 2024.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: • made progress reducing the overall number of referral to treatment waits for planned care services; and • met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: • clear, realistic and funded plan in place for planned care recovery in the short and longer term; and • a programme structure that appropriately supports the delivery of the plan.

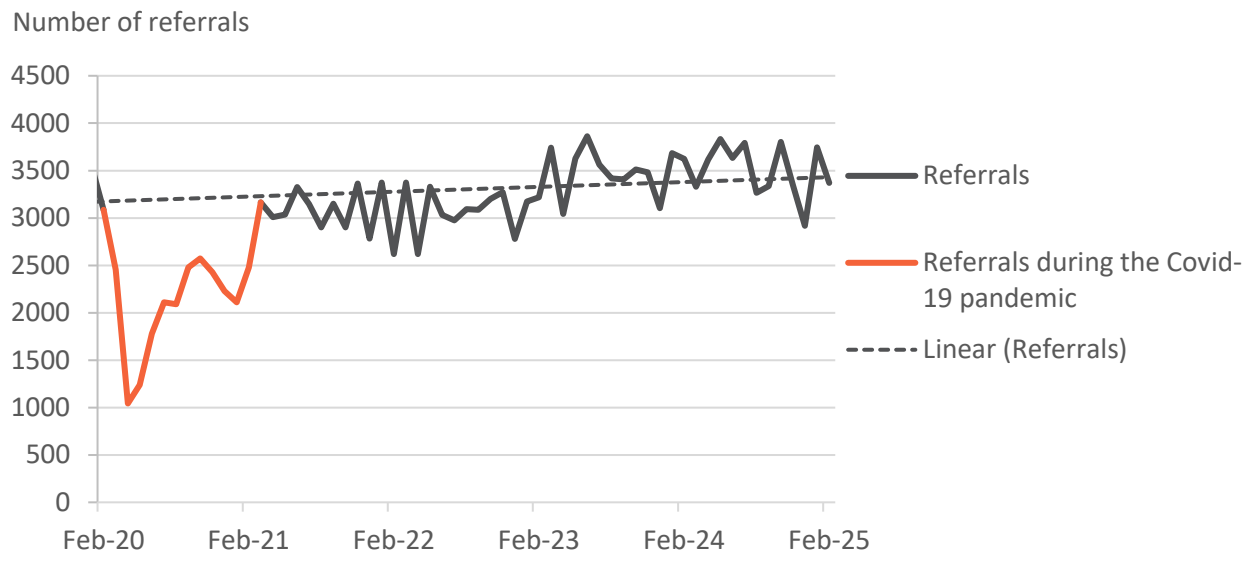
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short term and sustainable service models in the longer term. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

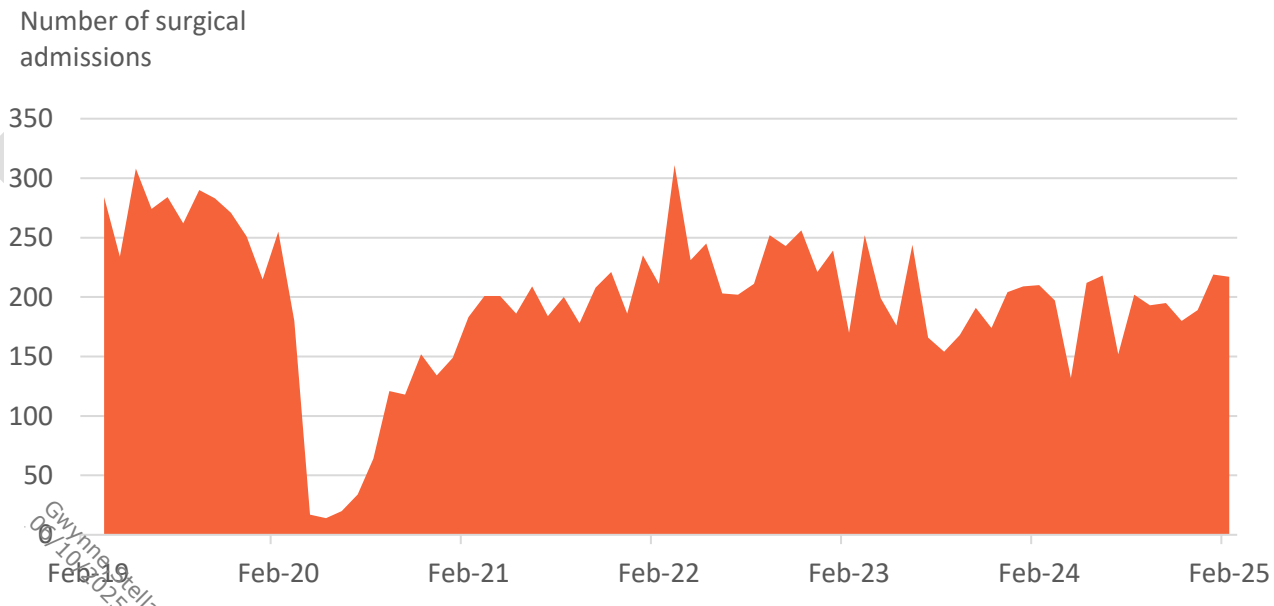
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Powys Teaching Health Board



Source: The Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels in Powys Teaching Health Board

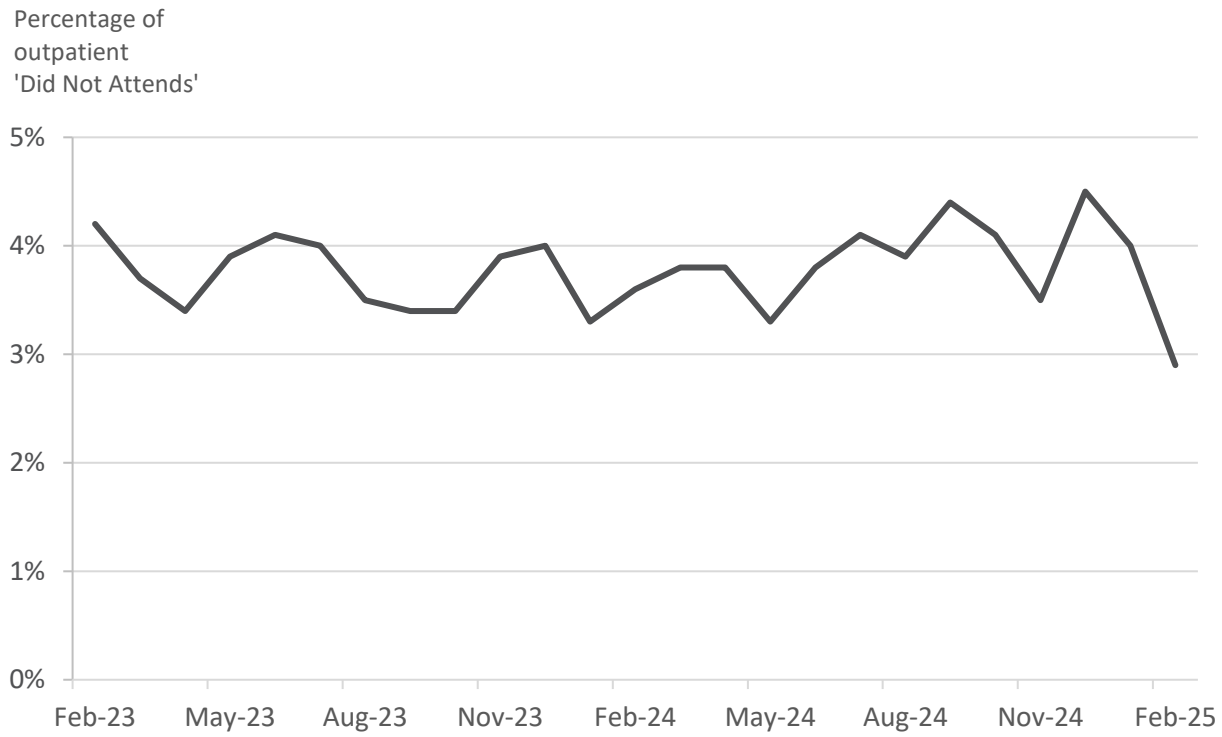


Source: Digital Health and Care Wales, secondary care dashboard

Outpatient services

54 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' is around 3.8% of total outpatient clinic activity. This equates to around 2,110 lost patient appointments in the most recently reported 12-month period, March 2024 to February 2025. It represents a lost opportunity cost of around £0.3 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £63,000.

Exhibit 18: the percentage of outpatient 'Did Not Attends' in Powys Teaching Health Board

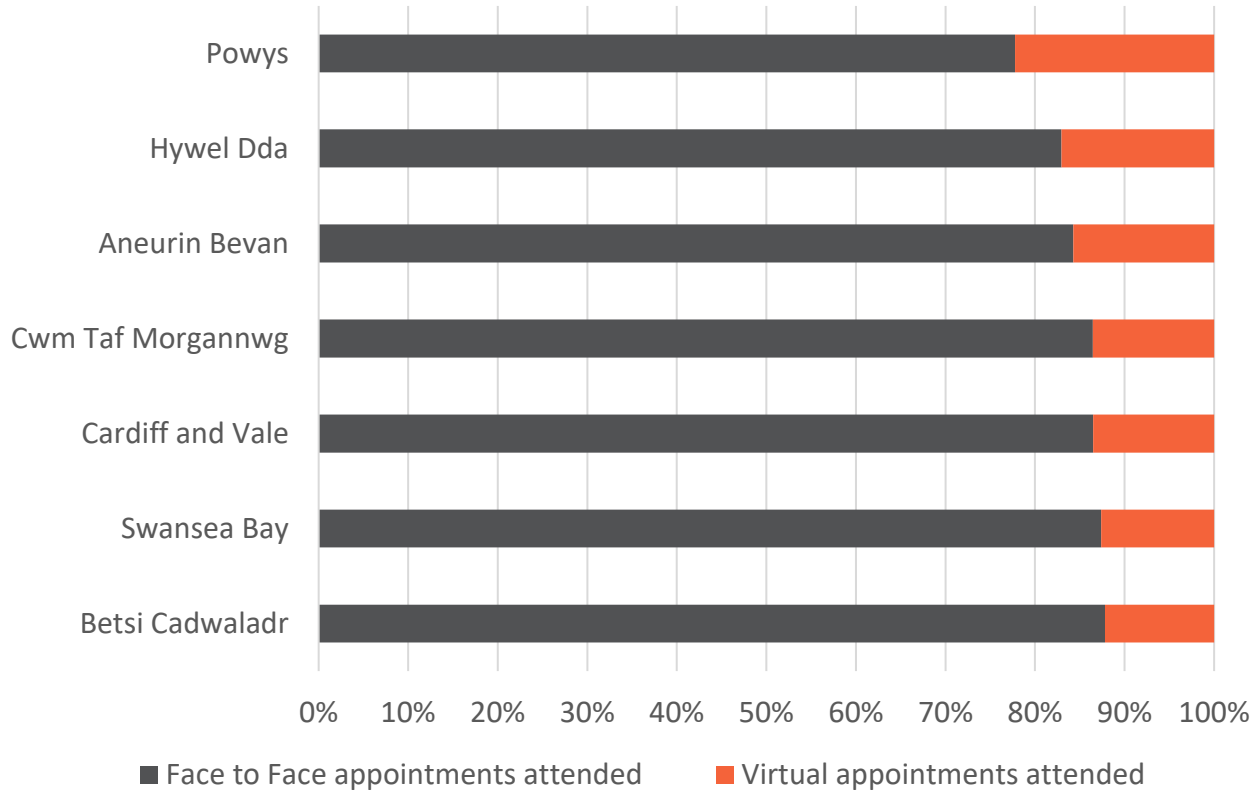


Source: Digital Health and Care Wales secondary care dashboard and datasets

[14] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

56 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well-adopted in most health boards. However, the take-up in Powys teaching Health Board is the highest in Wales.

Exhibit 19: proportion of elective outpatient attendances that are virtual appointments, for the period April 2024 to February 2025 (latest reported data)

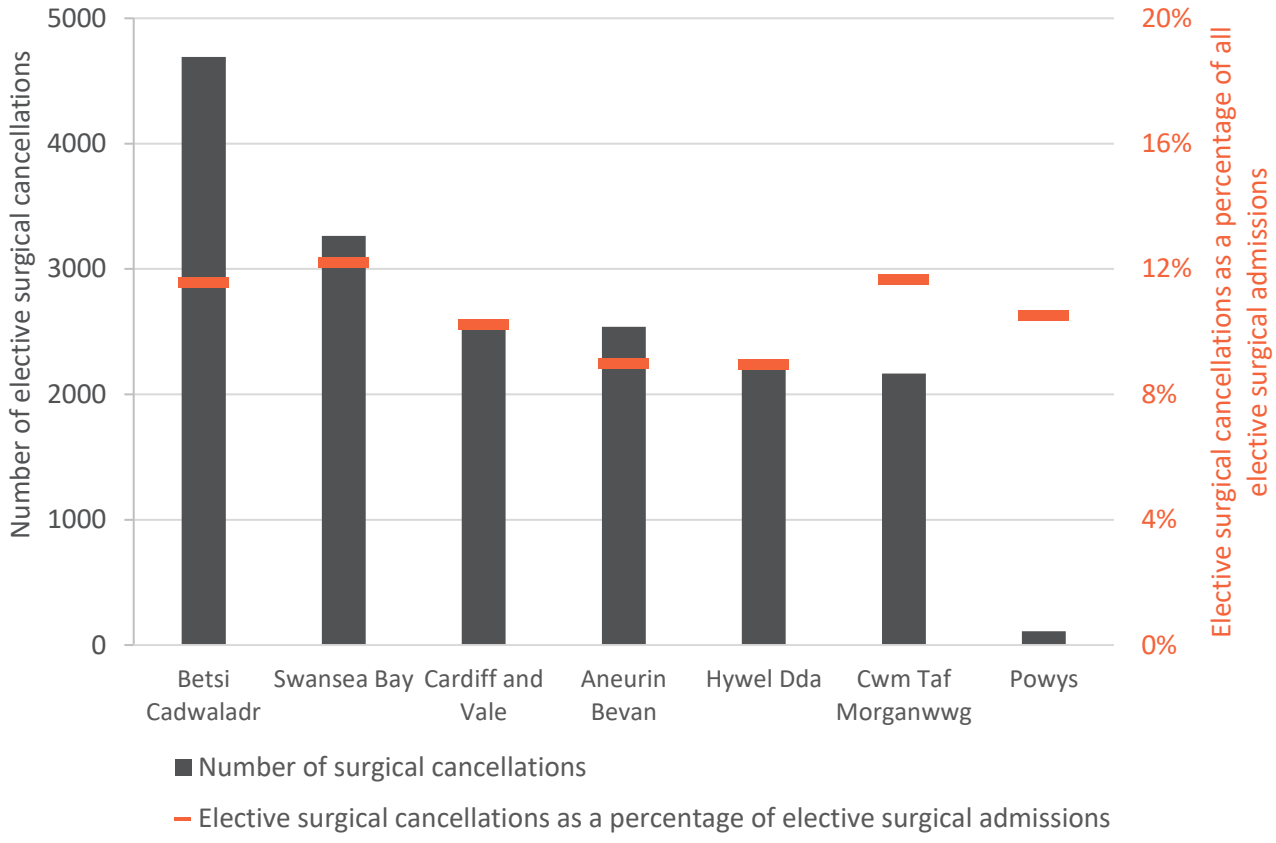


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

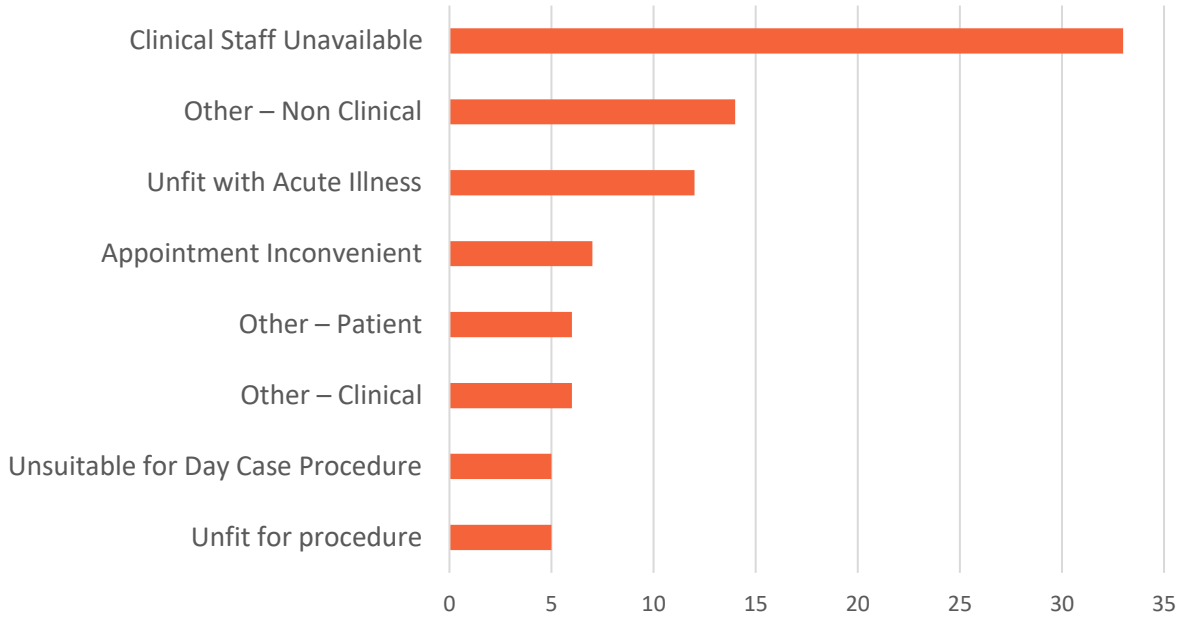
57 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board was 110 for the 12-month period March 2024 to February 2025 (**Exhibit 20**). While the actual cancellation numbers are lower than other health boards, the overall proportion of cancellations is reasonably high. **Exhibit 21** identifies the cancellation reasons. Clinic staff unavailability is a key issue for the Health Board. Our analysis also indicates that ophthalmology surgical cancellations is the service where the highest number of cancellations occur.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short notice (within 24 hours) surgical cancellations from March 2024 to February 2025, by reason in Powys Teaching Health Board



Source: Health Board submissions to the Welsh Government

Appendix 4

The management response to audit recommendations

Exhibit 22 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Longer term planning and costing R1 Over and above the commitments signalled in the Integrated Plan 2024-29 and Annual Plan 2024-25, the Health Board should develop a Planned Care improvement plan which aims to both design and deliver financially sustainable local services and affordable commissioning approaches in the medium to longer term. The plan should be costed, with realistic but	The 2025/26 Annual Plan contains more detailed Planned Care objectives with broader stakeholder involvement in the Plan development. A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. "Better Together" is PTHB promise to work together with citizens to review how and where we provide services, to ensure safety, to improve quality, and to make best use of resources that we can. We want to talk to patients and service users, people and communities, health and care staff, and our partner organisations.	June 2026	Assistant Director Community Services/Assistant Director Performance Commissioning

Recommendation	Management response	Completion date	Responsible officer
challenging milestones within it (Exhibit 2).	During 2025 PTHB are focusing on adult physical and mental health community services. After this we focus on planned care followed by services which support children. Families and women's health.		
Demand and capacity planning R2 The Health Board should ensure that its demand and capacity modelling approach informs short-term service capacity planning and longer-term service design. This should fully consider continued growth or expected changes in population demand for planned care services (Exhibit 2).	A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. Links Better Together Case for Change referenced in under R1 response.	March 2026	Assistant Director Community Services/Assistant Director Performance & Commissioning
Efficiency and productivity R3 To further improve efficiency and productivity, the Health Board should: • 3.1 Produce a progress report providing an update on the completion of recommendations arising from the Getting It Right	3.1 The Getting It Right First-Time actions now form part of the CIN Optimisation Frameworks and key transformation priorities reported/assured via the PTHB Planned Care Board. PTHB has agreed with NHS Executive that PTHB will focus on ophthalmology and orthopaedics as key priority areas identified in the PTHB. Key to progressing recommendations is speciality medical leadership and supporting clinical infrastructure which require investment proposals to resource.	December 2025	Assistant Director Community Services/Assistant Director Performance & Commissioning

Recommendation	Management response	Completion date	Responsible officer
First Time (GIRFT) reviews to be presented at Board. (Exhibit 6). • 3.2 Reduce the numbers of short notice surgical cancellations due to clinician unavailability (Exhibit 6). • 3.3 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% (Exhibit 6).	Progress on key priority areas are provided to the Board as part of Transformation, Integrated Performance and Annual Plan Reporting. The HB is currently awaiting feedback from NHS Wales Planned Care Programme in terms of optimisation framework maturity matrix returns submitted in Q1 2025/26. Transformation Fund Bids were developed to support GIRFT progress within PTHB including speciality leadership, MDT infrastructure and Programme Management. A successful internal investment bid for MSK/Orthopaedics has provided funding to appoint a speciality consultant lead for orthopaedics and supporting MSK infrastructure a similar investment proposal is being developed in 25/26 for ophthalmology. Progress report on Optimisation Frameworks including GIRFT to be provided as part of Performance & Finance Committee update.		
	3.2 SLAs with all providers are under significant challenge due to DGH pressures. The Planned Care Team continues to develop an MDT approach to support service sustainability shift left from reliance on consultant led model with digital healthcare underpinning wherever possible this is a long-term	March 2026	Assistant Director Community Services/Assistant Director

Recommendation	Management response	Completion date	Responsible officer
	goal focus is currently on ophthalmology and orthopaedics. As part of Better Together workstream review of PTHB commissioning across Planned Care will be undertaken to review opportunities to mitigate in reach fragilities.		Performance & Commissioning
	3.3 Theatre Transformation Plan in place as part of key priorities within PTHB community context no DGH, medical model. Working with regional partners to explore opportunities for mutual maximising utilisation of PTHB theatre estate at regional level.	March 2026	Assistant Director Community Services/Assistant Director Performance & Commissioning
Managing clinical risks associated with long waits R4 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks resulting from long waits. • 4.1 Develop and implement a consistent methodology for assessing the risk of harm to	4.1 PTHB Planned Care appointed a Senior Nurse Quality & Safety lead in October 2023 to further develop and strengthened Quality & Safety Framework and reporting within Planned Care Powys Provider. Clinical governance and oversight arrangements were further strengthened in October 2024 with the appointment of an Assistant Medical Director for Planned Care. Planned Care has a weekly Incident Panel Reporting Panel chaired by Senior Nurse Quality & Safety to review incidents, actions and learning (reported via Datix as part of All Wales Incident Reporting). There is a formal Planned Care Quality & Safety Meeting which reports into the Community Services Quality & Safety and health board	March 2026	Assistant Director Community Services/Assistant Director Performance & Commissioning

Recommendation		Management response	Completion date	Responsible officer
patients caused by long waits across specialties (Exhibit 7). • 4.2 Routinely report harm resulting from delays in access to treatment to the Quality and Safety Committee. This should include data for all Powys residents i.e. whether they are treated in Powys or receiving care commissioned by the Health Board (Exhibit 7).		Quality & Safety Committees. Risk, harm incidents are reported via this Framework. Commissioning, quality, performance meetings are held with each in reach provider which including standing agenda item for Quality & Safety. Clinical governance is being further strengthened with the appointment of speciality lead consultant for orthopaedics Sept 2025 and general surgery/endoscopy June 2025.		
	4.2	PTHB commissioned waits are discussed as part of PTHB commissioning assurance process with Quality & Safety as a standing agenda item at formal HB meetings with LTA providers and reported to Board as part of PTHB Integrated Performance Framework. Enhanced Quality and Safety waiting times report is under development.	March 2026	Assistant Director Community Services/Assistant Director Performance & Commissioning

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

AUDIT RISK AND ASSURANCE COMMITTEE	7 OCTOBER 2025
Subject:	**Learning from Annual External Audit of Accounts & Annual Report 2024/25**
Approved and presented by:	Pete Hopgood, Executive Director Finance, Capital, and Support Services and Elaine Lorton, Executive Director of Primary Care, Community & Mental Health
Prepared by:	Deputy Director of Finance /Assistant Director of Finance/Assistant Director of Complex Care/Finance Business Partner
Other Committees and meetings considered at:	Executive Committee – 1 October 2025 who endorsed the paper to the Committee.

PURPOSE:

Review of CHC processes following completion of the Annual Accounts. This is to inform the Audit Risk and Assurance Committee of issues identified during the 24/25 Annual Accounts audit process and demonstrate lessons learnt and actions underway to ensure such issues are not repeated.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

- Take **ASSURANCE** that the issues and learning identified as part of the 2024/25 audit are being addressed.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING 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		

EXECUTIVE SUMMARY:

This paper sets out the review undertaken and actions taken to address the findings from the External Audit of Accounts 24/25 in relation to Continuing Health Care (CHC) accruals. Concerns raised from external audit in this area and subsequent additional work undertaken by PTHB meant a delay in the signing of accounts for 2024/25.

The Audit Wales 'Audit of Accounts Report 2024/25' reported a significant matter relating to the Health Board's accounting of CHC Accruals as follows:

- *audit identified some significant issues with the valuation and classification of CHC accruals. Many of the issues that we identified were a result of the finance team being unaware of the most up to date information available held by the CHC team.*

This paper seeks to outline the review undertaken into these issues and the adjustment to processes identified to rectify and avoid recurrence of this issue for future years.

- Lack of external communication in a timely manner to CHC team when contracts change for packages.
- Internal Communication/Analysis including the timeless of administration, panel and updating database.
- Backlog of processing invoices from CHC to Finance/NWSSP
- Year End and the time to reflect on accruals.

Following a joint workshop between the teams affected, a series of actions have been agreed and are being implemented.

BACKGROUND:

During the 2024/25 Annual Accounts, a significant issue section was inserted into the Audit Wales ISA 260 as follows:

Within the year end CHC accruals, audit identified some significant issues with the valuation and classification of CHC accruals. Many of the issues that were identified were a result of the finance team being unaware of the most up to date information available held by the CHC team.

From our initial audit testing we were unable to gain the assurance we required over the valuation of CHC accruals as we identified multiple errors in our sample. Consequently, the Health Board undertook a further review of CHC accruals to ensure they were accurate and based on all relevant information available to the Health Board. That further review and its conclusions was presented to us on 4 July 2025.

After further audit testing of this and the Health Board's review confirmed the net overstatement identified by the Health Board of £437,000. Although this amount

was not corrected by the Health Board, based on the audit work completed audit were satisfied that CHC accruals in the accounts were materially correct.

Classification, in addition to the valuation issues identified above, the audit also identified potential misclassification of some CHC liabilities classified as accruals that should instead be classified as payables in Note 18 of the accounts.

The issues in relation to CHC accruals caused a delay in the signing of the accounts by the AGW from 27 June 2025 to 1 August 2025.

Audit Wales noted thanks to the Health Board in its Audit of Accounts Report – *Powys Teaching Health Board's quick and robust response to the issues identified during the initial audit testing, and the co-operation offered to the audit team throughou*t.

To further reinforce the issue a specific Audit Recommendation was made by Audit Wales and accepted by Powys Teaching Health Board (PTHB):

The Health Board should ensure that there are robust processes in place to ensure the completeness and accuracy of information used when calculating CHC accruals. It should ensure that the Manual for Accounts and accounting standards are followed when disclosing the CHC accruals balance in its year-end financial statements.

PTHB response to the recommendation:

The Assistant Director of Finance and the Assistant Director of Complex Care will work together to review and improve the processes.

Work is being undertaken between the Finance and Complex Care teams to streamline package and invoice processing approval flows. This workstream will be continued to encompass the recommendations identified above.

LESSONS LEARNT:

A workshop involving those involved in the process from amongst the CHC and Finance teams has been undertaken where the key findings (detailed below) were discussed. To address these reported issues further reflection has been undertaken and specific issues found during the Audit have been identified as detailed in the audit findings, audit work on CHC accruals noted several issues:

- An accrual was made for an individual who had passed away.
- Accruals were made for elements of care packages that had been cancelled.
- Accruals were not always made for cases that had been agreed at panel, because they had not been included in the CHC database.
- A CHC case that had been adopted by another Health Board had an accrual against it, despite being notified of this by the other Health Board, and:

- Misclassification of some balances that were included in the Non-NHS Accruals line in Note 18 that should have been included in Non-NHS Payables

The cause of many of these issues is the Finance team being unaware of the most up to date information available, which was held by the CHC team.

Steps undertaken to review issues and address weaknesses highlighted.

A workshop to discuss the "A summary of the errors found, and lessons learnt" was held in conjunction with the all the operational CHC teams and the Finance team on 12 August 2025. (Please see Appendix 1 for attendees) The meeting sought to ascertain the following:

- Original issues
- Additional work undertaken.
- Actions taken.
- Lesson learnt.
- What are we currently doing?
- What we are going to do differently going forward to gain assurance

Internal Communication/Analysis including the timeless of administration, panel and updating database.

- **Accruals System:** Emphasised the need for a more robust system for accruals, suggesting a focus on reviewing information on cases from January to ensure Finance are in receipt of the most up to date case information to ensure the best accuracy by year-end.

- **Teams –** The need to ensure no single points of failure. A business case paper for additional resource has been completed and is at Exec level for review during 2025/26.

- **Fast Track Reviews:** Service managers within Health and Local Authority working on the implementation of weekly or bi-weekly phone calls to monitor fast track cases, ensuring evidence of changes in need for local authority reviews are communicated as required.

- **Provider Responsibility:** The need to ensure providers were clear on their responsibility to update Enhanced Package of Care (EPC) forms and the challenges faced when they fail to do so, impacting the accuracy of care packages.

Lack of external communication in a timely manner to CHC team when contracts change for packages.

- **Learning Disability (LD): Case Reviews:** Regular reviews and the involvement of clinical teams to ensure accurate assessments due to complex nature and joint packages. LD was one area that showed areas of concern at year end. Recognising the complexity of these cases, issues raised were the number of disputes, the timely raising of these queries and the delay in replies. All LD packages are jointly funded with the Council approximately sixty-nine cases in a residential setting. There will be a focus on better engagement from clinicians and nurse assessor, so any changes are reported in a timely manner. There is no formal SOP in place for LD, and this will be picked up with the service, and the development of a SOP will be part of a joint work plan.

- **Powys County Council (PCC) Invoices:** Update on the status of invoices from Powys County Council where a number of queries/disputes had built up over time or had yet to be received, including disputes held and the need for timely invoicing.

- **New Funds Flow Form:** A new funds flow form proposed by Powys County Council for new cases, aiming to improve communication and agreement on care package costs was presented and would be pursued jointly to implementation.

- **Provider Responsibility:** The need to ensure providers were held to account on the responsibility of providers to update EPC forms, and the challenges faced when they fail to do so, impacting the accuracy of care packages.

Year End and the time to reflect on accruals added.

- **Year-End Preparation:** Preparing for year-end by reviewing one-to-one and two-to-one care packages earlier in the year to ensure accuracy.

- **Invoice Disputes:** The need to keep a list of disputed invoices and ensure timely communication with providers to resolve issues. Particularly with the timeliness of receipt of some invoices from Powys County Council (PCC).

- **Pending Packages:** Use of the NCCD to track pending packages to ensure accurate accruals.

Backlog of processing invoices from CHC to Finance/NWSSP

- **Powys County Council (PCC) Invoices:** Update on the status of invoices from Powys County Council where a number of queries/disputes had built up over time or had yet to be received, including disputes held and the

need for timely invoicing. The two parties are currently working together to resolve outstanding invoices.

- **New Funds Flow Form:** A new funds flow form proposed by Powys County Council for new cases, aiming to improve communication and agreement on care package costs was presented and would be pursued jointly to implementation.

ACTIONS:

Actions agreed following the workshop:

Internal Communication/Analysis including the timeless of administration, panel and updating database.

- **Timetable:** Finance will put a timetable together in early January outlining the year end dates and will work with the service to capture all deadlines needed for year-end (i.e. when to run reports, pending reports). A year end timetable is already produced and shared.

- **Commissioning Care Assurance and Performance System (CCAPS) packages & packages for Additional Care needs:** Finance to periodically look at CCAPS packages and packages with additional care (i.e. 1:1s and 2:1s), to ensure workload is reduced for year end. CHC team to keep an up-to-date spreadsheet of all the 1:1s, which Finance can review to assist if a gap within additional care is identified or when invoices missing. As part of the framework, we have the first 30 days of 1:1s for free (15 days for 2:1), this can be taken over a lengthy period. Therefore, it is hard to monitor and cause differences on the accrual if days are free or need to be paid for. By keeping up to date with invoices PTHB look to reduce the risk of out-of-date package data being used. In addition, Finance have introduced a new spreadsheet to record all invoices received and passed for payment, this will be used to identify gaps in invoice periods.

- **Invoices:** Service teams are to be more proactive with seeking missing invoices from suppliers. If PTHB is liable for the costs, then it is committed to pay. This will happen periodically and not just at year end. This will reduce the level of additional work required leading up to year end and improve the accuracy of the information in the system and the monthly forecasting.

- **Invoice Payment Failures:** PTHB failed to meet its PSPP target of paying invoices within 30 days, with 40% of delayed payments linked to CHC. This impacts supplier relationships, especially in the care home sector. Working on the time delays in which invoices enter the organisation and are passed

to Finance for onward payment to NWSSP is paramount to achieve the PSPP and cash flow to suppliers. The previous Purchase Order requirements have been removed and a new Panel based process for authorising/amending packages of care implemented to allow more timely processing of invoices.

Lack of external communication in a timely manner to CHC team when contracts change for packages.

- **CCAPS Framework Provider Compliance:** PTHB to meet with Joint Commissioning Committee (JCC) to discuss the Health Board's needs regarding frameworks for adults of working age, LD, and Child and Adolescent Mental Health Services (CAHMS) placements, specifically addressing provider responsibilities for updating Enhanced Package of Care (EPC) forms.

- **Relationships:** Working on relationships with Powys County Council to clear any outstanding issues. This includes the proposal of PCC Funds Flow Form Review. CHC team to review and gather feedback on implementation and necessary amendments before responding to PCC.

- **Communication:** Regular discussion to review cases where invoices have not been received from PCC, clarify reasons, and develop a plan of action for follow-up with the PCC.

- **Learning Disability:** Additional reviews and the involvement of clinical teams to ensure accurate assessments due to complex nature and joint packages. Potential using the new proposed Funds Flow Form with Powys County Council to ensure initial agreement on splits to ensure timely updates of NCCD & invoicing is clear.

- **Domiciliary Care:** CHC team have been working with Local Authorities on their frameworks in 2025/26, to use the approved providers. This ensures Rural and Town rates match. This allows invoices to be paid on a timelier basis as rates are agreed and known by the team reducing the number of queries and any time delays.

  CHC operational teams are to work with care providers to ensure invoices received by PTHB are as up to date as possible for all packages.

- **Statements:** This is a finding from completing the additional audit work. In most cases it was identified that the homes are on top of their invoicing and send them to PTHB in a timely manner but there was a delay in them being processed by operational CHC service teams. Statements are to be requested from our suppliers and that the support team in Finance review

these periodically following the current process with Agency suppliers. (as we do with Agency providers). CHC team will be responsible for requesting any missing invoices.

Backlog of processing invoices from CHC to Finance/NWSSP

- **Recording Data on NCCD:** Commitment by Nurse Assessors and CHC admin teams to ensure data is recorded in a timely manner. Recent additional work has been undertaken by allowing additional bank shifts and cross cover in the team to update the NCCD and includes recording of new packages and passing invoices for processing and payment. The need to ensure no single points of failure has been identified. It had been noted that a business case for additional resource has been prepared.

- **Administrative Constraints:** Delays in CHC processing experienced at the year end were impacted by the capacity of the admin team. Investment in this area is required to meet service demands together with these audit recommendations and improve financial performance.

  Cross cover across the CHC administration teams. It is noted and understood that there are significant differences in the nature of the work between the two teams, but additional cross cover would reduce the risk of single points of failure. This is to be explored further.

Year End and the time to reflect on accruals added.

- **Pending Packages:** Due to timescales the last run of the National Complex Care Database (NCCD) is before the 31st of March. Therefore, any packages known about but not approved by Panel will be tracked by adding to the NCCD as pending. Finance systems team has confirmed a report that can be run which shows these packages, the dates started, and the costs associated.

- **Materiality:** Finance team to look at both credit and debit balances at year end. It is not possible to look at all the debit balances at year end due to number of cases and time constraints. This review will be based on materiality or top twenty. Based on 2024/25 accrual values per case over £50K would be fourteen packages, over £25K 53 packages over £20K 74 packages over £10K would 175 packages. This would be on top of the current review of credit balances and debit balances under £500 to reduce immaterial accruals on the balance sheet. Finance will complete an analysis prior to year end of any balance where invoices are outstanding to NCCD YTD £s.

- **Communication**: This is key, although good channels of communication are already demonstrated, we need to ensure this is open, everyone is engaged, understands their role and takes ownership, this includes internal and external partners. Additional meetings at key periods of the year will be set up with monthly meetings for the last quarter of the year between operational teams and finance to ensure any risks are escalated in a timely manner.

  At year end a list of invoices received in the organisation by operational CHC teams but not sent to Finance for payment will be recorded and shared with Finance. This action will address the classification issue raised so that any invoices received by the THB prior to 31st March are classified as Non-NHS Trade Payables as opposed to accruals.

Status of Actions

The following table lists the actions, a due date, and the current status.

Action	Action Date	Complete/Not Complete
Workshop	12/08/25	Complete
Timetable	01/01/26	WIP
CCAPS & Additional Needs	01/01/26 – 31/03/26	WIP
Missing Invoices	31/10/25	WIP
Invoice Payment Failures	31/12/25	WIP
CCAPs Framework Provider Compliance	30/09/25	Complete
Relationships: Age debt PCC	31/10/25	WIP
Communication: PCC	31/12/25	WIP
Learning Disability	31/12/25	WIP
Domiciliary Care	31/06/25	Complete
Statements	30/10/25	ongoing
Recording Data on NCCD	30/10/25	WIP
Administrative Constraints	31/02/25	WIP
Pending Packages	31/03/26	WIP
Materiality	01/01/26 – 31/03/26	WIP
Communication	01/10/25 – 31/03/26	WIP

WIP = work in progress.

NEXT STEPS:

The Assistant Director of Finance – Accounts and Services and the Assistant Director of Complex Care will work together to review and continue to implement the above processes. This will include ensuring all people involved in

process are aware of their duties to ensure the information available at the financial year end is as up to date and comprehensive as possible to ensure an estimation for accruals reflect the liability position on 31st March.

The CHC workstream will be continued over the next 12 months to encompass the recommendations identified above together with a 2025/26 post financial year end review and reflect any further process changes required to streamline and provide timely information on which financial forecasting is based.

Appendix 1

List of attendees at the workshop to discuss the "A summary of the errors found, and lessons learnt" 12 August 2025

CHC Teams
(PTHB - Assistant Director Complex Care)
(PTHB - Head of Complex & Unscheduled Care (MH and LD)
(PTHB – Lead Nurse for Complex Care and Care Home Governance)
(PTHB - Senior Nurse Complex Care)
(PTHB - Complex Care Administrator)
(PTHB - Complex Care Administrator)
(PTHB - Complex Care Administrator MHLD)

Finance Team
(PTHB - Assistant Director of Finance)
(PTHB – Finance Business Partner Finance)
(PTHB – Directorate Assistant Finance Officer)
(PTHB - Finance Systems and Data Analyst)
(PTHB – Directorate Accountant Finance)

Apologies
(PTHB – Finance Management Accountant
(PTHB - FID Financial Accountant Finance)
(PTHB - Complex Care Administrator MHLD)

Agenda item: 5.6

AUDIT, RISK AND ASSURANCE COMMITTEE	07 October 2025
Subject:	Counter Fraud Update Report
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services Matthew Evans Head of Counter Fraud
Prepared by:	Matthew Evans, Head of Counter Fraud
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2025/26.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

- **RECEIVE** the update report for discussion;
- Take **ASSURANCE** that appropriate counter fraud systems are in place.

Approve/Take Assurance	Discuss	Note
		Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	The matters covered in this report are aimed at the strategic objective of transforming the Health Board into an Organisation with commitment to reducing economic crime levels to an absolute minimum and keeping them there in line with the requirements of NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Measures.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The purpose of this report is to update the Audit Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists since the last meeting.

Meetings are held on a regular basis with the Director of Finance, where progress against the annual work plan and with the LCFS case workload is discussed and monitored.

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

HEADING:

1. STRATEGIC GOVERNANCE

The Health Board's service level agreement with Swansea Bay University Health Board for the delivery of counter fraud services is due for renewal. Negotiations will be taken forward with the Executive Director of Finance, Estates and Support Services.

2. INFORM AND INVOLVE

Preparations are being made by the Counter Fraud Team for participation in international fraud awareness week. The Team are exploring use of AI for production of refreshed counter fraud literature including posters, information leaflets and articles for release to staff and members of the public. International fraud awareness week is due to take place November 16-22nd 2025.

3. PREVENT AND DETER

Following an identified risk of unknown third parties attending in place of registered agency workers an All Wales risk assessment is to be undertaken in relation to the recently revised All Wales Agency Contract Framework agreement. This work is being undertaken with Counter Fraud Liaison Group and is led by an LCFS from the Swansea Bay UHB Counter Fraud Team. Once concluded a review of local controls will be undertaken for assurance purposes with work ultimately resulting in completion of a local fraud risk assessment.

A Local Proactive Exercise aimed at measuring compliance with the Health Board's Declaration of Interests procedure will be undertaken in liaison with the Corporate Governance Team. The exercise will utilise National Fraud Initiative data which identifies staff members who are also linked to companies with whom the Health Board has contracted services or procured goods via creditors and companies house data.

4. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is set out below in anonymised data.

Reference	Date Commenced	Title	Type	Subtype
INV/25/02728	16/09/2025	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	NHS Staff Fraud – Employee Fraud	Working Whilst Sick
INV/25/01838	30/06/2025	Abuse of Position	NHS Staff Fraud – Employee Fraud	Employee Fraud – Other
INV/25/01658	12/06/2025	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01647	02/06/2025	Private treatment on NHS patient	NHS Staff Fraud - Dental	Charging for NHS Treatment
INV/25/01522	02/06/2025	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01521	02/06/2025	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01520	02/06/2025	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01519	02/06/2025	Abuse of Position	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/25/01130	15/04/2025	False Representation - Volunteer Public Member Validation	NHS Staff Fraud - Employee fraud	Travel/subsistence fraud

INV/25/00156	21/01/2025	Prescription Fraud - Patient living in England	NHS Patient Fraud	NHS Patients - Misuse of prescriptions
INV/24/03253	17/12/2024	Working Elsewhere - Dual Working	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/01904	10/04/2025	Theft of NHS Assets	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/00525	04/03/2025	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick

NEXT STEPS:

The Committee will continue to receive relevant reports at each meeting.

IMPACT ASSESSMENT – NOT REQUIRED

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe	x				A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely	x				
Effective	x				
Efficient	x				
Equitable	x				
Person Centred	x				
Workforce	x				
Leadership	x				
Culture	x				
Information	x				
Learn, Improve, Research	x				
Whole Systems Approach	x				

EQUALITY:

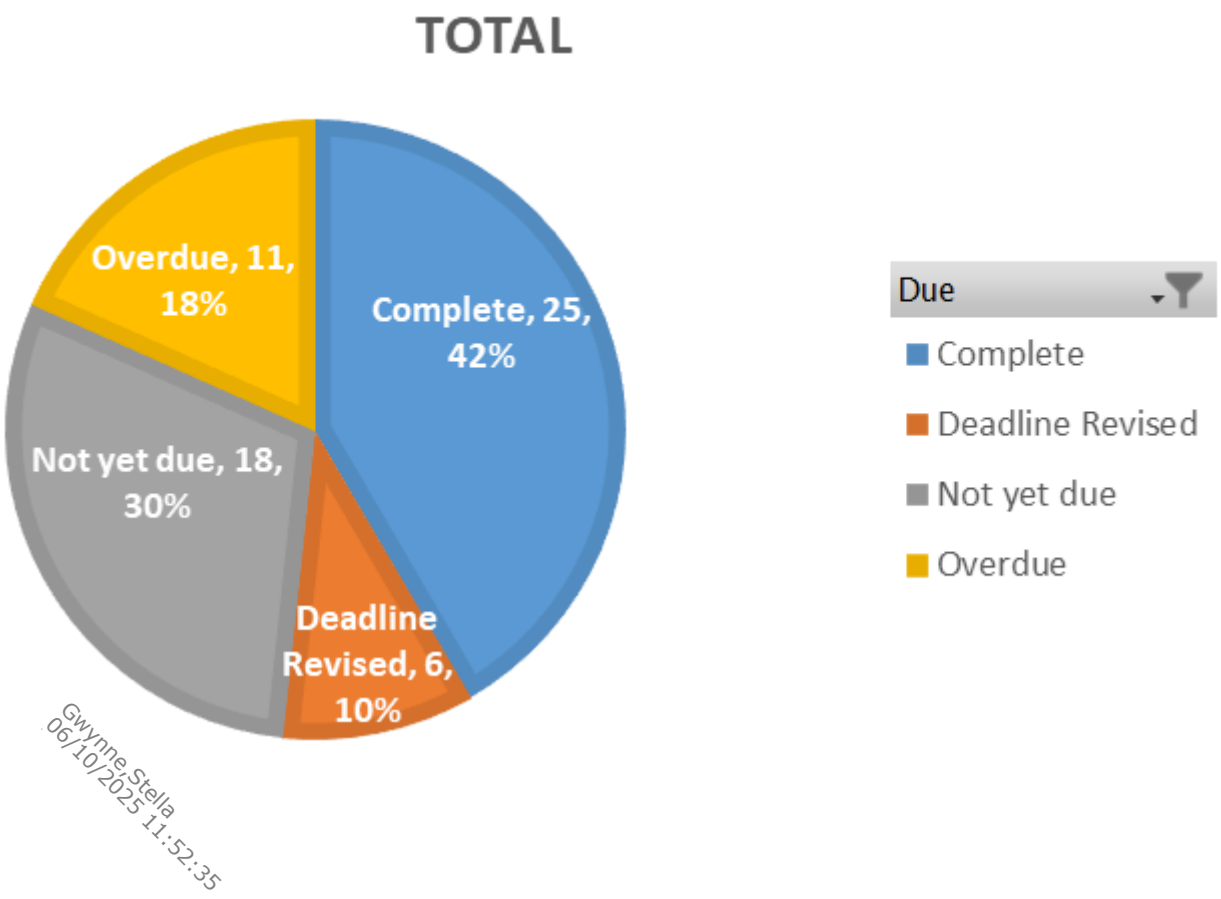
	No impact	Negative	Positive	Both	
Age	x				An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability	x				
Gender reassignment	x				
Marriage / civil partnership	x				
Pregnancy / maternity	x				
Race	x				
Religion or Belief	x				
Gender	x				
Sexual Orientation	x				
Welsh Language	x				
Socio-economic status	x				
Social exclusion	x				
Carers	x				

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	x				A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial	x				
Corporate	x				
Operational	x				
Reputational	x				

Subject:	Audit Tracking (Internal and External Audit)
Approved and Presented by:	Director of Corporate Governance
Prepared by:	Corporate and Governance Assurance and Risk Officer
Purpose:	The purpose of this paper is to provide the Committee with an overview of the position relating to the implementation of Audit findings, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of **04 September 2025.**
Recommendations:	The Committee is asked to: • **CONSIDER** the current position of outstanding Audit Findings and take **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations. • **CONSIDER** and discuss the current position of Internal and External Overdue Audit Findings with a particular focus on those findings given High Priority ratings.

Executive Summary:	The responsibility for the collation, monitoring and reporting of internal and external (Audit Wales) audit recommendations is the responsibility of the Corporate Governance Team. Information is managed throughout the year and reported to the Executive and Audit, Risk and Assurance Committee on a regular basis.
	
	The last report was received by the Audit, Risk and Assurance Committee on the 11 March 2025. The next report will be provided in March 2026. The report provides a summary of the overall position, updates to overdue findings and findings that have had their deadlines revised. The full updates for all findings are highlighted in red and are appended to this report, they include:
	
	• **Internal Audit Recommendations that:**
	  • **are Overdue**
	  • **have been COMPLETED since the previous report**
	  • **are NOT YET DUE for implementation**
	  • **have had their DEADLINE REVISED**
	
	• **External Audit Recommendations that:**
	  • **Are OVERDUE**
	  • **have been COMPLETED since the previous report**
	  • **are NOT YET DUE for implementation**



Summary of Internal Audit Findings since the last report in March 2025:

- 25 findings have been completed since the last report; (38%)
- 6 findings had their Deadlines Revised; (10%)
- 18 findings are Not Yet Due for implementation and; (30%)
- 11 findings are Overdue. (22%)
- There are 60 internal Audit findings in total on the live tracker as of September 2025.

SUMMARY of OVERDUE Internal Audit Findings

Internal Audit – Overdue Findings					
Internal Audit Priority	Director of Allied Health Professions, Health Sciences & Digital	Director of Finance, Capital & Support Services	Director of Nursing, Quality, Women & Family Health	Medical Director	**Total**
	Limited Assurance	**Reasonable Assurance**	**Limited Assurance**	**Reasonable Assurance**	
High	4	0	2	0	**6**
Medium	1	1	1	2	**5**
Low	0	0	0	0	**0**
Total	**5**	**1**	**3**	**2**	**11**

Summary:
11 findings are overdue, all are from the last financial year (2024/2025).

Completion Status
- 9 are partially completed
- 2 have no progress

Priority
- 6 are high priority
- 5 are medium priority
- There are no low priority

Assurance rating
- 8 relate to limited assurance reports;
- 3 relate to reasonable assurance reports

SUMMARY POSITION – Overdue Internal Audit High Priority by Executive Lead/Director

- Lead Executives are asked to give priority to the overdue recommendations with a particular focus on those findings with a high priority rating.
- Further updates will be provided to the ARAC Committee in the next report in March 2026.

Director of Allied Health Professions, Health Sciences & Digital							
PTHB Ref No	Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	No of months passed deadline
242528	Mattresses	Limited	High	R1	Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered.	August 25: Infection prevention and control emailed about training - there is some further discussion with drive about their offer under the contract. Awaiting an update from relevant officer. We have more substantive staff in post now with a reduction in 30 WTE vacancies and less agency use, so saturation of training is possible. Lead for each ward to be identified by each CSM. October 25: Drive Contract Manager has advised meeting with their Clinical Lead to confirm whether a programme of training can be implemented. Chased 01/10/25. Response awaited.	1
				R3	All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.	August 25: Email shared with all ward leaders by Head of Nursing Mattress audits all undertaken for the months of July and August, with oversight of compliance of completeness by CSM team - due for reporting through QSPE on 6th October 2025 October 25: Following recognition of delays in acquiring replacement mattress covers, each ward will hold a small stock of spares to enable immediate replacement as required.	1
				R4	A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.	August 25: This action requires completion - awaiting central resister to be shared by medical devices lead who is on leave. October 25: Bed and Mattress inventory work to be completed by end of October 25. Led by Medical Devices Manager in collaboration with Ward Managers.	1
				R6	Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.	August 25: There was an issue that some of the identifiable information on mattresses was coming off during the process of cleaning - a request has been made to ensure all information is attached to mattresses that has more permanence, this is under review.	1

SUMMARY POSITION – Overdue Internal Audit High Priority by Executive Lead/Director

Director of Nursing, Quality, Women & Family Health							
PTHB Ref No	Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	No of months passed deadline
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	High	R4	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	August 2025 update: Preferred option with business case agreed by executive committee 14/5/25. 1x Best Interest Assessor recruited. Administration in place. DoLS Co-ordinator recruitment was unsuccessful m however following readvertisement further interviews set for sept 25. Interim measure for external BIA assessments in place from the 18/9/25 and agency DoLS co-ordinator identified for 12 weeks and procurement commenced for this. October 2025: Executive lead has confirmed the delay is due time to recruit.	2
				R5	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	August 2025 update An increased rota is achieved through additional 5 signatories now trained and on the rota. Recruitment of DoLS Coordinator underway - interviews set for Sep 25. October 2025: Executive lead has confirmed the delay is due time to recruit.	2

Gwynne.Stella 06/10/2025 11:52:35

SUMMARY of DEADLINE REVISED Internal Audit Findings

Internal Audit – Deadline Revised Summary					
Internal Audit Priority	Director of Allied Health Professions, Health Sciences & Digital	Corporate Governance	Director of Finance, Capital and Support Services	Director of Primary, Community Care & Mental Helth	
	Reasonable Assurance	**Substantial Assurance**	**Substantial Assurance**	**Substantial Assurance**	**Total**
High	0	0	0	0	**0**
Medium	1	0	1	2	**4**
Low	0	2	0	0	**2**
Total	**1**	**2**	**1**	**2**	**6**

Summary
6 Internal Audit Findings have had their deadlines revised all of which are partially completed.
(1 relates to 2022/23 and 5 relate to 2024/2025)

Priority
- 4 are medium priority
- 2 are low Priority

Assurance rating
- 5 relate to substantial assurance reports
- 1 relates to a reasonable assurance report

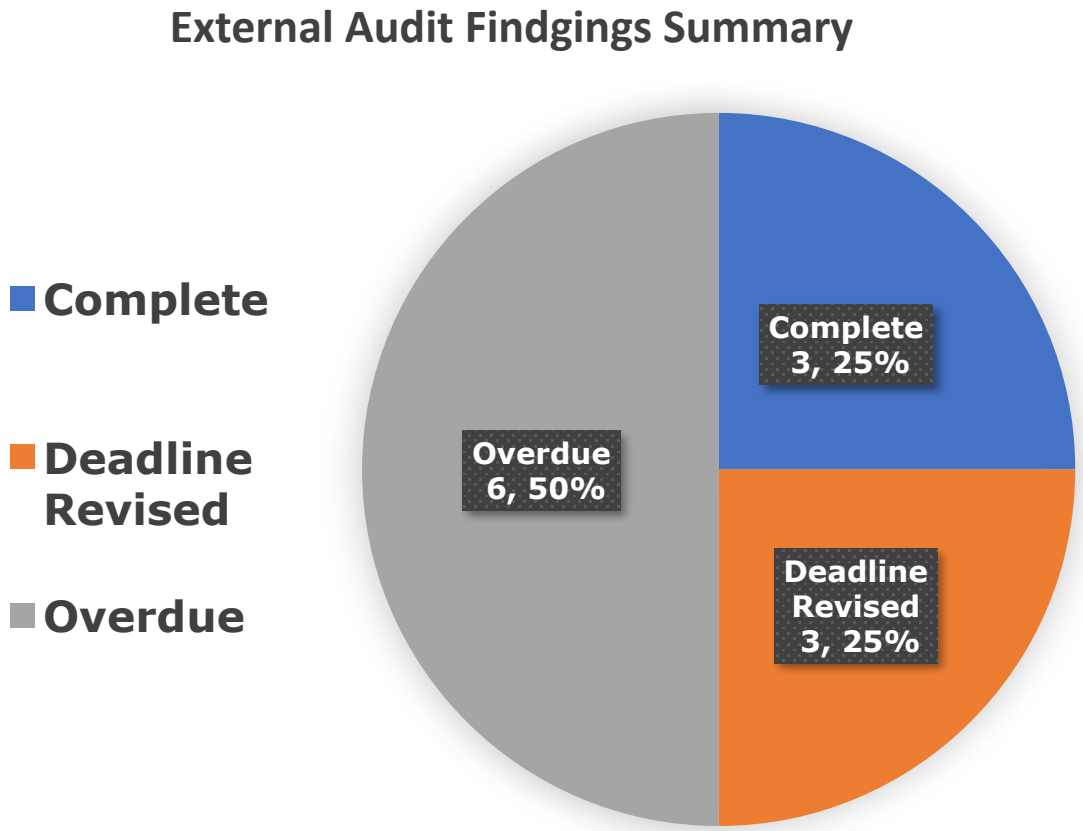
Detail of DEADLINE REVISED Internal Audit Findings

Internal Audit – Deadline Revised detail

Directorate	Internal Audit Title	Audit Assurance rating	Priority Rating	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline
Director of Allied Health Professions, Health Sciences and Digital	Therapies and Health Sciences Professional Governance Structure	Reasonable	Medium	October 2023	October 2025	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	August 2025 update: This work was deprioritised due to capacity, due to be reviewed October 2025.
Director of Corporate Governance	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Low	December 2024	March 2026	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.	August 2025: Statement had been prepared for inclusion in the next SFI update, currently shceduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemebnted sooner if there is a need to revise the SFIs for any other reason
Director of Corporate Governance	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Low	January 2025	March 2026	The Standing Financial Instructions should be updated to ensure references to the Head of Financial Services are updated to the Assistant Director of Finance (Accounting and Services).	August 2025: Update has been prepared for inclusion in the next SFI update, currently scheduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemented sooner if there is a need to revise the SFIs for any other reason
Director of Finance, Capital and Support Services	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Medium	March 2025	December 2025	Efforts should continue to ensure all FCPs with elapsed review dates are subject to an appropriate review process and submitted for the relevant approvals. Future review dates should then be defined, or an established review frequency should be determined and specified within each document.	August 2025 update: Relevant procedures have been reviewed and are ready for approval. Just formulating approval stream for the policy documents.

Internal Audit – Deadline Revised detail

Directorate	Internal Audit Title	Audit Assurance rating	Priority Rating	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline
Director of Primary Care, Community and Mental Health	Business Continuity Planning Final Internal Audit Report	Substantial	Medium	June 2025	November 2025	Completeness of Service Area BCP's Review of the six Service Area BCP's identified that whilst all followed the toolkit template, the contact names and telephone numbers of key staff had not been included in three of the six plans. In addition, one 'document owner' and three other key contacts could not be found on Outlook which suggests they may have left the organisation, and several other key contacts had moved on to new job roles and no longer had any BCP responsibilities.	August 2025: Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it is unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manager for Civil Contingencies.
Director of Primary Care, Community and Mental Health	Business Continuity Planning Final Internal Audit Report	Substantial	Medium	July 2025	November 2025	Annual tests of all service area BCPs will be scheduled and undertaken with subsequent completion of the debrief template and post incident report. Where testing is effectively undertaken via live incidents, full supporting documentation will be retained.	August 2025: Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it is unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manager for Civil Contingencies.



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Summary of External Audit Findings since the last report in March 2025:

- 3 findings have been completed since the last report; (25%)
- 3 findings had their Deadlines Revised; (25%)
- 6 findings are Overdue, of which 5 are partially complete and 1 has made no progress, (50%)
- There are a total of 12 External Audit findings on the live tracker as of September 2025.

- 5 of the overdue audit findings are from 2024/2025 and 1 is from 2023/2024.

- Please note that unlike the Internal Audit reports, External Audit is not given a priority rating or an assurance rating and therefore focus is given to those audits that are Overdue and have had their deadlines revised.

Detail of OVERDUE External Audit Findings

OVERDUE External Audit Findings by Directorate

Directorate	External Audit Title	Finding	Progress of Work underway	Status	No of months passed deadline
Director of People and Culture	Review of Workforce Planning Arrangements	Continue to roll out training that utilises the HEIW workforce plan template. Provide periodical updates to Executive committee of those managers who are required to undertake the training; have done so, to ensure that the competencies to complete workforce plans are embedded within the organisation. Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.	August 2025 - In light of the work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementation of new emerging operating models. This will ensure effective use of resources and mitigate the risk of misalignment and duplication of effort. It also ensures workforce planning is co-ordinated, evidence based and aligned to the strategic priorities of the Health Board.	Partially Complete	5
Director of People and Culture	Review of Workforce Planning Arrangements	Gain feedback from attendees both immediately after training and 3 months post training to understand effectiveness. Measure the number of workforce plans produced across the organisation.	August 2025 - In light of the work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementation of new emerging operating models. This will ensure effective use of resources and mitigate the risk of misalignment and duplication of effort. It also ensures workforce planning is co-ordinated, evidence based and aligned to the strategic priorities of the Health Board.	Partially Complete	5
Director of People and Culture	Review of Cost Saving Arrangements	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potential costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	Aug 2025 - Recommendation in Feb was for deadline to be extended to Q4 2025/26 in line with Better Together timeline. Work ongoing to confirm options for board approval to consult on future model and configuration of services for adult physical and mental health community services. Board decision on progression to consultation anticipated October 2025. Further phases of work across 2026/2027 will address planned care and women & childrens services. Recommend deadline is extended to reflect this.	Partially Complete	5
Director of People and Culture	Review of Cost Saving Arrangements	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	Aug 2025 - Better Together portfolio structure fully operational with some additional capacity and capability identified to support portfolio. Ongoing gaps in clinical specialty support to planned care and mental health, discussions with national programmes to secure support in these areas. Capacity challenges across corporate and operational services to deliver to timelines during period of increased pressure and scrutiny in other areas such as financial savings and national returns.	Partially Complete	5

Detail of OVERDUE External Audit Findings

OVERDUE External Audit Findings by Directorate

Directorate	External Audit Title	Finding	Progress of Work underway	Status	No of months passed deadline
Director of Nursing, Quality, Women & Family Health	Structure Assessment 2023	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	August 25 - CR to discuss with HB, this action is not aligned to the people's experience framework and is aligned to board member site visits and feedback.	No Progress	15
Director of Primary, Community Care & Mental Health and Director of Planning, Performance and Commissioning	Primary Care follow-up review	The Health Board should improve oversight at Board and committee level of performance within primary care by: increasing the coverage of primary care performance within its Integrated Performance Report.	August 2025: DPCCMH commenced conversations to develop dashboard. Wealth of information available from various departments i.e information; finance, commissioning and primary care. Requires pulling into a central repository/dashboard. Ongoing assurance via relevant papers to executive committees, including Board development and Board briefing sessions. Integrated Quality and Performance Framework refreshed for 2025/26. Continuation of Directorate Integrated Quality and Performance Group meetings including Primary, Community Care and Mental Health. The Integrated Quality and Performance Report (IQPR) does include and report on a limited number of primary care measures and will reflect detail from the Primary Care Dashboard once completed	Partially Complete	3

External Audit – Deadline Revised detail

Directorate	Internal Audit Title	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline	Status
Director of Corporate Governance and Director of Nursing, Quality, Women & Family Health	Structure Assessment 2023	July 2025	January 2026	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	August 2025 update- Implementation plan reviewed and roll out of moving risks to Datix system continues during Q2 & Q3. Work continues to onboard services to the Datix system, though uptake is slower than anticipated due to reduced capacity due to long term absence in the corporate team. The Once For Wales national team have offered to support in the transfer of risks on to the system where appropriate, this detail of this is currently being explored to potentially expediate the transfer. Request extension to January 2026.	Partially Complete
Director of Primary Care, Community and Mental Health	Primary Care follow-up review	March 2025	March 2026	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects	August 2025: Delays with establishment of Professional Nursing Collaborative. Unlikely to be implemented this financial year. Strengthening cluster voice in RPB Executive Group - meeting being arranged to include DPCCMH input. progressing the merging of the mid and south cluster - T&F group set up and engagement with stakeholders will shortly be commencing. Proposed Revised Deadline of Mar-26 due to delays mentioned above	Partially Complete
Director of Primary Care, Community and Mental Health	Primary Care follow-up review	June 2024	October 2025	In conjunction with ongoing operational requirements, including contract reform. Review resources available to increase capacity in the Primary Care Services Team. Develop a training plan for the Primary Care Services team to support succession planning and ongoing resilience.	August 2025: Team resource reviewed and revised structure proposed. Work being led under the direction of DPCCMH as part of a wider Directorate workforce review. 'grow your own' approach to increase team resilience under way. Formal and informal training opportunities underway, developing the team etc.	Partially Complete

Appendices:

The following appendices are provided with more details:

- 6.3a – Internal audit - recommendations completed since last report
- 6.3b – Internal audit - recommendations not yet due
- 6.3c – Internal audit - recommendations that are overdue
- 6.3d – Internal audit - recommendations with revised deadlines
- 6.3e – External audit - recommendations completed since last report
- 6.3f – External audit – recommendations that are overdue
- 6.3g – External audit - recommendations with revised deadlines

Internal Audit Findings - completed since last report

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
242515	2024/2025	Capital Systems Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Head of Capital	R2	Medium	Expected Evidence of Implementation: • Suitable completion of the Procurement Strategy form in the PID	When Frameworks have been used, the appropriate rules of appointment have been consistently followed and are compliant. The Frameworks include tendered, competitive rates but in some instances, a further option for mini competition between Framework Suppliers is possible, which may deliver further cost reduction on the published rates. An explanation of where/why the optional mini tender process was implemented or not will be recorded in the PID, form 2.1.	01/11/2024	01/04/2025	Complete	Complete		**August 2025:** The revised PID form will 'go live' in April to support project pipeline 2025/26				Yes		3	Jul-25	10/02/2025
192022	2019/2020	Outpatients Planned Activity	Reasonable	Director of Primary Care, Community and Mental Health	Head of Planned Care	R1	Medium	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access Policy within the health board will be developed that details roles and responsibilities and sets out the general principles and rules for managing patients through their elective care pathway. WG are currently reviewing national waiting times standards (RTT) in light of COVID19 19 and the impact of new ways of working e.g. digital appointment solutions like Attend Anywhere. The Patient Access Policy will be updated in line with the revised WG guidance once published.	Mar-21	Mar-22	Complete	Complete		This work has been delayed due to covid but also now needs to be considered in line with national guidance on pathways and the Powys renewal priorities. This will take until end of the year. This work is now further delayed due to the required Health Board adoption of Care Pathways. A revised policy document will aim to be completed by Nov 24 **February 2025** - Reassigned to Primary Care (Originally assigned to Planning and Commisioning)- QSEG has been stood down and the new management system is in place. Delay decision-making around further reporting due to Executive Director of Nursing availability. **August 2025** - The complexity of outpatient pathways (in and out of county), locations and process is asignificant undertaking and gives cause for concern due to changes and the impact of the document. Community Healthcare Pathways are available in PTHB as part of national roll out and further development work for PTHB context on-going as part of transformation workstream. Revised RTT Guidance received from WG Q1 25/26 Patient Access Policy underdevelopment will be presented to October Planned Care Board for approval. Recommend copmpletion of the audit action which is now out of date and to continue with current focus on delivery against the revised RTT guidance.	Waiting for overall WG rollout. See earlier comment	Adopt treat in turn methodology and adherence to extant all Wales access policy	Jun-23		52	40	Jul-25	Aug-25
202108	2020/2021	Partnership Governance – Programmes Interface	Limited	Director of Corporate Governance		R1	High	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes. A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21	Jun-25	Complete	Complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position. **Feb 2022** update - some high level work commenced with this action in 2022 but due to a variety of factors the work has not been completed. The new Director of Corporate Governance / Board Secretary took up post in January 2023 and will ensure the development of the partnership governacne guidance document is included for the 2023/24 year. Revised date requested to 31 March 2024. **April 2023 -** action is on track for March 2024, reports will be provided as the year progresses. **April 2023 -** The Live Well: Mental health partnership reports to each Regional Partnership Board meeting. An assurance report will also now be included to the Boards Patient Experience, Quality and safety meeting on an annual basis. The report has been added to the Committee's work plan for 2023-24. **Nov 2023** - RPB report introduced at Board level on a bi-annual basis (first report 29 Nov 2023) with enhanced reorting of RPB Board activity at each meeting. The framework is intended to be completed for the target date, there is a risk of not achieving this due to staffing capacity, the Board Assurance Framework will take priority. Feb 2024 - in Nov 2023, when the Board considered the revised annual delivery plan, the Board agreed that the action be defered to 2024/25. Recommended date change to Dec 2024. all other mitigations mentioned above continue to be in place. **April 2024 -** update as per above. Date needs to be changed to Dec 2024. **June 2024** - action remains planned to be completed for Dec 2024. **Aug 2024** – action remains planned to be completed for Dec 2024. **Jan 2025** – targets date not delivered, progress made to design the approach to the partnership framework with details of range of partnerships being populated. Annual Delivery Plan updated to request a date change to June 2025 due to staff change and capacity. In the meantime, all of the Boards main partnership arrangements continue to be reported at each meeting of the Board. **August 2025** - The Partnership Governance and Assurance Framework was approved in April 2024 and reported to the Board and Planning, Partnerships and Population Health Committee for assurance, most recently on 21 May and 14 August 2025 respectively.	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	Mar-24		46	1	Jul-25	
202115	2020/2021	Winter pressures and flow management	Reasonable	Director of Primary Care, Community Care and Mental Health		R2	Medium	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update process.	2.1 Agree – cannot action until further consultation. Recent engagement with DU has suggested DTOC will return by end of year. If this is the case policies and procedures will need recommencing & revision if required. 2.2 Flow charts & diagrams of discharge requirements circulated to staff, placed in shared access folders and discussed in team meeting. Will be a standard agenda for assurance of understanding & interpretation by staff. 2.3 The update of any policies will be in line with Welsh Government direction on DTOC and discharge planning, so we are working within national guidelines.	Mar-22	Apr-25	Complete	Complete		**Update August 2025: This Internal Audit was transferred to the Director of Primary, Comunity Care and Mental Health Directorate from August 2025 , at this point the action had been completed.** **Updated Dec 2024** - Guidance released in November 2024. Raised at system escalation meetings and agreed for review and system assessment against best practice recommendations. Workshop session scheduled for December 23rd 2024, with aim to provide compliance report, action plan and update to JLT in January 2025. Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements. Nov 2023- DTOC system now revised to Pathways of Care Monitoring. PTHB has been reporting on a monthly Census since April 2023 and working with the delivery unit through regular action planning. Patient pathways are embedded on admission. National guidelines for discharge have been published, PTHB local discharge guidelines under review- to work with our partners in development with aim of completion by end of January 2024. 31/1 The reluctant to leave procedure and dishage guidelines have been circulated for comment. The discahrge hospital guidance has been revised but pending an addition of the choice element TBC by WG. Delivery Unit confirmed this will be released soon. Both procedures are in line with Welsh Government guidance released in November 27/1/2024 - Management of reluctant to leave published. Discharge guidance for PTHB in draft & ready to be circulated once choice element has been published by Welsh Government. Confirmation from NHS exec this will be due "soon". **26/02/25 -** Updated National guidance document finally released in September 2024, and made available to Health Board in October 2024. In response, Health Board have undertaken a full refresh of policy and draft discharge policy completed in December 2024. Some challenges from winter pressures have delayed wider engagement, but planned for stakeholder engagement in March 2025, with expectation will be presented to organisational governance for sign off by April 2025.	Dec24 - Competing workload pressures for teams, but intended for prioritisation. 27.03.2024 - Choice element needs to be added for discahrge guidance, WG advised due soon. As an interim discahrge guidance has been completed in anticapation of adding the choice element	Dec 24 - Operational practice is mitigated through compliance with system policies and processes. Early adoption of recommendations for Choice, and daily reporting in place with system escalation in place. 27.03.2024 - Mitigated with the pathways of care discharge guidance being followed. Cannot implement local choice, should be guided nationally. As an interim Pathway of Care Discharge National Guidance to be followed, ESR training availbale and Manmagement of Reclutant to Leave to be followed	**DEC 24** - Compliance review and action planning completed by January 2025 **01/02/2024** - Reluctant to leave **28/2/24** - Discharge guidance **27/3/24 -** Discharge guidance due "soon" is the update from NHS exec, hopefully early Spring, Once released will circulate internal discharge guidance for approval & release. Draft compelte.	https://nhswales365-my.sharepoint.com/:w:/r/personal/claudia_pshea_wales_nhs_uk/Documents/The%20Management%20Of%20Reluctant%20to%20Discharge%20Procedure%20GNPk%2053.docx?d=wbbc26a1d5570481082272756beb2f4cd&csf=1&web=1&e=JYFX0J	40	3	Jul-25	
242511	2024/2025	Cleaning Standards Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director – Support Services Duncan Crawley, Service Improvement Manager	R6	Medium	Management should review all information that is currently recorded and available in respect of Cleaning Standards. Discussions should then take place as to what Committee this information should be reported to and the frequency of the updates.	1. Create a reporting dashboard which brings together what is currently recorded and available in respect to cleaning standards. 2. Confirm which Management Meeting and Executive Commitee this dashboard is reported to.	01/04/2025		Complete	Complete		We currently track and report on cleaning standards via a dashboard, with reporting restricted currently to the IPC Committee, the Facilities Management Teams and assigned stakeholders on their specific request. Once the new Cleaning Standards Group is established, this will be realigned. Management will review the existing data, decide the appropriate committee for reporting, and establish the reporting frequency. The dashboard will consolidate the information, and we will confirm the relevant management and executive committees for reporting. **22.8.2025 update** The Environmental Cleanliness and IPC Standards Group has now been formally established and will stand up in September 2025. The Group has been confirmed to report into the Infection Prevention and Control Committee, ensuring that assurance, monitoring, and improvement activity is aligned within the governance structure. Evidence is available in cell P3				Yes		150S	Jul-25	12/11/2024
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Finance, Capital and Support Services	Ian Jackson, Financial Accountant	R4	Medium	Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.	Agreed - The finance department are reliant on local administration teams advising of changes required. A full review will be undertaken and signatories updated to reflect current signatories only where required	31/03/2025		Complete	Complete		**August 2025 update:** List reviewed and amended mandates submitted						150S	Jul-25	10/02/2025
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Finance, Capital and Support Services	Ian Jackson, Financial Accountant	R5	Medium	Financial limits should be implemented in respect of all authorised signatories of subsidiary bank accounts. In cases where higher limits are determined to be necessary, consideration should be given to adding a stipulation requiring two signatories to authorise payments which exceed a predefined threshold.	Agreed - Officers will work with the bank to ensure the documentation is updated for all accounts to define a limit where this is currently omitted.	31/03/2025		Complete	Complete		**August 2025 update:** List and limits reviewed and amended mandates submitted where required						150S	Jul-25	10/02/2025
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Finance, Capital and Support Services	Ian Jackson, Financial Accountant	R6	Medium	A list of authorised signatories should be maintained and subject to periodic review.	Agreed - A list of mandate signatories will be defined and subject+H61:H62 to regular review	31/03/2025		Complete	Complete		**August 2025 update:** List reviewed and amended mandates submitted and revised listing held on sharepoint						150S	Jul-25	10/02/2025

242513	2024/2025	Records Management Final Audit Report	Substantial	Director of Finance, Capital and Support Services	Wayne Tannahill, Associate Director of Capital, Estates and Property	R1	Medium	Although fire detection is in place, there is no fire suppression in records storage areas.	The Health Board will consider the feasibility of introducing fire suppression within record storage areas	31/03/2025		Complete	Complete		Feasibility to retro fit fire suppression systems to record store is bering undertaken for informed evaluation of corrective action against outcomes. **August 2025 update:** Quotations for installation have been requested from two sytem designers and very high (>£100k) indicative costings have been received for installation. Protection of records is not mandated by NWSSP, nor is it advised as necessary by NWSSP Fire Engineering team. Prioritisation is given to preservation of life and building integrity over records management and will receive funding as priority. NWSPP inform that no other site across Wales have invested in records fire suppression systems. Action closed as the cost is prohibitive in relation to the risk and is not standard practice across NHS Wales.						1506	Jul-25	10/02/2025
242514	2024/2025	Staff Retention Final Internal Audit Report	Reasonable	Director of People and Culture	Julia Williams, Workforce Retention Lead	R2	Medium	Management should ensure that the local Workforce Retention Plan is fully developed as soon as possible with the allocation of target dates for the completion of actions and is then made available for use for by the Health Board. The initiatives that have been developed following the analysis undertaken by the Health Board's Retention lead should be incorporated into the Plan to ensure that they are effectively implemented.	Develop the Workforce Retention Improvement Plan for Powys Teaching Health Board and gain Executive sign off prior to implementation.	31/03/2025		Complete	Complete		**Feb 25** Workforce Retention Imporcement Plan is in draft and awaiting review by senior colleagues in People and Culture. It will be shared with the Workforce Retention steering group before Executive sign off. **August 25** - The Workforce Retention Imporvement plan as been developed and it's implementation will be monitored by the Workforce Retention Steering group.						1506	Jul-25	10/02/2025
242514	2024/2025	Staff Retention Final Internal Audit Report	Reasonable	Director of People and Culture	Julia Williams, Workforce Retention Lead	R3	Medium	Management should ensure that the current plans are fully implemented, and then explore any further ways of improving the completion rate of exit questionnaires, ensuring adequate staff communication is put in place. There should also be a system in place to formally include the relevance and need to complete exit questionnaires at local management training and corporate induction programmes. The exit questionnaire process guidance should be finalised for use by the Health Board.	Complete development of manager and employee information around exit questionnaires and communicate this with all staff through a multi-modal communication plan Complete quality improvement project to improve exit questionnaire completion rate for Registered Nurse's with the Community Services Group and replicate successes across the organisation. Ensure exit questionnaire relevance and importance is included in programme of education within the PTHB Managers Programme and Corporate Induction. Finalise the process for escalation of exit questionnaire data and publish on PTHB Sharepoint.	January 2025 March 2025 December 2025 January 2025		Complete	Complete		**Feb 25** Following discussion with senior leadership team in People and Culture, a review of the exit questionnaire process has taken place. The process achieves low completion rate and the data available from the process does not provide robust information to allow for changes to be implemented. It also only captures staff leaving the orgnaisation rather than those moving internally too. Therefore, the decision has been made to chnage the current process and develop a leavers toolkit which not only provides information to staff and managers, it includes a template leavers questionnaire for managers to complete with departing staff members, and an online questionnaire for leaving staff members to complete independently. Development is well underway and once complete we will implement a communication plan, and ensure information is provided in the PTHB managers programme and corproate induction. **August 25** - A full leavers toolkit has been developed, which includes a new way of recording exit questionnaires (now called leavers questionnaire) information. A Q&A as well as a clear descriptor of how Leavers Questionnaire feedback will be dealt with has been agreed with TUs and included in the toolkit. The new process was launched on 1st July 2025. A review has been agreed to be undertaken after 3 months through WPRG.						1506	Jul-25	10/02/2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R2	Medium	Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.	A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training put into place for the Managing Authority.	March 2025 July 2025 September 2025		Complete	Complete		20/02/25 -Business case made to IBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. Information requested from ESR to start analysis of training needs around MCA. The next MCA operational and Practice Improvement Group in March 25 has an agenda item for practice improvement action plan for MCA training. Plan to now add this to the digital platform and monitor in the same way as requests made by education for information.						1506	Jul-25	10/02/2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R3	Medium	The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required.	28/02/2025		Complete	Complete		20/2/25 - Action First who have this contract have provided Safeguarding Team with required documentation that is held and monitored by the Business manager. August 2025: In liasion with procurement agreed that provider will ensure we are advised and updated with the relevant documents of any new assessor that provides assessments to PTHB. Completed.						1506	Jul-25	10/02/2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R6	High	Management reports should be developed to record ongoing performance against the target dates. These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required. The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether or not the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data.	The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A DoLs Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group.	March 2025 June 2025 June 2025		Complete	Complete		20/02/25 -Business case made to IBG. Agreement to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. The case tracker spreadsheet has been developed and commenced from the 17/2/25. Updated data reporting will commence from April 25. August 2025 This action is now completed						1506	Jul-25	10/02/2025
242518	2024/2025	Community Cardiology Service Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Helen Hathaway and Donna Jones	R1	High	Service management has identified that the current budgeted staffing levels in respect of the Cardiology Diagnostics & Management Clinic and Cardiac Rehabilitation Service are inadequate to ensure efficient and effective delivery of patient management and treatment. This position is evidenced by the times for referrals and assessments we noted as part of our testing under Objective 3. A Business Case to increase and improve staffing is due to be submitted to the Health Board Investments Benefits Group in early 2025.	Business Case to be taken to IBG in February 2025, to ensure sustainable and robust service structure and delivery. Standard Operating Procedure (SOP) is currenting being updated to reflect current service and vision for future. When draft completed, SOP to be formally signed off in March 2025	01/03/2025		Complete	Complete		**August 2025:** Cardiology business case developed in April 2025, but advised will need to await outputs from Better Together programme before advancing further. Recommend completion of the audit action as now part of Better Together actions.						1506	Jul-25	
242518	2024/2025	Community Cardiology Service Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Helen Hathaway	R6	Medium	The Community Cardiology Service is supported by a Power BI database that integrates the patient data held on the clinical and patient management systems and produces management information relating to Service performance that is regularly reported to the Clinical Service Group Operations and Quality & Safety Groups. However, we were unable to verify if there is any provision in place for onward reporting of the Service's performance to an appropriate Health Board Group or Committee	Demand and capacity data is being closely monitored for each area and specialism for community cardiology. Discussed during bimonthly service governance meeting and escalated as needed.To set up a demand and capacity graph for each service area, to show monthly data and trend of demand, to be completed by end of March 2025.	31/03/2025		Complete	Complete		**August 2025:** Action Closed and completed. Onward reporting of the Service's performance via bimonthly CSG meetings to Assistant Director of community services.						1506	Jul-25	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Zoe Ashman/ Amie Symes	R1	Medium	Responsible individuals have been designated within each partner organisation but robust collaborative working governance arrangements are yet to be established.	An agenda item will be raised at the ALN Integrated Steering Group with the intention of establishing more clearly defined governance arrangements in respect of the partnership working arrangements. It will be requested that the newly established governance arrangements are employed to ensure that the strategic plan and actions listed within the work plan are subject to a documented approvals process and that monitoring procedures are established in order to address outstanding actions.	01/09/2025		Complete	Complete		**August 2025 update:** New governance arrangements have been agreed with escalation processes across partnership agencies. Strategic plan has been updated and reporting requirements clarified						1506	Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	USC Senior Manager	R1	High	The Health Boards 'Community Hospital Discharge Policy & Procedures' (GNP042) is outdated and does not include the specific requirements and processes that are detailed in the September 2024 WG hospital discharge guidance. The WG document is key to patient flow and sets out the guidance on Hospitals Discharge standards for health, social care, third and independent sector partners in Wales. The update to the Health Board's Hospital Discharge Policy & Procedures will need to incorporate all the necessary elements of the guidance to ensure the delivery of optimal outcomes is fully addressed. For example, D2RA, SAFER, REDtoGREEN and Prevent Deconditioning. Including a 'Planning your Discharge' Letter as an appendix to the Policy would also be advantageous.	Develop an updated 'Community Hospital Discharge Policy & Procedures', incorporating all relevant information from the September 2024 WG hospital discharge guidance.Once the Policy has been developed, staff will be made aware of its existence, and it will made accessible to staff via the intranet pages.	01/04/2025		Complete	Complete		**August 2025:** Community Hospital Discharge policies and procedures Completed and approved for use 8th January 2025 GNP 042						1506	Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	USC Senior Manager	R2	Medium	The Integrated Patient Flow SOP (GNP 088) documents the overarching approach adopted by the Health Board and Powys County Council (PCC) to ensure appropriate flow of Powys residents, both in the Community Hospitals and bordering District General Hospitals. The procedure references the WG Six Goals for Urgent and Emergency Care (with a hyperlink to the relevant document on page 8) and also mentions the D2RA model and Hospital Discharge Guidance. However, the hyperlink for the D2RA pathway incorrectly directs to the Six Goals Policy, whereas it would be more appropriate to link the 'Delivering optimal outcomes and experience for people in hospital'. The link to the Hospital Discharge Policy also needs to be updated once the Policy has been developed. This SOP is primarily operational in nature, emphasising governance, reporting on Pathways of Care Delays and Census, as well as system escalations. Recent modifications to several of these processes have occurred and the policy requires an update to align with the new Patient Flow List which was introduced on 21st October 2024. Additionally, it should include the new Ready to Go units and the governance related to user access for SharePoint.	Revise the Standard Operating Procedure to incorporate the recent modifications to several processes and verify that all links are functioning properly.	01/04/2025		Complete	Complete		**August 2025:** Community Hospital Discharge policies and procedures Completed and approved for use 8th January 2025. 12/8/25 Joint SOP revised post Audit to include updated changes to include the new patient flow list. Signed off 30th July for publication							Jul-25	
242523	2024/2025	Llandrindod Wells Phase 2 Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Wayne Tannaill	R1	Medium	PTHB Capital Procedures p22 state: The Risk Register should list all the identified risks along with mitigating actions and the potential cost/programme implications associated with the risk. Noting the above we found that there was a comprehensive project risk register, categorising risks by type and ownership and had been regularly reviewed and updated. However, it did not include cost calculations, which are a key aspect of effective risk management.	For future projects the HB will ensure that the Project Risk register includes cost calculations, to inform identification of contingency requirements and forewarn of potential shortfalls.	31/05/2025		Complete	Complete		**August 2025 update:** Risk Registers are costed as far as practicable.							Jul-25	
242523	2024/2025	Llandrindod Wells Phase 2 Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Wayne Tannaill	R2	Medium	Key Performance Indicators: The THB has appointed a supervisor to ensure the SCP delivered work to the required quality. The SWWRCF framework specifies that 'Project KPIs must be completed monthly and compiled quarterly by each region'. It was unclear how The THB's adviser's performance was being reviewed or assessed. While such evaluations are not mandatory within NHS Wales beyond the Building for Wales frameworks, implementing a structured review process for all appointments—regardless of the framework—would be a prudent approach. This would provide objective data for Post-Project Evaluations and help inform future project decisions and appointments.	The THB have developed a set of key performance indicators to be utilised to assess both the Supply Chain Partner and THB appointed Advisers. These are used on Major projects not utilising the Building for Wales Framework. For this project the KPI's set out under the framework have been completed however there were some issues with the format of the form – the framework have been contacted but no response was received. The HB also complete performance reviews on consultants and contractors at the end of each project and regularly hold Lessons learnt workshops on major projects	31/05/2025		Complete	Complete		**August 2025 update:**The THB have developed a set of key performance indicators to be utilised to assess both the Supply Chain Partner and THB appointed Advisers. These are used on Major projects not utilising the Building for Wales Framework. The HB also completes performance reviews on consultants and contractors at the end of each project and regularly hold Lessons learnt workshops on major projects.							Jul-25	
242526	2024/2025	Quality and Safety Governance Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R1	Medium	On going changes to the Integrated Quality Report. We note that work is already underway and ongoing regarding the presentation of the IQR and future changes that may be required as a result of new/ updated legislation and frameworks the Health Board has to comply with. The IQR is an evolving report responsive to changes relevant to the Duty of Quality and the organisation. For instance, over time the IQR has evolved with the addition of the bereavement framework. There will also be some upcoming changes that will affect the reporting structure of the IQR as a result of the Welsh Government People's Experience Framework and changes regarding the Duty of Candour and how targets are going to be met.	People's Experience Framework paper to Executive Team in q2PTR changes to be taken to Exec Team 18 June	30/09/2025		Complete	Complete								Jul-25	
242526	2024/2025	Quality and Safety Governance Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R2	Medium	CIVICA review outcome: 85% is the benchmark set for positive responses on an all-Wales basis and is used to determine the position of any outcome. The benchmark does not relate to the number of respondents but the positivity of the response irrespective of the size/ number of people responding. The table which has the collated result used for benchmarking does not state its metric is in percentages. We also note that graph 9 was completed by only one person in Dec 2024. A part of the table under graph 8 should also have shown a red or amber highlight for the overall satisfaction level but was showing as all green. However, the Datix Administrator explained that this is a system error and this function cannot be manipulated, and no form of adjustment can be made to it. Graphs 10 & 11, 12 & 13 and 14 did not state the period of coverage, and the Datix Administrator was also unable to determine the period the data within the graphs related to.	The quarter dates will be displayed in the relevant graphs.	31/07/2025		Complete	Complete		**August 2025 update:** Escalation reporting agreed and in place							Jul-25	

242526	2024/2025	Quality and Safety Governance Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R3	Medium	Clarity on Impact of Information within the IQR: The information on IP&C Claims, Redress & Clinical Negligence, and Early warnings notifications reported in the IQR are extracted from datix. These were some of the sampled areas we reviewed as a part of our testing under objective two. The purpose of the IQR is to provide the Executive Committee and PEQS Committee with an overview of the Quality and Safety agenda across the Health Board. However, we noted that the relevance of some of the figures highlighted within the report was sometimes unclear, specifically on how they enable the Health Board to demonstrate that quality has been improved through the monitoring of the figures over time via the IQR.	Year to date analysis of Performance will be included within the IQR where this is applicable.	31/07/2025		Complete	Complete		**August 2025 update:** IQR updated to demonstrate change/improvement/deterioration over time. Inclusion of clinical service update from directorate Quality structures also included within Q1 report.							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R5	Medium	Retention of completed mattress audits. Completed mattress audits are generally retained on the individual wards. They are not held centrally and are not therefore available for review or oversight. We were informed that a mattress audit Teams channel had been set-up but has not been fully implemented and is not therefore fully operational.	All mattress audits will be retained centrally, either on the Teams channel or SharePoint so that they are readily available to all staff who need access to them.	31/08/2025		Complete	Complete		**22.8.2025 update:** This action is complete, all mattress audits are in a shared teams channel with HoN access, AD to also be provided with access.							Jul-25	

Internal Audit Findings - not yet due

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Zoe Ashman/ Amie Symes	R4	Medium	Data validation exercises are being undertaken but assurances cannot yet be made with respect to the completeness of data contained in the ALN App.	Data validation exercises will continue and regular compliance reports will be made to the Planning, Partnerships and Population Health Committee.	01/12/2025		Not yet due	Partially complete		**August 2025 update:** Progress – PTHB digital tool for managing flow of information and compliance with the standards of the act is now embedded – data validation continues on a monthly basis and reported on through W&C IQPG. Recent Paper presented to PPP&P Committee						1506	Jul-25	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Zoe Ashman/ Amie Symes	R5	Medium	The system by which notifications of suspected cases where additional learning needs have been identified and are issued to parents / carers and the Local Authority is yet to be established.	The system will be finalised and validated.Progress reports will be made in the ALN Update to the PPPH Committee.	01/12/2025		Not yet due	Partially complete		**August 2025 update:** The appropriate sharing of information between teams is taking place. Plan to now add this to the digital platform and monitor in the same way as requests made for information by education.						1506	Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Service Managers	R3	Medium	Compliance with D2RA module within ESR: A request for a list of staff who have completed the D2RA course revealed that only one individual had done so. The USC Senior Manager clarified that some staff completed the training before the D2RA module was launched on ESR. Consequently, a request has been sent to all staff to retake the course to ensure their records are updated in ESR. There is no specific deadline for retaking this module, but discharge remains a regular agenda item in their internal meetings. Furthermore, bi-monthly meetings are held with Ward Staff. Although this training is not formally structured, it includes updates on policies and encourages discussions about the impact of these changes on patient care.	Establish a specific timeframe for staff to retake the course, ensuring accountability and timely compliance.Monitor training progress and follow up with staff who have not yet completed the module. Consider using the existing bi-monthly meetings to emphasise the importance of the training, address questions, and provide support for those retaking the course.	01/12/2025		Not yet due	Partially complete		**August 2025:** Whilst not a mandatory expectation of learning via ESR, it is acknowledged as part of the 6 Goals for urgent and emergency care workstreams, pathway of care delays and discharge to recover and assess processes, the importance for further education to support effective and proactive discharge planning. An intranet page is available to all ward teams with access to downloadable educational posters and how to access ESR training. Reminder of the training option via ESR sent out to all ward teams and also the flow team for completion 12/8/25. Team managers to monitor compliance.	Competing workloads on clinical teams	Line managers to monitor ESR compliance. Line managers to encourage staff completion	End of Q3				Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R4	High	The R2G standard has been integrated into the DigiFLO application and by default, all patients are categorised as red, requiring staff to manually update their status to green each day. Staff members comprehension of R2G days did not completely align with the guidance provided by Welsh Government. All patients listed on the DigiFLO Whiteboards for Y Bannau Ward and Eynt Ward were indicated as having a red day. This suggests that staff may not be adequately updating or using the R2G feature on the DigiFLO application. Furthermore, the manual boards are showing discrepancies, with some patients recorded as having a Green Day, leading to inconsistent reporting	Provide clear, step-by-step guidance for staff to fully understand the "Red2 Green Process" and how to correctly apply it using both the manual and electronic whiteboards.Conduct refresher training sessions for staff to ensure they fully understand the process. Incorporate the D2RA pathway and R2G standard to the handover documentation.	01/12/2025		Not yet due	Partially complete		**August 2025** - The R2G standard is being embedded through Powys DigiFLO, supported by the issue of a Standard Operating Procedure (CSG 001, Sept 2024) and user-friendly "How to Guides" accessible via the intranet. Targeted face-to-face training was delivered across all sites through the Powys DigiFLO Information Roadshow (Nov 2024–Feb 2025), reinforcing correct use of the R2G function and decision-making process.	August 2025 - Community hospital practices do not readily support routine R2G completion, with dependency on adapting board round and handover processes.	August 2025 - A revised board round and handover approach is being explored to support consistent R2G use.	Q3 2025				Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R5	Medium	The Hospital Discharge guidance from WG emphasises there must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub, to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway. Furthermore, once the decision of the definitive discharge pathway has been agreed, the patient and their family or unpaid carer and existing care providers must be informed and be provided with details of the decision. We could not find sufficient evidence within the existing systems to clarify how the decision regarding the D2RA Pathway was made. Additionally, the communication of this rationale from the ward to the discharge coordination hub remains unclear. It is also uncertain how families and caregivers have been informed about this decision.	Establish a standardised procedure for recording the decision making process related to the D2RA Pathway, ensuring that the rationale and supporting evidence are clearly outlined. Additionally, document how families and caregivers have been informed about these decisions within the appropriate systems.	01/12/2025		Not yet due	Partially complete		**August 2025** - D2RA is being embedded through Powys DigiFLO, supported by the issue of a Standard Operating Procedure (CSG 001, Sept 2024) and user-friendly "How to Guides" accessible via the intranet, which provide information and guidance on the allocation and recording of D2RA Pathways. Targeted face-to-face training was delivered across all sites through the Powys DigiFLO Information Roadshow (Nov 2024–Feb 2025), to support the correct allocation and recording of D2RA Pathway and decision-making process.	August 2025 - There is dependency on timely input from multi-disciplinary teams, which can delay consistent pathway decisions.	August 2025 - A revised board round and handover approach is being explored to strengthen MDT input and timely recordin	Q3 2025				Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R6	Medium	Utilisation of DigiFLO whiteboards: The DigiFLO whiteboard app can be installed on phones, tablets, laptops, and large screens, with nine wards currently equipped. It replicates manual whiteboard processes but faces information governance challenges, particularly maintaining an audit trail to track changes. Currently, large screens are accessible to all staff, but generic accounts only allow display access. Modifications require logging in with individual identification on a computer. Future plans include tap-to-login or PIN systems to enable broader access, including bank and agency staff. The current utilisation of the DigiFLO whiteboards is mixed with some departments still relying on manual whiteboards, as observed during the audit of the two wards.	Conduct targeted training and engagement sessions for departments still relying on manual whiteboards to demonstrate the benefits of the electronic whiteboard and address barriers to adoption. Expedite the implementation of a secure tap-to-login or PIN-based system to ensure accurate tracking of user actions while improving accessibility for all staff, including temporary personnel.	01/12/2025		Not yet due	Partially complete		**August 2025** - Utilisation of DigiFLO whiteboards is supported by the Standard Operating Procedure (CSG 001, Sept 2024), alongside "How to Guides" and resources available on the intranet. These have been reinforced through the DigiFLO Information Roadshow (Nov 2024–Feb 2025), which provided targeted support for staff across all sites. Built-in audit functionality within Powys DigiFLO enables the tracking of user actions, ensuring information governance requirements are met. While a mixed approach remains in place with some reliance on manual whiteboards, utilisation of Powys DigiFLO as the digital option has increased. Options to improve accessibility for temporary personnel are being scoped, including the potential use of a PIN-based access system, though this remains exploratory rather than a confirmed development.	**August 2025** - Challenges remain around displaying DigiFLO on communal ward screens, licensing and cost implications, and establishing appropriate access arrangements for temporary staff (linked to licensing considerations).	**August 2025** - Ongoing scoping of access solutions, including communal display options and licensing models, is being progressed	Increased utilisation - 2025/26 Temporary staff access - 2026/27				Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R7	Medium	Clinical Frailty Score: The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigiFLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigiFLO whiteboards will l be updated accordingly once this new score is implemented.	Utilise the DigiFLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack.	01/03/2026		Not yet due	Partially complete		**August 2025** -Powys DigiFLO has the ability to record Clinical Frailty Scores (CFS), with guidance provided within the Standard Operating Procedure (CSG 001, Sept 2024) and accompanying "How to Guides." Training was delivered through the Powys DigiFLO Information Roadshow (Nov 2024–Feb 2025) to support staff in using this functionality. Recording of CFS is not yet consistent. The CEDAR Hospital-Acquired Deconditioning Tool is now in pilot across other Health Boards; however, as this is a manual recording tool, it cannot currently be integrated into Powys DigiFLO.	**August 2025** - Limited visibility of Powys DigiFLO on communal ward screens and the manual nature of the deconditioning tool, which increases time demands on staff.	**August 2025** - Continued embedding of Powys DigiFLO to improve awareness and consistent recording of CFS.	2026/27				Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Emma McGowan	R8	Medium	U se of Inpatient Notes within WNCR: Within WNCR, there is a dedicated section for Inpatient Notes that allows users to a 'note type' when updating entries, depending on the contributor or content being added. Available options include MDT Review, and Discharge discussions. The admission details and the estimated Date of Discharge (EDD) is also recorded in the system. As part of the sample testing, we examined the Nursing Notes and although it provided insights into patient mobility, nutrition, and assistance needs, the information could better align with the Hospital Discharge guidance. The notes should include indicators of whether a patient is experiencing a red or green day and the rationale behind this, thereby demonstrating that the R2G framework has been considered and discussed. Currently, the information provided is limited. Furthermore, the discharge discussion notes section within the Inpatient notes is infrequently utilised, with only three instances identified out of twelve. As highlighted in key findings 5 and 11, fully utilising WNCR to record all key information would enhance documentation practices and establish a more comprehensive audit trail.	Establish a step-by-step guidance on what should be recorded within the Inpatient Notes under each specific 'note type' so that the information recorded is better aligned with the Hospital Discharge Guidance. The guidance should cover the following: • Highlight the key elements of the guidance that must be reflected in the Nursing Notes (e.g., indicators of R2G days, rationale for observations). • MDT Review Notes to include how the decision regarding the D2RA Pathway was made and communicated to patient and family. (Key Finding 5) • Enhance Discharge Discussion Notes by including key information, such as: o What was discussed with the patient or their family, including discussions around EDD. (Key finding 10) o Date the 'Planning your Discharge' Letter was issued and to whom it was issued. (Key Finding 11) After the guidance has been established, inform staff about its availability	01/12/2025		Not yet due	Partially complete		**August 2025:** Work is underway to clarify the relevant documentation and requirements. Initial steps include reviewing the use of Inpatient Notes within WNCR and identifying gaps in alignment with Hospital Discharge Guidance. A step-by-step guide is being considered to support consistent documentation under each note type, including Nursing Notes, MDT Reviews, and Discharge Discussions. Further detail will be provided as this work progresses on this recommendation							Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R9	Medium	Patients with complex needs: Patients categorised under Pathway 3 present complex needs. Those who are either CO or Discharge Ready and require Nursing Care must undergo a DST assessment or a PAN assessment by the appropriate ward. The findings should be sent to the Complex Care Team for review and submitted to the panel as needed.	Improve documentation practices by implementing a standardised template or clear guidelines for recording and tracking key dates, such as when assessments are forwarded to the Complex Care Team and when panel approvals are granted. This will enhance transparency and traceability and help to identify themes and trends.	01/12/2025		Not yet due	Partially complete		**August 2025:** This action is currently being progressed through the Complex Care and Continuing HealthCare workstream, where a key focus is on Data, Metrics, and Digital Platforms. The Complex Care team is leading efforts to explore and evaluate suitable digital solutions to support individuals with complex needs, and work is actively underway to identify the most appropriate options.							Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R10	Medium	Estimated Date of Discharge (EDD) Powys Community Hospitals: As part of the sample testing, we compared the EDD recorded on the manual whiteboard to those documented in the WNCR. We identified three instances within Eynt Ward where the dates did not align. Additionally, we examined the interval between the admission date and the date when the original EDD was established. Across both wards, we discovered six cases where the EDD was set more than seven days post-admission, with the longest delay being 51 days.	Clear guidance on the management and recording of EDD needs to be established. Each patient should have an agreed-upon EDD confirmed during their initial Multidisciplinary Team (MDT) meeting or within 24 hours of admission, which must be documented and communicated to the patient and their family or caregivers. Any discussions or modifications regarding the EDD should occur and be recorded prior to the expiration of the original EDD.	01/12/2025		Not yet due	Partially complete		**August 2025** - Developments have been made within Powys DigiFLO to support monitoring and maintenance of Estimated Date of Discharge (EDD) records. EDD expectations are reinforced through the Standard Operating Procedure (CSG 001, Sept 2024), including that all patients should have an EDD recorded on WNCR and that EDDs should be updated in line with the most up-to-date clinical information and estimated discharge date. Within Powys DigiFLO, EDDs are displayed on a colour-graded scale to indicate when they are approaching (<7 days) or highlighted in red if the date has passed or an EDD has not been entered, supporting timely review							Jul-25	
242522	2024/2025	Cancer Services	Reasonable	Medical Director	Chris Moss/Simon Mclellan	R3	High	Fragmented IT Infrastructure for national cancer services performance: Despite formal agreements and governance structures, the Health Board faces several challenges in tracking cancer patients (Powys residents) across providers (English and Welsh). The majority of issues are outside the Health Board's control and relate to the national IT infrastructure in place: • There is no shared SCP Pathway Identifier, making it difficult to follow patients transferred between providers. • Commissioning performance Data from English providers is centrally held by the Commissioning service Unit and is provided to the Health Board Monthly. However, we note that the data is pseudo-anonymised and cannot be traced back to individual patients. • The HB often receives information only after treatment has commenced. Attempts to access NHS England's central data warehouse have been made by the Digital and Performance team however these have not resulted in a solution. Currently there is reliance on manual data feeds from individual English trusts which introduces inconsistency and administrative burden. There is a lack of clarity and consistency in recording the point of suspicion dates by Welsh providers. This is critical because the point of suspicion is the official start of the SCP clock and directly impacts performance metrics and patient tracking.There are also operational delays in diagnostics and histology commissioned services. Delays in reporting which can leave patients in a suspected status but still open on the WPAS system, awaiting confirmation. This affects the ability to close/downgrade pathways and accurately reflect the point of suspicion and subsequently meet the milestones against the SCP targets. We note that this is an intentional approach put in place by the Health Board where pathways are not downgraded until consultants	The Health Board will continue to advocate, engage and work with providers and with DHCW/NHS Wales and NHS England to attempt to improve the current state of IT Infrastructure surrounding national cancer performance data.	01/03/2026		Not yet due	No progress		**29/07/2025 update:** Following discussion at APAC, further discussion to take place beween Board Sec and Audit Wales re this action.							Jul-25	

242525	2024/2025	General Medical Services Unified Contract Assurance Framework	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	R1	Medium	Standard Operating Procedure: Practice Visit Report Assurance Ratings: Testing undertaken in Objective 4 identified that there is no SOP in place to clarify and formalise the process for the assessment and awarding of Practice Visit Report Assurance Ratings that underpin the potential invocation of the Framework Escalation Ladder, in absence of this approach being provided within the Framework Guidance.The Contract and Visit Governance Report includes twelve Assurance Ratings - one for each assessed Health & Care Quality Standard, and where there is an even or 'close call' split of ratings across the twelve Standards, as we identified in several of the five Reports, there is no current process to determine the final overall Assurance Rating	National guidance is due to be produced that will document and formalise the process for the assessment and awarding of Practice Contract and Visit Governance Report Assurance Ratings. Following production of the National Guidance, management will ensure that it is followed for future Practice Visits.	01/12/2025	01/04/2026	Not yet due	No progress		**August 2025:** Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therfore this deadline needs to be moved on to 01/04/26	National Work	National Contract Assurance review group meetings planned	01/04/2027				Jul-25	
242525	2024/2025	General Medical Services Unified Contract Assurance Framework	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	R2	Medium	Overall assurance rating for the Practice Visit Assessment reports: Our review of each of the five GMS Contract and Visit Governance Reports identified that, based upon the individual Standard Assurance Ratings stated within, all five Reports could have potentially contributed towards the justification of triggering the Framework Escalation Ladder on the basis of an 'averaged' Limited Assurance rating.The Framework guidance states that the Escalation Ladder should be used 'If a contractor receives a Governance Visit Report with Limited or no assurance AND the PCGFRP is either not accepted or monitoring shows non-compliance. However, as noted within Finding 1, there is currently no process for determining the overall assurance rating, and no overall rating was provided for any of the five GMS Contract and Visit Governance Reports produced during the current cycle.The introduction of an overall Assurance Rating and a brief summary to justify this Rating within the Contract and Visit Governance Report would also be of use to GMS Contractor Practice Management Teams as an overall position statement relating to the assessment undertaken	Following receipt of the national guidance referenced in Finding 1, the Primary Care Team will ensure that an overall assurance rating is determined and recorded for all future GMS Contract and Visit Governance Reports.	01/12/2025	01/04/2026	Not yet due	No progress		**August 2025:** Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therfore this deadline needs to be moved on to 01/04/26	National Work	National Contract Assurance review group meetings planned	01/04/2027				Jul-25	
242527	2024/2025	Risk Management & Assurance Final Internal Audit Report	Reasonable	Director of Corporate Governance	Stella Gwynne	R1	Medium	Directorate Risk Registers: Review of the Risk Register for People & Culture, and Mental Health & Learning Disabilities Service, identified that whilst both bore evidence of regular review and update, there were some minor errors and inconsistencies in completion. A number of these related to the calculation and rating of the score which should be addressed by the move to the Datix system. One recurring issue was that the column for actions already taken often included actions that appeared to be on-going.	The Health Board will ensure that appropriate guidance and training is provided to all relevant staff to accompany the revised risk management framework and the implementation of the DatixCloudIQ system. The Health Board will also review the "what has been done to manage the risk to date" field and instead consider "what existing measures are already in place to control the risk" to help to avoid the issue of partially completed actions being included in this field, which currently may give a false assurance that the risk is being effectively managed.	01/11/2025		Not yet due	Partially complete		August 2025: Datix Risk Management Module continues to be rolled out, ORR template has ben updated to relfect suggested wording	August 25: Work continues to onboard services to the Datix system, though uptake is slower than anticipated due to reduced cpacity due to long term absence in the corporate team. .	The Once For Wales national team have offered to support in the transfer of risks on to the system where appropriate, this detail of this is currently being explored to potentially expediate the transfer.	Linked to ful rollout of Datix System				Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R7	High	No central monitoring and reporting arrangements are in place. As highlighted under the previous objectives, there is currently no central register of all mattresses in place, and no process for recording compliance with cleaning requirements or the completion of monthly mattress audits. As a result, there is also no central monitoring or reporting of information relating to mattresses. The information that should be captured and reported would be expected to include the following: • Details of all mattresses on each ward; • Confirmation of compliance with cleaning and maintenance requirements; • The number of mattress audits undertaken; • The number of issues identified analysed by category; and • The length of time taken to resolve the issues identified analysed into appropriate time bands. Furthermore, the report should include previously reported results so that comparison and trends can be identified and drawn out. This information should be regularly reported to appropriate Groups within the Localities and Service Group.There should also be a clear mechanism for escalating any serious issues identified through the reports up to an appropriate Committee of the Board.	A system which captures the information suggested, will be put in place for mattresses along with appropriate reporting within the Localities. A clear mechanism for escalation of serious issues will also be established.	30/09/2025		Not yet due	Partially complete		**22.8.2025 Update:** * Helen Kendrick to confirm the action of a central register - to be held on a SharePoint site for wide team access. * All CSM have received a copy of the PowerPoint update to come to every CSG QSPE meeting - inserted for records. This evidences the requirement for tracking and raising of issues. - Amendment, the document cannot be inserted due to editing rights so will share documents in an email. * We have also asked for a tracker of orders for replacement covers and mattresses and a review of cleaning practices & education provision. We are revieing whether we can add the mattress audits to MEG digital system to Ahava clear dashboard.							Jul-25	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Zoe Ashman/Luke Jones (DECLO)	R2	High	he DECLO has undertaken some training initiatives and offers individual assistance to colleagues who require guidance in relation to ALN issues but a formal or regular training programme is not currently in place.	Training initiatives will be revisited; a training schedule will be produced, informed by existing or refreshed data about staff knowledge and confidence, and details of training availability will be made available to relevant staff. Records will then be maintained of attendance at completed training.	01/09/2025		Not yet due	No progress		**August 2025 update:** Due to the focus on clarity of data processes this has not been able to progress – there is slippage anticipate but a focus during the Autumn/Winter term						1506	Jul-25	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Zoe Ashman/ Amie Symes	R3	High	A plan is in place, and whilst listed outcomes were appropriate, some were found to be unclear in terms of the means by which they are to be achieved. Target dates either have not been listed, are ambiguously defined, or have elapsed.	Monitoring procedures in relation to the partnership's Strategic Priorities Plan will be reviewed and it will be ensured that regular reports are made at an appropriately senior level, with reference to the reviewed governance arrangements specified in Key Finding 1.	01/09/2025		Not yet due	Partially complete		**August 2025 update:** Clarity of arrangement have been agreed – monitoring through an embedding period now. Escalation reporting agreed and in place.						1506	Jul-25	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R11	Medium	'Planning your Discharge' Letter Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. The Welsh Government Hospital Discharge guidance includes a template for a 'Planning your Discharge' letter, which should be provided to patients. This letter emphasises that discharge planning should already be in progress and outlines the importance of facilitating a quick and safe discharge to enhance the patient's recovery. Powys Community Hospitals. Our sample testing identified only one instance out of twelve where the system recorded that this letter had been issued. The WG guidance does not specify the appropriate timing for issuing the letter. It is therefore important for the Health Board to decide whether the letter should be provided after the patient's initial MDT review or included as part of the admission pack. Additionally, it would be beneficial to document the issue of the discharge letter in the Discharge Discussions section of the WNCR. (Key Finding 9)	Ensure that a 'Planning your Discharge' Letter is issued to each patient. Establish clear guidance on when the letter should be issued. Ensure that the issue of the letter is documented within WNCR system, as highlighted in key finding 9.	01/09/2025	01/12/2025	Not yet due	No progress		**August 2025:** Discussion underway to allocate a suitable lead for action and delivery. Recommend a revised delivery date of 1/12/2025							Jul-25	

Internal Audit Findings - that are overdue

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R1	Medium	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	and format (spreadsheet, table, dashboard etc). Medium Agreed Management Action Target Date Responsible Officer1 Update DoLS policy.	31/01/2025		Overdue	No progress		20/2/25 - DoLS policy re-draft will commence upon outcome of business case as this will determine content.						1506	Jul-25	10/02/2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R4	High	The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	March 2025 June 2025		Overdue	Partially complete		20/02/25 -Business case made to IJBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. August 2025 update Preferred option with business case agreed by executive committee 14/5/25. 1x Best Interest Assessor recruited. Administration in place. DoLS Co-ordinator recruitment was unsuccessful m however following readvertisement further interviews set for sept 25. Interim measure for external BIA assessments in place from the 18/9/25 and agency DoLS co-ordinator identified for 12 weeks and procurement commenced for this.						1506	Jul-25	10/02/2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R5	High	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	March 2025 June 2025		Overdue	Partially complete		20/02/25 -Business case made to IJBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. Information requested from ESR to start analysis of training needs around MCA. The next MCA operational and Practice Improvement Group in March 25 has an agenda item for practice improvement action plan for MCA training. August 2025 update An increased rota is achieved through additional 5 signatories now trained and on the rota. Recruitment of DoLS Coordinator underway - interviews set for Sep 25						1506	Jul-25	10/02/2025
242522	2024/2025	Cancer Services	Reasonable	Medical Director	Ruth Corbally	R1	Medium	Formalisation of the Cancer Group We understand that the Executive Medical Director chairs the Cancer Group. Throughout our fieldwork we were unable to determine the nature of the group, its alignment within the wider governance structure for the Health Board and its decision-making abilities.	The purpose of the Cancer Group will be decided and whether it has been set up to operate as a Steering Group (Strategic oversight and focus) or a Task and Finish Group (task and objective based). Further to this, a Terms of Reference document will be documented and will be taken through the HB governance structure for scrutiny and sign off.	01/08/2025		Overdue	Partially complete		**29/07/2025 update:** Arrangements underway. TOR being drawn up and first meeting planned							Jul-25	
242522	2024/2025	Cancer Services	Reasonable	Medical Director	Chirs Moss	R2	Medium	Methodology for recording action logs arising from CQPRM: Whilst action logs are kept and are being discussed at every meeting, the current methodology for documenting actions could be improved. Currently actions are logged within individual documents for each meeting. We also note that the numbering format for actions is not traceable to the respective meeting it was raised, and target dates/re-vised target dates are not being populated.	The actions from CQPRM meetings will be documented by means of using a spreadsheet as opposed to individual word documents for each meeting. Also, target dates and revised target dates for completion of actions will be set in place.	01/08/2025		Overdue	Partially complete		**12/8/25 update**: Capacity challenge currently within Commissioning Team due to retirement and vacancies. Plans in place to enact this once recruited to vacancies (Commissioning Manager x 1; Commissioning Support Officer x 1)							Jul-25	
242523	2024/2025	Llandrindod Wells Phase 2 Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Wayne Tannaill	R3	Medium	The THB noted that on the advice of their Advisers they had opted to seek a performance bond to provide assurance on delivery of the work rather than a parent company guarantee. It was confirmed that despite a request from the THB's Advisers in January 2025 the performance bond had not been provided by the SCP. The contract contained option X13 (Performance Bond) which amounted to a cost of 10% of the contracted sum. Whilst noting the contract requirement for a performance bond, at the time of reporting the project was only 3 weeks from completion and therefore the performance bond would be of minimal value to the THB at this stage. Management should therefore consider the omission of the performance bond requirement from the contract (via formal contract change processes) and the reduction in associated costs.	The THB will ensure deduction/reimbursement of the cost associated with the provision of a performance bond	31/05/2025		Overdue	Partially complete		**August 2025 update**: Professional consultants to persue deduction/reimbursement of the cost associated with the provision of a performance bond							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R1	High	Lack of awareness and specific training on the Health Board's Mattress Policy.Limited specific training on the Health Board's mattress policy has been provided and so most staff have limited awareness of its requirements.Furthermore, no register is maintained which records who has received specific training and how this compares with those staff undertaking the work	Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered.	30/07/2025		Overdue	Partially complete		28.08.2025 update: * Infection prevention and control emailed about training - there is some further discussion with drive about their offer under the contract. Awaiting an update from Gareth Thomas. * We have more substantive staff in post now with a reduction in 30 WTE vacancies and less agency use, so saturation of training is possible. * Lead for each ward to be identified by each CSM.							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R2	Medium	No monthly confirmation of compliance with the Health Board's policy. There is currently no process in place whereby the ward leads confirm at the end of each month that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy.There is also no periodic review undertaken by the CSMs to check completion and follow up on any issues where necessary.	A system will be implemented to record monthly confirmation from the ward leads that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. The records will be reviewed by the Community Services Managers and followed up where necessary. A summary of these declarations will also be incorporated into the reporting arrangements under Finding 7.	31/08/2025		Overdue	Partially complete		**28.08.2025 update:** Audit channel in Teams confirms that each ward have undertaken a mattress check. * Confirmation from the North and Mid CSM that they have undertaken an oversight check of mattresses. * Plan in place for the South CSM to undertake oversight checks - to be confirmed end of September 2025.							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R3	High	Monthly mattress audits not completed by all wards. As detailed above, monthly mattress audits are not being completed by all wards.Furthermore, the audit templates in the mattress policy were not consistently used.	All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.	30/07/2025		Overdue	Partially complete		**22.8.2025 Update:** * Email shared with all ward leaders by Head of Nursing (see email as unable to embed documents). * Mattress audits all undertaken for the months of July and August, with oversight of compliance of completeness by CSM team - due for reporting through QSPE on 6th October 2025							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R4	High	Confirmation that actions are taken to address issues identified: Where issues were identified in the mattress audits that we reviewed, there was generally no confirmation whether action had been taken to rectify the issues and if so, when it occurred. We also noted that there is currently no register in place that records the mattress audits and details any issues identified and the actions taken to address them.	A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.	30/07/2025		Overdue	No progress		**22.8.2025 update:** This action requires completion - awaiting central resister to be shared by medical devices lead who is on leave.							Jul-25	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R6	High	Missing mattress audit information. Mattress identifier numbers and identifiable signatures were often missing on the mattress audits we reviewed. On some of the audits we also noted that there was no information recorded for a number of the mattresses, and the reasons for the omissions were not indicated.	Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.	30/08/2025		Overdue	Partially complete		**22.8.2025 update:** There was an issue that some of the identifiable information on mattresses was coming off during the process of cleaning - a request has been made to HK to ensure all information is attached to mattresses that has more permanence, this is under review.							Jul-25	

Internal Audit Findings - deadline revised

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
222318	2022/2023	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Assistant Director of Therapies and Health Science	R3	Medium	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	Oct-23	Oct-25	Deadline Revised	Partially complete		**November 2023:** WOD engagement with ESR team and NWSSP regarding potential to strengthen process through existing TRAC/ESR systems. Delayed meeting due to WOD/NWSSP capacity but re-engaged Nov 2023 and meeting planned. Deadline revised to reflect this. **July 2024:** No progress on this action following secondment of Deputy Director of AHPs & HS for first half of 2024. Reengagement with WOD required. **December 2024** - No progress made as Deputy Director of AHPs & HS was on secondment for first half of 2024 and was then successful in getting a new role, leaving the post vacant. Reengagement with WOD required when new deputy Director in post . **February 2025** - Review undertaken to assess feasibility of this action for delivery with view remaining that this should be acheivable with appropriate engagement. HR engaged by new Deputy Director of AHPs & HS to recommence progression of this action. Meeting scheduled for March 25 with key stakeholders to re-explore options and establish an action plan with associated timelines for delivery. **August 2025** - This work was deprioritised due to capacity to be reviewed in October 25.	capacity in WOD	low risk and manual processes in place			21	#NUM!	Jul-25	Mar-23
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Corporate Governance		R1	Low	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.	Agreed - The SFIs are mainly standard documents provided to the THB by Welsh Government with some minor amendments for local circumstances. The THB will put a note on the document to state that the SFIs will be internally reviewed every 2 years should a review by Welsh Government not be undertaken during that period.	31/12/2024	31/03/2026	Deadline Revised	Partially complete		**February 2025:** Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval. **August 2025:** Statement had been prepared for inclusion in the next SFI update, currently shceduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemebnted sooner if there is a need to revise the SFIs for any other reason						#NUM!	Jul-25	10/02/2025
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Corporate Governance	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)	R2	Low	The Standing Financial Instructions should be updated to ensure references to the Head of Financial Services are updated to the Assistant Director of Finance (Accounting and Services).	Agreed - The change to title will be made at next update of Scheme of Delegation scheduled for late 2024.	31/01/2025	31/03/2026	Deadline Revised	Partially complete		**February 2025:** Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval. **August 2025:** Update has been prepared for inclusion in the next SFI update, currently shceduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemebnted sooner if there is a need to revise the SFIs for any other reason				Yes		#NUM!	Jul-25	10/02/2025
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Finance, Capital and Support Services	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)	R3	Medium	Efforts should continue to ensure all FCPs with elapsed review dates are subject to an appropriate review process and submitted for the relevant approvals. Future review dates should then be defined, or an established review frequency should be determined and specified within each document.	Agreed - There is currently LHB review of policy process underway which is due to conclude during 24/25. All FCPs will be reviewed and where required approval undertaken and where required review frequency included within the document.	31/03/2025	31/12/2025	Deadline Revised	Partially complete		**August 2025 update**: Relevant procedures have been reviewed and are ready for approval. Just formulating approval stream for the policy documents.		current procedures remain extant		Yes		#REF!	Jul-25	10/02/2025
242521	2024/2025	Business Continuity Planning Final Internal Audit Report	Substantial	Director of Primary Care, Community and Mental Health	David Farnsworth/ Ruth Derrick	R1	Medium	Completeness of Service Area BCP's Review of the six Service Area BCP's identified that whilst all followed the toolkit template, the contact names and telephone numbers of key staff had not been included in three of the six plans. In addition, one 'document owner' and three other key contacts could not be found on Outlook which suggests they may have left the organisation, and several other key contacts had moved on to new job roles and no longer had any BCP responsibilities. Three document owners were recorded by job title but were not named.	The key contact names and telephone numbers will be updated for all 6 BCP's. A process will be developed to ensure all staff contact names and telephone numbers are kept up to date.	30/06/2025	Nov-25	Deadline Revised	Partially complete		**August 2025:** Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it's unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manger for Civil Contingencies.							Jul-25	
242521	2024/2025	Business Continuity Planning Final Internal Audit Report	Substantial	Director of Primary Care, Community and Mental Health	David Farnsworth/ Ruth Derrick	R2	Medium	Testing of BCP's Service area BCP's should be tested annually in accordance with the Health Board's BCP guidance. The two Community Services Group BCP's had been tested during live incidents, but no planned testing exercises had been carried out. Information on testing for the four Mental Health BCP's was requested but no information was provided in relation to any completed or planned testing.	Annual tests of all service area BCPs will be scheduled and undertaken with subsequent completion of the debrief template and post incident report. Where testing is effectively undertaken via live incidents, full supporting documentation will be retained.	31/07/2025	Nov-25	Deadline Revised	Partially complete		**August 2025:** Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it's unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manger for Civil Contingencies.							Jul-25	

External Audit Findings - completed since last report

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health		R3	The Health Board should examine how it can gather additional workforce data on the number and skills of all staff working within its primary care settings, in the absence of national solutions.	To capture and review workforce data across Independent Contractors and the impact of instability in primary care due to increase in demand and recruitment challenges, to include: • Identifying workforce needs in primary care • Improving workforce planning and supporting sustainability •Promoting and encouraging multiprofessional working • Improving access and capacity for student training and placement opportunities to promote longer term sustainability of Powys primary care. This will inform the roll-out of the Primary Care Workforce Plan across Powys (linked to National Workforce Plan)	Mar-25		Complete	Complete		**August 2025:** Workforce data available for GMS Contractor staff. Training provided via the P&CCA on Sustability, Resilience and Appraisal skills, development of the Nurse Education Forum, development of standardised PC Induction, working with HEIW to develop 'stay' conversations, development of a cross-contractor sharepoint site and suite of training resources, development ongoing for receptionist competency standards, Senior Practitioner in post holding multiprofessional working discussions and informing Practice plans. significant progression with student nurse training with 50% Practices hosting, non-clinical SIM training developed by P&CCA. monthly workforce reporting requirements now in place for Optometry and Dental contractors. Workforce data to be analysed to inform future workforce planning and support sustainability. Linking in with WOD business partners to progress.	workforce data reporting offers a limited data set for Optom & Dental (compared to GMS)			Monthly reports for workforce data in Primary Care.			Jul-25	Jul-24
242502	2024/2025	Primary Care Follow-up Review	Director of Corporate Governance		R4	The Health Board should develop an action plan for raising the profile of primary care in the organisation and ensuring sufficient coverage of primary care challenges and performance within committee agendas	Develop a timeline for presentation of primary care reports at Executive Committee and Board level to provide regular reporting and assurance, to include challenges and risks.	Jul-25		Complete	Complete		January 2025 - Primary Care is an active consideration across all work programmes, Committee terms of reference reviewed in May 2024 to focus Committee roles with further consideration being made for 2025/26 changes. **August 2025:** 2025/26 Committee Terms of Reference and work plans were approved by the Board in May 2025, with regular reporting via the Executive Committe to the Finance and Performance Committee, the Planning, Partnerships and Population Health Committee and a twice yearly summary report to the Board.							Jul-25	Jul-24
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health		R7	The Health Board should establish a central primary care services management group to manage primary care services as a whole and maximise opportunities for integrated working.	Establish a Primary Care Services Management group covering the four contractor professions to include clinical, managerial and finance representation	Sep-24	Mar-25	Complete	Complete		**August 2025:** Group established. Terms of reference developed to include expanding membership along with co-opted representation. Initial meeting of expanded membership to be held 11/09/2025							Jul-25	Jul-24

External Audit Findings - that are Overdue

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
232401	2023/2024	Structure Assessment 2023	Director of Nursing, Quality, Women and Family Health		R3	Develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	May-24		Overdue	No progress		**Jan 25** The People's Exeperience Framework is awaited from Welsh Government. Funds are available to develop a Patient Experience Lead. JD being written. **Feb 25** Peoples Experience Framework still awaited **August 25 -** CR to discuss with HB, this action is not aligned to the peoples experience framework and is aligned to board member site visits and feedback.						8	Jul-25	Mar-24
242501	2024/2025	Review of Workforece Planning Arrangements	Director of People and Culture		R1	To ensure service level workforce plans are consistent, for the next planning cycle, the Health Board should ensure all directorates and/or service areas develop a workforce plan using the HEIW workforce plan template	Continue to roll out training that utilises the HEIW workforce plan template. • Provide periodical updates to Executive committee of those managers who are required to undertake the training; have done so, to ensure that the competencies to complete workforce plans are embedded within the organisation. Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.	Quarter 4 2024/2025		Overdue	Partially complete		Dec 24 - Workforce planning (WFP) training continues to be available for managers to access tbrough multiple modalities. such as 1-hour information and awareness session, through to more detailed training accessed via online or face to face classroom based training. 38 staff have completed the full training to date with leadership teams from across Mental Health, Womens & Childrens, Digital and Corporate Nursing receiving the 1-Hour awareness sessions. Gap analysis completed of those managers who have completed training and identified those managers with workforce planning responsibility that would benefit from the training. Identified list of managers to be shared with relevent Director/AD in Q4 for consideration. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed. HEIW have offered funding (until 31st October 2025) for a Workforce planning manager role to support the development of local MH WFP's aligned to the national strategic Mental Health WFP. The role has been advertised, interviewed and an offer made, but candidate then went on to withdraw. Role has been re-advertised again and is currently at the shortlisting stage. In order to support managers to develop WFP, WOD Business Partnering Team will share HEIW template to clinical directorates pre-populated with up-to-date workforce data - Q4. **Feb 25 -** Targetted discussion with Assistant Directors has taken place with an identifed list of senior managers to prioritise in relation to training delivery (9 of these have booked sessions). In total, the workforce planning training in line with the HEIW template has been delivered to 39 managers (through a variety of routes/approaches). Our training approach has continued to develop based around service needs and has included the devleopmet of a bespoke awareness session and more recently, targetted practical follow up sessions to explore the 6 step toolkit in more detail. Workforce information and signposting to how to get this information has been included as part of training delivered. As we progress to practical follow up sessions as outlined above, we anticipate that we can provide more specific pre-populated workforce information sections. **August 2025 -** In light of the work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementaton of new emerging operating models. This will ensure effective use of resources and mitigate the risk of misalignement and duplication of effort. It also ensures workforce planning is co-ordinated, evidence based and aligned to the strategic priorties of the Health Board.	Capacity of managers with WFP responsibility to complete WFP training and subsequent WFPs. Unclear what future demand is until Route Map to Sustainability work has been defined/completed. Difficulties in recruitment to WFP Manager role.	People & Culture WFP Lead continues to develop organisational level WFPs	2025/26				Jul-25	Jun-24
242501	2024/2025	Review of Workforece Planning Arrangements	Director of People and Culture		R2	The Health Board should develop an evaluation framework to measure whether the roll out of workforce planning training is achieving its intended purpose and improving service level workforce planning	• Gain feedback from attendees both immediately after training and 3 months post training to understand effectiveness. • Measure the number of workforce plans produced across the organisation.	Quarter 4 2024/2025		Overdue	Partially complete		Dec 24 - P&C Business Partnering Team have developed an evaluation framework which gathers feedback from attendees following the training delivery. Refreshed evaluation questionnaire due to be sent to all those that have attended training to date to understand current utilisation of WFP knowledge and skills. **Feb 25** - An evaluation form has been developed and it is anticipated this will be finalised and sent to attendees by end of March 2025. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed. **August 25** - In light of the work work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementation of new emerging operating models. This will ensure effective use of resources and mitigate the risk of misaligenement and duplication of effort. It also ensures workforce planning is co-orindated, evidence based and aligns with the strategic priorities of the Health Board.	Percentage of those attendees completing evaluation questionnaire.		Q4 2024/25				Jul-25	Jun-24
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning		R5	The Health Board should improve oversight at Board and committee level of performance within primary care by: 5.1. increasing the coverage of primary care performance within its Integrated Performance Report. 5.2. increasing the focus on outcomes and experience	Progress the development of a Primary Care Dashboard as part of Integrated Performance Report presented to Executive and Board Committees. Frequency to be agreed	Dec-24	May-25	Overdue	Partially complete		**August 2025:** DPCCMH commenced conversations to develop dashboard. Wealth of information available from various departments i.e information; finance, commissioning and primary care. Requires pulling into a central repository/dashboard.Ongoing assurance via relevant papers to executive committees, including Board development and Board briefing sessions. **06/08/2025** - Integrated Quality and Performance Framework refreshed for 2025/26. Continuation of Directorate Integrated Quality and Performance Group meetings including Primary, Community Care and Mental Health. The Integrated Quality and Performance Report (IQPR) does include and report on a limited number of primary care measures and will reflect detail from the Primary Care Dashboard once completed.							Jul-25	Jul-24
242503	2024/2025	Review of Cost Saving Arrangements	Director of People and Culture	Director of Improvement and Transformation	R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potention costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	Agreed – The Health Board has established a programme of work around future sustainability with programme and workstream structure: - 'Task force' in place to examine three areas: • the future model (building on existing work) • options and decisions around when to achieve financial breakeven. • new opportunities based on analysis of data and benchmarking. Identified timeline in place with initial engagement planned for 24/25.	Oct-24	Mar-25	Overdue	Partially complete		New directorate stood up October 2024 under new Director of Improvement & Transformation post. The Route Map to Sustainability work has been progressed to a new programme delivery structure with associated Finance team representation. Case for Change, Journey to Consultation, Clinical service redesign and Estate implications in development. As options are developed these will be costed and included in financial planning. Partially complete as work accelerated however full qualitification of potential costs and savings will not come through until later in FY25/26. Feb 2025 - No further update - recommend extention of deadline to Q4 2025/26 in line with Better Together timeline. **Aug 2025 -** Recommendation in Feb was for deadline to be extended to Q4 2025/26 in line with Better Together timeline. Work ongoing to confirm options for board approval to consult on future model and configuration of services for adult physical and mental health community services. Board decision on progression to consultation anticipated October 2025. Further phases of work across 2026/2027 will address planned care and women & childrens services. Recommend deadline is extended to reflect this.	Capacity in key roles/teams to work at pace on options development.	Ongoing mitigation through existing operational measures.	TBC				Jul-25	Nov-24
242503	2024/2025	Review of Cost Saving Arrangements	Director of People and Culture	Director of Improvement and Transformation	R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the Accelerated Sustainable Model.	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	Oct-24	Mar-25	Overdue	Partially complete		New directorate stood up October 2024 under new Director of Improvement & Transformation post. Resource plan for delivery of Improvement & Transformation activity will be included in Better Together programme and wider Improvement activity. Feb 2025 - No further update - recommend extention of deadline to Q1 2025/26. **Aug 2025 -** Better Together portfolio structure fully operational with some additional capacity and capability identified to support portfolio. Ongoing gaps in clinical specialty support to planned care and mental health, discussions with national programmes to secure support in these areas. Capacity challenges across corporate and operational services to deliver to timelines during period of increased pressure and scrutiny in other areas such as financial savings and national returns.	Capacity in key roles/teams to identify additional resource requirements	Ongoing mitigation through existing team deployment to areas of highest priority	TBC				Jul-25	

External Audit Findings - with revised deadlines

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
232401	2023/2024	Structure Assessment 2023	Director of Corporate Governance/Director of Nursing, Quality, Women and Family Health		R5	The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	Jul-25	Jan-26	Deadline Revised	Partially complete		April 2024 - plans in place and on target June 2024 - plans continue to progress with 12 teams/service areas now included within Datix. Work will continue over the summer to move more areas into the system. Full roll out may be slightly later than target but progress is positive. **Dec 24** The Health Board continue to roll out the requirement that all risks for all directorates to be captured in the RL Datix system. **Jan 25 -** The Health Board will record all risks on RL Datix by Summer 2025. Request extenstion to July 2025 **August 2025 update**- Implementation plan reviewed and roll out of moving risks to Datix system continues during Q2 & Q3 Work continues to onboard services to the Datix system, though uptake is slower than anticipated due to reduced capcity due to long term absence in the corporate team. The Once For Wales national team have offered to support in the transfer of risks on to the system where appropriate, this detail of this is currently being explored to potentially expediate the transfer. Request extension to January 2026.	National issues surrounding the once for Wales Datix system						Jul-25	Mar-24
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health	Director of Primary Care, Community and Mental Health	R1	The Health Board should review the relative maturity of clusters, to reflect on the existing arrangements, address any potential gaps and strengthen Health Board support where necessary.	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects at cluster level through 'start well', 'live well', 'age well' programmes – a bottom-up approach to increase cluster maturity. Progress will be monitored via the ACD readiness checklist and assurance provided through the RPB Executive Grou	Mar-25	Mar-26	Deadline Revised	Partially complete		**August 2025:** Delays with establishment of Professional Nursing Collaborative. Unlikley to be implemented this financial year. Strengthing cluster voice in RPB Exective Group - meeting being arranged to include DPCCMH input. progressing the merging of the mid and south cluster - T&F group set up and engagement with stakeholders will shorty be commencing. Proposed Revised Deadline of Mar-26 due to delays mentioned above						Jul-25	Jul-24
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health		R6	The Health Board should strengthen its Primary Care Services Team by: 6.1. Reviewing the resources available to ensure it has the necessary capacity to deliver local and national priorities, alongside meeting day-to-day operational and business need. 6.2. Ensure that training and development opportunities extend to all members of the team and develop a succession plan.	in conjunction with ongoing operational requirements, including contract reform. Review resources available to increase capacity in the Primary Care Services Team. Develop a training plan for the Primary Care Services team to support succession planning and ongoing resilience.	Jun-24	Jun-25	Deadline Revised	Partially complete		**August 2025:** Team resource reviewed and revised structure proposed. Work being led under the direction of DPCCMH as part of a wider Directorate workforce review. 'grow your own' approach to increas team resilience under way. Formal and informal training opportunities underway, developing the team						Jul-25	Jul-24

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.8

Audit Risk and Assurance Committee	**07 October 2025**
Subject:	**FINANCIAL CONTROLS 2025/26**
Approved and presented by:	Pete Hopgood Executive Director of Finance, Capital Estates and Support Services
Prepared by:	Deputy Director of Finance Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	Executive Committee – 17 September 2025 who endorsed the paper to the Committee.

PURPOSE:

To inform the Audit, Risk and Assurance Committee of the financial controls in operation during 2025/26 financial year within the Health Board.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **RECEIVE** the contents of this paper taking **ASSUANCE** from the financial controls in place.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

Standing Orders and Standing Financial Instructions are at the forefront of all business the Health Board conducts. In recognition of a worsening financial position additional scrutiny and processes have been introduced to ensure tighter control of the expenditure the Health Board commits. A number of these are explained in this paper.

CONTROLS IN OPERATION:

Standing Financial Instructions and Scheme of Delegation

Local Health Boards in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. The Standing Orders for PTHB and Glossary of Terms, including the Standing Finance Instructions and Scheme of Reservation and Delegation of Powers are available via the attached link:
Board Governance - Powys Teaching Health Board

The organisation currently has four key limits in operation for the approval of expenditure. These are as follows:

ORACLE REQUISITIONS	Authority Delegated to
Up to **£10,000**	Nominated Budget holder for specific cost centres
£1,000 to **£25,000**	Assistant Directors
Up to £50,000	Executive Directors
Up to £100,000	Chief Executive

Having relatively low values to Assistant Director level at £25k means that the Executive team have sight of all significant purchases or contracts. However, a comparatively low delegation level for Executive Directors means that a high volume of orders need Chief Executive approval.

Procurement Threshold

Value1	Minimum Competition2	Lead	Waivers, or exceptions to tender rules
Up to £5,000	Best value to be shown	Budget owners	-
£5,000 to £24,999	3 quotations	Procurement Services	Head of Procurement or Director of Finance or CEO

£25,000 to OJEU threshold for supplies and services3 **£25,000** to **£1m** for works	**4 tenders**	Procurement Services	Single Tender Action Authorised by CEO
Above OJEU threshold for supplies and services3 to **£1m**	**5 tenders**	Procurement Services	Single tender action prohibited
Above OJEU threshold for works4	**Procured via Designed for Life: Building for Wales**	Procurement Services	Single tender action prohibited
Over **£1m (other than D4L)**	**WG approval required**	Procurement Services	-

1 Total value excluding VAT.
2 Subject to existence of suitable suppliers
3 Threshold from January 2014 for Supply and Services is £111,676
4 Threshold from January 2014 for works is £4,322,012

Advice from the Procurement Services, provided by NHS Wales Shared Services Partnership, must be sought for all requirements in excess of £5,000 and the THB is able to take advantage of economies of scale of All Wales Clinical and Non Clinical consumables/service contracts in operation.

Non Pay Scrutiny Group

A Non-pay Scrutiny Group (NSG) has been established in the Health Board and meets on a fortnightly basis. All orders for non medical/clinical goods and services are automatically flagged by the Procurement Team, and any orders greater than £1,000 are reviewed by the Non-pay Scrutiny Group.

The group asks the following types of questions:

- Is there a clear and compelling rationale for this expenditure?
- Is this needed now or can we wait until next year?

Where they have any queries these are followed up with the approving manager. This process aims to be a helpful and constructive way to maintain costs to help us live within our means, including helping managers identify alternative approaches that may be more prudent.

Training, Travel and Expenses

To help manage non-pay expenditure and increase capacity in the organisation, attendance at external training, conferences, and development events has been paused unless deemed essential to the individual's statutory role or service-critical delivery. All internal training will be reviewed and prioritised as necessary.

The THB is also reviewing participation in external forums where travel and time commitments may impact local capacity or incur unnecessary costs. Managers are being asked to undertake the following:

- Managers should review current attendance at national networks

- Where meetings are not mandatory, attendance should be reduced, rotated, or moved to virtual formats
- Attendance should be prioritised based on statutory requirement, regulatory need, or clear organisational benefit
- Virtual attendance should be prioritised over in-person attendance to reduce travel costs
- With immediate effect, we are limiting work-related travel, external venues and overnight accommodation.

Except where strictly essential for service delivery, patient care, or compliance with legal or regulatory duties, THB managers are being asked to :

- Pausing non-essential off-site travel
- Restricting overnight stays unless there is no viable alternative
- Encouraging virtual or local attendance where possible
- Defaulting to virtual meetings where this is feasible and appropriate
- Limiting printing, postage, and physical distribution of materials
- Reviewing use of administrative office spaces to ensure efficient estate use
- Building digital skills and confidence to reduce duplication and streamline work

NB, attendance at key programmes of work linked to delivery of our key strategic aims that require in person attendance, e.g. Better Together events, will be deemed as essential.

Long Term Agreements/Service Level Agreements

The Health Board commissions healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The commissioning department oversees that the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

The Health Board receives monthly contract monitoring returns alongside detailed patient datasets, which identify activity and price for prior months.
The finance team support the commissioning team in validating and giving assurance on the information supplied, and the Health Board also works with an English Commissioning Support Unit to validate and suport challenges related to services commissioned from English providers.

Regular CQRM (contract oversight) meetings are held with all providers, lead by the commissioning team and supported by finance, quality and operational colleagues to ensure the Health Board is receiving appropriate and best value care for our patients.

The pharmacy team at PTHB also supports control by validating all high cost drugs spend, raising challenges related to formulary used, price charged and categorisation of drugs.

Payments are made to providers on a monthly basis, calculated using the contract values set for the financial year, a schedule of which is shared with all relevant finance and commissioning coleagues, and approved by DoF prior to payment.

Continuing Health Care

The expenditure area of Continuing Health Care (CHC) contracts is supported by an All Wales operational framework outlining clinical processes and assessment practices to be undertaken. The financial aspect of the process is heavily scrutinised via Resource Panels and financial management oversight and activity data.

Routine, formal reviews are conducted annually, alongside informal reviews and care plan revision. High need and high-cost placements are reviewed as a priority and in the case of enhanced care, predominantly within MH & LD, these are tracked and reviewed through the weekly panel process. This means that a clients condition is monitored for any deterioration/improvement and the package amended (if required) based on that review.

Payments are made to providers once authorisation has been obtained at Panel and the organisation limits in operation for the approval of expenditure has been completed.

This remains a significant increasing expenditure area for PTHB based on the aging population, complexity of care needs and increasing rates charged for such placements.

Through the external audit, issues with the timeliness of the administration of the CHC database and subsequent recognition of expenditure were identified. Action has been taken to reduce the backlog of invoices requiring authentification and to improve the timeliness of updating the database. A specfic paper on the learning points has been prepared for this audit committee. Any controls, which are introduced or amended as a result of that exercise are not included here.

Primary Care Expenditure

Within primary care there is the prescribing drugs budget and four areas of contractor payments:

- General medical services
- Dentists
- Community pharmacists
- Opticians

The majority of contractual primary care payments are made centrally by NWSSP, the values are driven by NHS Wales agreed contract terms and conditions.

All Health Boards are sighted on the expected contractual payments and reconcile payments made against expected values. Where identifed, any discrepancies are then reported back to NWSSP. The Health Board maintains detailed working papers to ensure these reconciliations are as tightly scrutinised as possible.

Where payments are made against variable activity claims, there is a post payment verification process, centrally commissioined and delivered external to THB. The THB is made aware of any discrepances and will become involved should further investigation be required.

Any non-contractual payments will be processed through the internal THB procurement and approval processes.

The THB works with primary care providers to encourage the most cost effective means of dealing with conditions which do not have detrimental impact on the patient and regularly reviews data for any outliers to peers in this area.

The Health Board works closely with dispensers across Powys to ensure that best value of money is acheived on behalf of the Powys patients. Payments are controlled and processed centrally and the Health Board actively reconciles and scrutinises expenditure.

Pay Expenditure

As well as requirements outlined in the Standing Financial Instructions and the additional measures implemented during 2024/25 have been further strengthened in 25/26. Initially, the Board supported the immediate delivery of variable pay reductions through reduced use of agency and locums and a vacancy freeze for all posts to be overseen by the revised vacancy control process. Two of the key processes in support of this area are outlined below with details of how they have been further strengthened in 2025/26:

Variable Pay Group

The Variable Pay Group is chaired by the Executive Director of Finance and includes Deputy Directors, Assistant Directors, and service leads. The primary purpose of the group is to reduce reliance on agency staffing across operational services through the following measures:

- Detailed management information to inform workforce planning.
- Improved monitoring and challenge of operational practices.
- Clear pathway for requesting agency staff to eliminate unnecessary agency spend.
- Understanding the reasons behind agency usage on each occasion.
- Effective rostering and use of bank staff.
- Staff engagement and recruitment of bank staff.
- Increased permanent recruitment of staff.

During Q2, the THB introduced a phased approach to a stop all Health Care Support Worker agency staff by September 2025 with targeted and significant reduction in our reliance on agency staff for registered nurses and medics. These initiatives are essential to ensure service quality, value for money and promote workforce stability.

Other than in exceptional circumstances

- From 30 June – the health board ceased off-contract agency use of Healthcare Support Workers (HCSWs)
- From 14 July – No off-contract agency use of Registered Adult Nurses
- From 28 July – No off-contract agency use of Registered Mental Health Nurses
- By 25 August – No agency use of any kind for HCSWs

The THB are supporting these measures with:

- Executive-level approval required for all other agency bookings including locums, AHPs or any other temporary staffing.
- Stronger use of PTHB's internal staff bank and fixed-term cover arrangements
- Increased visibility of agency usage and spend by service area.
- Implemented changes to establishments, shift allocation and rota redesign to reduce reliance on temporary cover.

Vacancy Control Process

To help manage workforce costs, THB has further strengthened its approach to vacancy control, with the intention of more posts being frozen and, therefore, not proceeding to appointment. This ensures that recruitment is aligned with our service priorities and financial position.

From Quarter 2, additional scrutiny of recruitment and vacancies has been introduced. The Vacancy Control Panel has been replaced by a process, which requires explict Executive Director consideration of vacancies.

In PTHB this includes:

- Recruitment to essential roles only
- All vacancies to be reviewed and approved by a Panel of Executive Directors who will also approve all new posts going forward for recruitment.
- Prioritising internal development, redeployment and acting-up opportunities

A frozen vacancy will remain in the staffing establishment this year, but recruitment is paused or deferred, meaning the post is not actively advertised or

appointed to. Any changes to staffing establishments/budgets longer term would be in line with the usual budget management processes. Line managers are reminded to work closely with People & Culture Business Partners before progressing recruitment activity.

Investment and Benefits Group

The Investment and Benefits Group (IBG) is a sub-committee of the Executive Committee. It is a Health Board wide process to support the management of revenue business cases. As part of IBG there is a panel that supports the Executive Team in overseeing the management of investment business cases (revenue) to ensure they are in line with the board's strategic goals and corporate objectives. The main aims are to assess business cases for quality assurance, governance and value for money and to receive post implementation evaluations of the extent to which intended benefits have been achieved.

Budgetary Control and Savings

The Health Board's budgetary control framework outlines the financial control requirements to ensure that the Powys Teaching Health Board (PTHB) operates within its allocated resources.

Key aspects of this framework include:

- Ensuring that all principal budget holders sign accountability letters. These letters set out the Health Board's budgets in line with the board approved plan, including staffing establishments.
- Budget holders are responsible for managing their delegated budgets and ensuring compliance with financial control procedures. They must regularly review financial management procedures and adhere to the standards set out in the document. Regular training is provided by the Finance team.
- The Chief Executive, advised by the Executive Director of Finance, determines the required savings for the year. The Finance Directorate monitors progress on savings targets throughout the year and reports both internally and externally through the Health Board's savings tracker.
- Meetings are held with all budget holders throughout the year, and at least quarterly with Assistant Directors, Deputy Directors and Directors. These meetings are supported by regular enhanced financial dashboards outlining the year-to-date position, the forecast, and the status and forecast of savings schemes.
- In addition, the Health Board conducts quarterly directorate performance reviews led by the CEO and the Performance team, which include a review of the directorate finances.

- The CEO and Director of Finance also meet with each Executive Director individually to discuss the status of their savings plans and financial performance.

Audit Wales reported to the October 2024 ARAC meeting its report on Review of Cost Savings Arrangements at Powys Teaching Health Board. The report outlined that while the Health Board met its agreed deficit target for 2023-24, its recent track record of delivering against its overall savings targets is variable. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on introducing a new, more financially sustainable service model and to ensure it has the necessary skills and capacity to support the changes required. A paper regarding the structure and capacity of the Finance Directorate is being considered by Executives. Work is being taken forward via the Better Together programme for changes to the model of services in the medium term.

Income

Income outside of Welsh Government funding support is minimal in both value and nature. Healthcare agreements for services provided to PTHB to other bodies is subject to the same review as that outlined within Health Care Agreements Section above and the main sources of income are related to funding for projects by external bodies such as national charities such as Macmillan or Arts Council for Wales.

Internal Audit

There is a programme of regular internal audit reviews of financial and operational controls. This provides an independent source of assurance to the organisation over whether controls are appropriately designed and operating effectively. Recent reviews of financial systems have received the following assurance ratings:

- Budgetary control (21/22) – substantial
- Treasury Management (24/25) – substantial
- Core Financial Systems General Ledger and Accounts Receivable planned for Q3
- Budget Setting (review how the Health Board sets delegated budgets to meet its agreed financial plan) planned for Q3

NEXT STEPS:
Controls will continue to be implemented and reviewed as appropriate.

IMPACT ASSESSMENT - NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both
Safe				
Timely				
Effective				
Efficient				
Equitable				
Person Centred				
Workforce				
Leadership				
Culture				
Information				
Learn, Improve, Research				
Whole Systems Approach				

EQUALITY:

	No impact	Negative	Positive	Both
Age				
Disability				
Gender reassignment				
Marriage / civil partnership				
Pregnancy / maternity				
Race				
Religion or Belief				
Gender				
Sexual Orientation				
Welsh Language				
Socio-economic status				
Social exclusion				
Carers				

RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical				
Financial				
Corporate				
Operational				
Reputational				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.9

Audit, Risk and Assurance Committee	**Date: 07 October 2025**
Subject:	**Risk Management and Board Assurance**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Strategic Risk Register and Board Assurance Framework Dashboard – PTHB Board 30 July 2025
Appendices:	Appendix A – Strategic Risk Register (Board, July 2025) Appendix B – Board Assurance Framework Dashboard (Board, July 2025) Appendix C – Board Assurance Framework Analysis Principles

PURPOSE:

This report provides the Committee with an update on progress against the implementation of the Risk Management and Board Assurance Frameworks since the approval of the RMF in March 2025.

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE** from the update on progress provided against the implementation of the Risk Management Framework (RMF), and
- Take **ASSURANCE** from the update on progress provided against the implementation of the Board Assurance Framework (BAF)

Approve/Take Assurance	Discuss	Note
√	x	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The corporate risks are a reflection of the significant risks to the delivery of the health board's strategic objectives and therefore underpin all wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	

8. Transforming in Partnership	Y	

STRATEGIC AND COMMITTEE RISK REGISTERS

In March 2025 the Board approved a revised Risk Management Framework (RMF). The key fundamental change within the revised framework was the closure of the Corporate Risk Register (CRR), to be replaced with a Strategic Risk Register, owned by the Board and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk, owned by the Executive Committee.

Following approval of the revised RMF, the Corporate Governance Team worked closely with the Board, individual Executive Directors and Assistant and Deputy Directors to develop the new SRR.

On 30 July 2025, the newly developed Strategic Risk Register (SRR) (Appendix A) was formally adopted by the Board. The SRR will report to the Board 3 times per year, (July, November, March) and will be accompanied by the Board Assurance Framework Dashboard and Organisational Risk Register (ORR) (when developed). When the Board does not receive the full SRR or BAF (as detailed below) it will receive a Risk Summary Report based on the previous SRR's data.

The ORR, the risk register sitting below the SRR, should consist of 15 or so of the highest priority operational risks within the Health Board for oversight and management by the Executive Committee. The Executive Committee has tasked it's sub-group the Operational Leadership Group (OLG) with the development of the ORR in readiness for reporting to the November 2025 Board.

Following adoption of the SRR, each Committee has had the risks within their respective remit's allocated to them in the form of a Committee Risk Register (CRR), the CRR will be a standing item on each Committee's agenda. The Audit, Risk and Assurance Committee's CRR is included on the meeting's agenda as agenda item 5.9.

RISK MANAGEMENT

In March 2025 the Board approved a revised Risk Management Framework (RMF). The RMF recognised 2025/26 as a transitionary year with a number of key fundamental changes due to take place, including:

- An update to organisations risk infrastructure, as noted above.
- A transfer of all operational risks to the RM Datix System
- The development of refreshed training materials and
- Updated internal governance for the oversight of risk

<u>Datix Risk Management System</u>

Implementation of the Datix Risk Management System is underway with four services currently actively using the system (Community Services Group, Allied Health Professionals and Health Sciences, Medicines Management and Infection Prevention and Control). Work over the last quarter has been focused on updating the system and ensuring it is aligned to the Health Board's Risk Management

Framework and will therefore integrate effectively into the Health Board's risk management approach.

With the system now broadly aligned to the Powys approach work is now underway, alongside the Once for Wales team to develop training and onboarding materials for services to use the system. The Organisational Risk Register will also be held on the Datix system and managed by the Corporate Governance team.

Wider service roll-out has been slower than initially hoped due to reduced capacity within the Corporate Governance Team but also pressures within the wider organisation. In order to be sensitive to the ongoing service pressures, services have been contacted to seek volunteers to onboard onto the system with the support of the Once for Wales team and four more services (Mental Health and Learning Disabilities, Primary Care, Complex Care and Estates, Capital and Support Services) are due to transfer into the system imminently. Throughout the remainder of 2025/26 the Corporate Governance Team will continue to work with services to onboard incrementally whilst remaining sensitive to the broader demands on services.

Training

As noted above, detailed training materials including demo videos are currently under development for the RM Datix system. More general risk management training on the Fundamentals of Risk Management and Risk Management in PTHB in also under development by the Corporate Governance Team and will be rolled out to the organisation in Q3/Q4 in the form of webinars and training videos available to all staff. This training will focus on:

Section 1: The Fundamentals of Risk Management

- Key principles of Risk Management
- What is a risk?
- Describing a risk
- Recording a risk
- Options for managing a risk
- Mitigations and Planned Actions
- Scoring
- Review

Section 2: Risk Management in PTHB

- The Risk Management Framework
- Risk infrastructure
- Escalation
- RM Datix System
- Reporting

Service/team/group specific management training will remain available on request.

Internal Governance

In May 2025 the Executive Committee approved a revised sub-group structure, which including the dissolution of the Risk and Assurance Group – the Group previously tasked with the oversight and escalation of operational risk and the integration of the RMF. The former Groups responsibilities in regard to the oversight and escalation of operational risk were transferred to the Operational Leadership Group (OLG) a newly developed sub-group constituted of Assistant and Deputy Directors and responsible for overseeing key cross-organisational issues on behalf of the Executive Committee. The OLG first met in May and meets monthly. The Executive Committee has tasked the OLG with the development of the ORR for Executive Committee approval and onwards reporting to the Board.

Alongside this, to support with the broader integration of the RMF across the organisation at all levels the Corporate Governance team is working with services to identify Risk Champions, in order to constitute a 'Risk Champions Forum' consisting of key support staff from across each Directorate responsible for the administration and integration of the risk management framework. This Forum is intended to provide a mechanism for shared learning, consistency with the Framework, and appropriate challenge and feedback.

BOARD ASSURANCE FRAMEWORK DEVELOPMENT

In May 2024 the Board approved a revised Board Assurance Framework (BAF), recognising that the BAF is a complex system comprising of a number of key systems including:

- Risk Management Framework
- Quality and Performance Framework; and
- The overall system of governance deployed by the Board and the Chief Executive in ensuring good governance within the organisation.

The update provided in this paper will focus on the Risk Management element of the BAF. Following approval of the RMF in March 2025, work was undertaken to develop a BAF Dashboard in support of the Health Board's SRR. Seeking/providing assurance that the actions deployed by the Board to manage/mitigate its key risks are adequate and effective, and presenting an opportunity to undertake further action where gaps or weaknesses are identified. The Committee received and provided scrutiny of the proposed BAF Dashboard templates at its meeting in July 2025 prior to the presentation of the fully developed BAF Dashboard, alongside the SRR to the Board on 30 July 2025. The Board Assurance Framework Dashboard, as received by the Board in July in included as Appendix B.

When under development it was suggested by members that it would be beneficial to have insight into the operation of the BAF Dashboard, and as such the Board Assurance Framework Analysis Principles document has been developed. This document demonstrates the mechanism and standards by which the information is analysed to produce the ratings and findings within the dashboard. This document will continue to be developed as the approach to the BAF continues to embed and mature.

Following development of the BAF Dashboard the focus into Q3 and Q4 will be the development and integration of a detailed Board Assurance Framework for each Strategic Risk. This is under active development with a template produced and work currently underway to develop the detail for SRR 001 – Financial Balance intially.

The detailed BAF will draw out:

- Key risk controls and whether they are proactive or reactive
- Gaps in control
- Control improvement actions
- Key sources of assurance against the controls mapped against the three lines
- Gaps in assurance
- A summary of the BAF Dashboard Assurance Ratings

It is suggested that the full detailed BAF will also be supported by single document action plan which will draw together the control improvement actions for each risk. The BAF detail will be reported to the Board twice per year (January and September) and will provide the Board with the opportunity to consider whether controls and assurance are effective, adequate and well balanced however also the opportunity to assess the level of gaps on control and assurance and whether they are comfortable with the level of control improvement actions or whether more or less should be done, thus providing a clear steer to the organisation. The BAF detail will be shared with the Audit, Risk and Assurance Committee in due course.

NEXT STEPS:

Work will continue to be undertaken by the Corporate Governance to develop, mature and integrate the organisation's approach to risk management and board assurance, and regular reporting will continue this and other appropriate meetings.

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

Strategic Risk Register

July 2025

STRATEGIC RISK DASHBOARD – JULY 2025

Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/×	Lead Board Committee	Link to Strategic Priorities:
EDoFC &E	SRR 001	**Financial Sustainability**	The Health Board is unable to achieve its duty to achieve financial breakeven (and therefore sustainability).	**4 x 5 = 20**	→	Cautious	×	Finance and Performance	Cross-cutting (All SPs and WBOs)
EDP&C	SRR 002	**Innovation and Strategic Change**	The Health Board is unable to successfully deliver and realise the benefits of transformation	**3 x 4 = 12**	*	Eager	×	Planning, Partnerships and Population Health Committee	Several SPs and WBOs 4 and 8
EDPP&C	SRR 003	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for commissioned services	**5 x 4 = 20**	→	Open	×	Patient Experience, Quality and Safety	SP 11 and WBO 8
EDPCCMH	SRR 004	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for provided services.	**4 x 4 = 16**	→	Open	×	Patient Experience, Quality and Safety	Several SPs and WBOs 4 and 8
EDPCCMH	SRR 005	**Performance and Service Sustainability**	Primary Care is unable to respond to demand.	**4 x 4 = 16**	↓	Open	×	Planning, Partnerships and Population Health Committee	Several SPs and WBOs 4 and 8
EDP&C	SRR 006	**Workforce**	The Health Board is unable to recruit and retain an appropriate workforce.	**4 x 4 = 16**	→	Cautious	×	People and Culture	Cross-cutting (All SPs and WBOs)

Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/×	Lead Board Committee	Link to Strategic Priorities:
EDoFC &E	SRR 007	**Quality**	The care provided in some areas is compromised due to the health board's estate being not fit for purpose.	**4 x 4 = 16**	➔	Minimal	×	Finance and Performance	SP 09 and WBOs 1 and 4
EDPH	SRR 008	**Innovation and Strategic Change**	The Health Board is unable to shift to a primary prevention focused health care system	**16**	✱	Eager	×	Planning, Partnerships and Population Health	SP 1 and WBO 1
EDPCCMH	SRR 009	**Performance and Service Sustainability**	The Health Board is unable to stabilise the growing implications of Continuing Health Care	**4 x 4 = 16**	✱	Open	×	Finance and Performance	SP 6 and WBO 4
EDPH	SRR 010	**Safety**	The Health Board is unable to respond in a timely, efficient, and effective way to a major incident, or critical incident	**4 x 4 = 16**	✱	Averse	×	Planning, Partnerships and Population Health	Cross-cutting (All SPs and WBOs)
EDAHPHS&D	SRR 011	**Performance and Service Sustainability**	Failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.	**3 x 5 = 15**	✱	Open	×	Audit, Risk and Assurance	Cross-cutting (All SPs and WBOs)
DCG	SRR 012	**Reputation and Public Confidence**	The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.	**3 x 5 = 15**	✱	Open	×	Finance and Performance	Cross-cutting (All SPs and WBOs)

KEY:

Executive Lead	
EDoFC&E	Executive Director of Finance, Capital and Estates
EDP&C	Executive Director of People and Culture
EDPP&C	Executive Director of Planning, Performance and Commissioning
EDPCCMH	Executive Director of Primary Care, Community and Mental Health
EDPH	Executive Director of Public Health
EDAHPHS&D	Executive Director of Allied Health Professionals, Health Sciences and Digital
DCG	Director of Corporate Governance/Board Secretary
CEO	Chief Executive
Trend	
*	**New risk**
→	**Risk score unchanged since last report**
↓	**Risk score decreased since last report**
↑	**Risk score increased since last report**

RISK HEAT MAP – JULY 2025

Almost certain 5				SRR 003 – Commissioning	
Likely 4				SRR 004 – Provider SRR 005 – Primary Care SRR 006 – Workforce SRR 007 – Estate SRR 009 – CHC SRR 010 – Emergency Response	SRR 001 – Financial Balance
Possible 3				SRR 002 – Transformation	SRR 011 – Digital SRR 012 – Public Confidence
Unlikely 2					
Rare 1					
LIKELIHOOD X IMPACT	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**

SRR 001	**There is a risk that:** The Health Board is unable to achieve its duty to achieve financial breakeven (and therefore sustainability).	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L4 x I5 = 20 Inherent: L4 x I5 = 20 Target: L2 x I4 = 8	**Risk Category:** Financial Sustainability **Boards Risk Appetite:** **Cautious**
Executive Lead: Executive Director of Finance, Capital and Support Services		**Assuring Committee:** Finance and Performance Committee
Latest review date: July 2025 **Added to register:** June 2024 **Link to Strategic Priorities and Wellbeing Objectives:** Cross-cutting risk relevant to all SPs and WBOs		**Cause/source of risk:** The Health Board reported a £15.8m deficit in 2024/25 It is forecasting a £28.3m deficit in 2025/26 Savings programme of £23.1m Underlying deficit of £42.1m **Risk materialising would result in:** Failure to achieve the statutory duty to breakeven

Controls (What has been implemented to manage the risk?)	**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**

7.1	Financial Plan approved by Board. Subsequent AO letters set out savings target of £23.1m.	Plan approved by Board	Reasonable	Board
7.2	Additional control - Introduced joint CEO and ED Finance only focussed meetings with each Exec Director individually.	Regular meetings and agreed action monitoring	Reasonable	Board
7.3	Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.	Plan Management	Reasonable	Board
7.4	Group established for Variable Pay, identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. Variable Pay, CHC and Commissioning regular deep dive areas of focus at F&P Committee to track actions to improve.	Reports to F&P Committee	Reasonable	Board
7.5	Investment Benefits Group- focus on benefits realisation of previous investments, including consideration of dis-investment.	Delivering VFM, improving efficiency and sustainability, report to Executive Committee	Reasonable	Board
7.6	Regular communication and reporting to Welsh Government and NHS Wales Performance and Improvement (Financial Planning and Delivery Directorate) regarding the impact of pressures on Financial Plan and underlying position.	Monthly Meetings and reporting in line with Escalation plan.	Reasonable	Board

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**

Executive Directors are focussed on delivery of £23.1m savings targeted for 2025/26.	DFC&SS	Reported regularly to Board and Exec Committee and D&P	Ongoing	Ongoing
Executive Team workshops focussed on actions to reduce expenditure in 2025/26.	DFC&SS	Workshops held w/c 7 July. Outcome to be reported to Board in July	Ongoing	Ongoing

Additional information:

Rationale for current score:

- The Plan includes a £23.1m savings target. This is not currently being achieved.
- The Health Board is experiencing greater cost pressures than its recurrent mitigating actions and additional funding can contain. This is leading to an increase in its underlying deficit. Assessed as £42.1m.
- The scale of this deficit against annual expenditure of circa £480m makes it probable that the organisation will not be able to comply with its statutory duty to breakeven for some time.

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 002	**There is a risk that:** The Health Board is unable to successfully deliver and realise the benefits of transformation	
Current Risk Score: **12**	**Risk rating detail:** (likelihood x impact) Current: 3 x 4 = 12 Inherent: 4 x 4 = 16 Target: 2 x 4 = 8	**Risk Category:** Innovation and Strategic Change **Boards Risk Appetite:** Eager
Executive Lead: Executive Director of People and Culture		**Assuring Committee:** Planning, Partnerships and Population Health
Latest review date: July 2025 **Added to register:** July 2025 **Link to Strategic Priorities and Wellbeing Objectives:** Cross-cutting risk relevant to all SPs and WBOs		**Risk cause/source:** • Insufficient capacity to deliver across the Better Together Portfolio • Insufficient cognition and capability to deliver the level of transformational change across the Better Together Portfolio • Lack of organisational and public readiness for change • Timescales are too challenging to deliver • Inability to invest in estate and infrastructure required to deliver level of transformational change across the Portfolio • Financial recovery plan FY25/26 impacts on ability to deliver the Better Together portfolio • Unable to access reliable data and/ or deliver digital transformation and infrastructure to support change • Misalignment with key dependencies both external and internal to the portfolio

		Risk materialising would result in: Will not deliver improved quality and sustainability of services or make better use of resource. Health Board will remain in escalated measures. Services remain fragile with significant variation / inconsistency in service provision creating inequity and gaps Unable to develop clinical services plan required as part of Level 4 de-escalation criteria. Commissioning spend continues to escalate. Unable to realise wider benefits of transformation in a timely manner Reputational damage		
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
2.1	Transformation programmes in place under the Better Together Portfolio, in line with PTHB Strategic Priorities, to provide the capacity to deliver the transformational deliverables required to support delivery of a balanced financial plan within 3-5 years.	• Transformation updates provided to Executive Committee • Portfolio Highlight report, Portfolio and Programme workbooks, minutes and assurance reports from the Better Together Portfolio including North Powys	Reasonable	Executive Committee

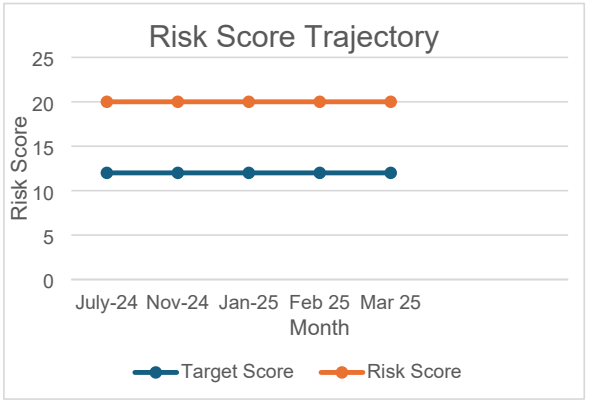
		Wellbeing Programme, Frailty & Community Model incorporating the Six Goals for Urgent & Emergency Care Programme, Planned Care & Diagnostics Programme, Mental Health Transformation Programme, Business Efficiencies Programme and Temporary Service Change Programme		
2.2	Better Together Portfolio Board established as a Sub—Group of the Executive Committee	• Regular reporting to the Executive Committee	Substantial	Executive Committee
2.3	Oversight of Better Together and Transformation integrated into Terms of Reference of F&P, P&C and PPPH Committees	• Regular reporting to Board Committees and onwards assurance provided to Board	Substantial	Multiple Board Committees
2.4	Better Together Phase 2 engagement programme has been developed and commenced including staff roadshows and workshops as well as several public events across Powys.	• Review and report on outcomes arising from engagement	Reasonable	Better Together Portfolio Board
2.5	Monthly informal Planning update meetings with WG including Better Together update	• Regular informal discussion with WG leads	Substantial	N/A
2.6	Wider stakeholder engagement plan in place with regular Primary Care, PCC, PAVO and Llais interface.	• Inputs and reporting from primary care workshops and meetings.	Reasonable	Better Together Portfolio Board

		• Inputs and outputs from wider stakeholder engagement meetings.		
2.7	Ongoing assessment of delivery capacity as portfolio plan develops. Monitored through Portfolio Board and reported to Executive Committee	• Portfolio Board reporting to Executive Committee	Reasonable	Better Together Portfolio Board

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Continued implementation of transformational programmes aligned to the PTHB Strategic Priorities to deliver agreed benefits and deliverables	DSI&T	This continues	Ongoing	On track
Implementation of Strategic Change deliverables to support achieving financial sustainability	DSI&T; Executive Director Programme Leads; Programme SROs	Approved Temporary Changes implemented for 6 month period and under evaluation.	July 2025	On track
Ongoing public, staff and stakeholder communication & engagement	DSI&T; Director of Corporate Governance	ODEC workstream established to oversee delivery of Comms & Engagement activity to support portfolio delivery Resource plan supported and in implementation.	Ongoing	On track
Map dependencies within portfolio and external to portfolio including strategic change being enacted on PTHB borders and assess impact and areas for close	DSI&T; Director of Planning, Performance & Commissioning	This continues	Ongoing	On track

monitoring				
Development of Estates Strategy	Associate Director of Capital, Estates & Property	Close working with Better Together programme to support strategy development	Ongoing	On track
Assess dependencies with digital work plan	DSI&T; Director of AHPs, Health Science and Digital	Dependencies and interdependencies under ongoing assessment	Ongoing	On track
Additional information:				
N/A				
Associated organisational risks (ORR):				
• Organisational Risk Register under development Q2 2025/26.				

SRR 003	There is a risk that the Health Board is unable to respond to the demand for commissioned services	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Planning, Performance & Commissioning		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: July 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:**		**Cause of risk and rationale for current score:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures • Planned care recovery continuing to accelerate in NHSE. • High volumes of patients waiting > 52 weeks and > 104 weeks in NHS Wales. Cabinet Secretary expectations to improve waiting times in NHS Wales. • The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality. **Risk materialising could result in:** • Poorer outcomes and experience for the citizens of Powys • Difficulty in balancing performance and financial plan

SP 11 and WBO 8				
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
7.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers. Low assurance currently due to robustness of referral data. Exploring alternative data sources (e.g. activity) whilst working through improved data set for GP referrals.	Limited	Executive Director
7.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Executive Director
7.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Executive Director
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	Executive Director

7.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the Finance and Performance Committee and Board as well as future planning	Various data sources including operational & performance data. Qualitative information from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections	Limited	Executive Director

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue regular meetings with commissioned service providers. ▪ Secure performance improvement trajectories from providers. ▪ Insourcing contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Quality and Performance Report. ▪ Continuing to work to obtain robust data for referrals from NHSW and NHSE GPs for Powys residents.	Executive Director of Planning, Performance and Commissioning (supported by DPCCMH)	Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand expected performance 2025/26 and to be reviewed and discussed through CQPRMs. Planned Care Insourced provision tender exercise delayed. Mitigating actions put in place to ensure continuity of service provision whilst tender exercise undertaken. Paper	April 2025 and ongoing	On track

		presented to Executive Committee for decision. Established Commissioning Oversight and Assurance Group (COAG), chaired by Exec DPPC, to provide a forum for internal oversight and escalation of performance monitoring of commissioned non-specialist services.		
▪ Cancer	MD (supported by DPPC)	Added to this version of the risk register. Actions to be agreed. Cancer Working Group chaired by Medical Director. CQPRMs and COAG cover all specialties with commissioned providers.	TBA	TBC
<u>Urgent and Emergency Care</u> ▪ CQPRMS cover all specialties with commissioned providers including UEC. ▪ Continued work on 6 Goals plan to reduce admissions and secure timely discharge.	DPPC (supported by DPCCMH)	CQPRMS and COAG cover all specialties including urgent and emergency care. Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient	April 2025 and ongoing	On track

Commented [NJ1]: Can we put anything in about revived cancer Working Group?

Commented [NJ2R1]: Also COAG will cover all specialities

▪ Strengthening arrangements for admissions to community beds in NHSE. ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee ▪ Secure performance improvement trajectories and improvement plans from providers.		experience, incidents and resultant investigations, clinical indicators. Several recent ICAP meetings have been cancelled. Regular attendance at CCLG and sub- committee structure. New governance structure being developed by the JCC with establishment of Ambulance Services and 111 Collaborative Commissioning Integration Group. Terms of Reference awaited. Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.		
<u>All indicators</u> There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	DPPC	Integrated Quality and Performance Framework (IQPF) has been reviewed and refreshed for 2025/26. As part of the IQPF, the Integrated Quality and Performance Report will continue to provide information across the NHS Wales Performance Framework	April 2025 and ongoing	On track

		measures including Cancer and 4 hour ED waits.		

Additional information:

Rationale for current score:

Planned Care

NHS Wales

- Latest validated position to month 1 (April 2025):

	Apr-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting	Stage 1 pathways over 52 weeks	
Welsh Providers	% of Powys residents < 26 weeks for treatment	All pathways waiting over 36 weeks.		All pathways waiting over 52 weeks.		All pathways waiting over 104 weeks.				
Aneurin Bevan Local Health Board	62.4%	708		398		7		2712	154	
Betsi Cadwaladr University Local Health Board	47.8%	285		172		33		689	89	
Cardiff & Vale University Local Health Board	43.7%	177		111		12		387	46	
Cwm Taf Morgannwg University Local Health Board	53.0%	327		189		3		920	91	
Hywel Dda Local Health Board	59.3%	449		238		7		1533	0	
Swansea Bay University Local Health Board	56.3%	610		317		0		1956	0	
Total	57.2%	**2556**		**1425**		**62**		**8197**	**380**	

- Swansea Bay UHB and Hywel Dda UHB continue to meet the stage 1 waits target reporting zero pathways over 52 weeks for Powys residents. However, the overall position in Wales increases in pathways over 52 weeks with Aneurin Bevan UHB and Cwm Taf Morgannwg UHB reporting special cause concern.
- Only Swansea Bay UHB remains compliant in April reporting no pathways over 104 weeks. All other providers bar Cardiff and Vale UHB continue to report special cause improvement. But the overall number increases from 41 in March to 62 in April 2025.

Challenges

• NHS Wales Planning and Performance Frameworks 2025/26:
  ○ No patients waiting over 104 weeks for referral to treatment.
  ○ No patients waiting over 52 weeks for new outpatient appointment.
  ○ No patients waiting over 8 weeks for specified diagnostics.
• Welsh acute care providers continue to experience ongoing challenges due to increased demand and service sustainability issues.
• Powys residents who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents living in southwest health economy wait the longest.
• Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.

Actions & Mitigations
• Welsh including Powys provider services, have mobilised additional capacity including insourcing, outsourcing, increase usage of additional payments for clinical activity. • Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider. • Continued to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted. • PTHB developed productive pathways for planned care with actions including referral management, effective clinically led pathways, implementation of GIRFT recommendations, theatre utilisation improvement. • All Welsh providers have been formally contacted to request confirmation of when those patients waiting > 104 weeks will be seen.

NHS England

- Latest validated position month 12 (March 2025):

	Mar-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting
English Providers	% of Powys residents < 26 weeks for treatment	All pathways waiting over 36 weeks.		All pathways waiting over 52 weeks.		All pathways waiting over 104 weeks.		
English Other	69.4%	41		6		0		252
The Robert Jones and Agnes Hunt Orthopaedic Hospital	52.0%	1307	H	660	H	40	H	3755
The Shrewsbury and Telford Hospital NHS Trust	60.2%	1316	H	371	H	0		4815
Wye Valley NHS Trust	70.1%	571	L	113	L	0		3430
Total	59.7%	**3235**	H	**1150**	H	**40**	H	**12252**

- Powys residents in England have consistently waited less time for treatment except for Robert Jones & Agnes Orthopaedic Hospital NHS Foundation Trust (RJAH), all wait bands are reporting special cause concern at an aggregated level.
- **Wye Valley NHS Trust (WVT)** reports the best performance of all Powys commissioned providers with 70.1% of pathways waiting under 26 weeks for treatment, 113 wait over 52 and of these 4 pathways wait between 77 and 104 weeks for Ophthalmology and respiratory medicine. WVT is the only English provider to consistently report special cause improvement for all key wait bands.
- **The Shrewsbury & Telford Hospital NHS Trust (SATH)** reports a more challenged position with all key wait bands reporting special cause concern e.g., the total numbers of waiters in these bands is increasing. The key challenged specialties for long waiting pathways in SATH are Ophthalmology and Oral Surgery which make up 24 of the total 27 pathways between 77 and 104 weeks.
- **The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)** remains the most challenged English provider for long waits the SPC chart (right) shows a growing trend of very long waiters and with all key wait bands are reporting special cause concern. Historically RJAH has always been challenged by complex spinal pathways but in March of the 40 total breaches 16 are for Knee & Sports Injuries, 12 are complex spinal, 10 reported for Arthroplasty pathways, and 2 in upper/lower limb. The longest wait for a complex spinal pathway awaiting specialist unit was reported by the provider at 307 weeks.

Challenges

- English acute care providers continue to experience ongoing challenges due to increased demand and service sustainability issues.
- Powys residents who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents living in southwest health economy wait the longest.
- Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.
- NHS England 2024/25 priorities:
    - Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
    - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- SATH reviewed and updated their patient administration system during Q1 2024/25, this has unfortunately been challenged with system problems and waiting list including outpatient and inpatient data disrupted, the health board are awaiting confirmation on the resolution of this challenge.

Actions & Mitigations

- English providers have mobilised additional capacity including insourcing, outsourcing, increase usage of additional payments for clinical activity.
- Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider.
- Continued to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted.
- PTHB developed productive pathways for planned care with actions including referral management, effective clinically led pathways, implementation of GIRFT recommendations, theatre utilisation improvement.

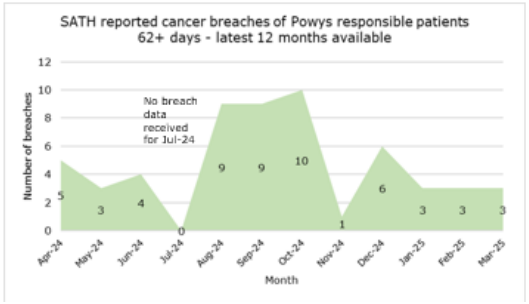
- Work ongoing with NHSE providers, primarily RJAH, SaTH and WVT, re PTHB Commissioning Intentions 2025/26, commissioning to NHS Wales treatment targets.

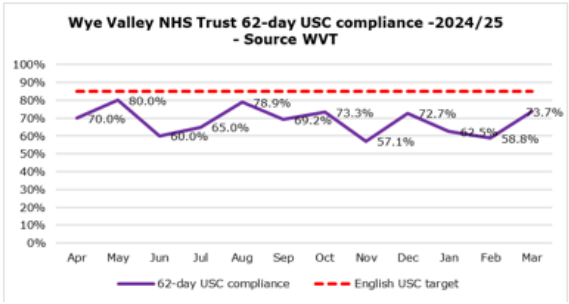
Cancer

- Cancer performance remains poor against the 62 day targets in both English and Welsh commissioned services.

Welsh Provider Cancer Performance Per SCP 62 Day Target - Last 12 Months

HealthBoard	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03	2025-04
Aneurin Bevan UHB												
Pathways With Treatment	10	11	18	16	11	9	13	16	15	16	16	8
Treated Within 62 Days	5	9	10	10	7	8	7	9	11	9	11	4
Breaching 62 Day Target	5	2	8	6	4	1	6	7	4	7	5	4
% Treated Within Target	50%	82%	56%	63%	64%	89%	54%	56%	73%	56%	69%	50%
Betsi Cadwaladr UHB												
Pathways With Treatment			4	1	1	1	3	2		1		3
Treated Within 62 Days						1	3	2				2
Breaching 62 Day Target			4	1	1					1		1
% Treated Within Target			0%	0%	0%	100%	100%	100%		0%		67%
Cardiff And Vale UHB												
Pathways With Treatment				1				1	1			
Treated Within 62 Days				1					1			
Breaching 62 Day Target								1				
% Treated Within Target				100%				0%	100%			
Cwm Taf Morgannwg UHB												
Pathways With Treatment	4	3	4	7	6	5	3	9	4	3	5	3
Treated Within 62 Days	1	1	1	4	2	4		4	1	1	1	
Breaching 62 Day Target	3	2	3	3	4	1	3	5	3	2	4	3
% Treated Within Target	25%	33%	25%	57%	33%	80%	0%	44%	25%	33%	20%	0%
Hywel Dda UHB												
Pathways With Treatment	8	8	8	8	8	5	7	7	9	7	6	9
Treated Within 62 Days	3	5	6	6	5	2	6	2	6	5	3	4
Breaching 62 Day Target	5	3	2	2	3	3	1	5	3	2	3	5
% Treated Within Target	38%	63%	75%	75%	63%	40%	86%	29%	67%	71%	50%	44%
Swansea Bay UHB												
Pathways With Treatment	7	11	10	14	7	11	9	11	11	4	7	6
Treated Within 62 Days	6	5	8	8	5	7	5	8	6	1	5	
Breaching 62 Day Target	1	6	2	6	2	4	4	3	5	3	2	6
% Treated Within Target	86%	45%	80%	57%	71%	64%	56%	73%	55%	25%	71%	0%
Pathways With Treatment	**29**	**33**	**44**	**47**	**33**	**31**	**35**	**46**	**40**	**31**	**34**	**29**
Treated Within 62 Days	**15**	**20**	**25**	**29**	**19**	**22**	**21**	**25**	**25**	**16**	**20**	**10**
Breaching 62 Day Target	**14**	**13**	**19**	**18**	**14**	**9**	**14**	**21**	**15**	**15**	**14**	**19**
% Treated Within Target	**52%**	**61%**	**57%**	**62%**	**58%**	**71%**	**60%**	**54%**	**63%**	**52%**	**59%**	**34%**





Powys key provider provisional cancer waiting times standards NHS England - All patients e.g., including non-Powys residents (table 1)

Mar-25	SATH	WVT	All English Providers	Target
28-day FDS	62.5%	76.9%	78.9%	75%
31-day DTT	96.6%	91.1%	91.4%	96%
62-day USC	66.6%	69.3%	71.4%	85%

Urgent and Emergency Care (latest position April 2025)

Welsh Emergency Access (A&E) providers

- Powys residents have seen a slight increase to 66.3% for those waiting under 4 hrs in Welsh units.
- Number of patients reported waiting over 12 hrs was 124 for April 2025

English Emergency Access (A&E) providers

- It should be noted that the English information is not complete, Shrewsbury and Telford NHS Trust data has not been available consistently from Q1 2024/25.
- PTHB residents attending English emergency units see the longest wait with 47.4% reported in March as waiting less than 4hrs in their units.
- Of the reported health board 140 patients were reported waiting over 12hrs (predominately Wye Valley NHS Trust).

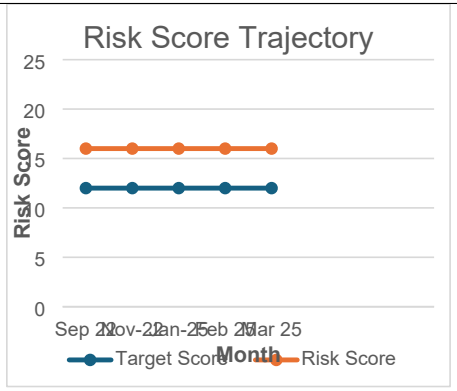
Data Quality

- Information on emergency department waits can be delayed especially from English providers, this results in retrospective updates of performance which will be noticeable between reporting month although minor.

Update including impact of actions to date on current risk score:

Improved performance experienced within NHS England commissioned service providers; expected improvement in NHS Wales expected following issue of additional planned care monies in 2025/26, and national procurement process for outpatients and treatments. Continued inequity of access for PTHB residents accessing NHSW services in comparison with NHSE.
Associated organisational risks (ORR):
• Organisational Risk Register under development Q2 2025/26.

SRR 004	**There is a risk that the Health Board is unable to respond to the demand for provided services**

Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Primary Care, Community and Mental Health (PCCMH)		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: July 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:** Several SPs and WBO 4 and 8	 **No change to risk score although additional control and migration added.**	**Cause of risk:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures. **Risk materialising would result in:** • Poorer outcomes and experience for the citizens of Powys • Increased system pressure across urgent and emergency care pathways. • Reduced efficiency in patient flow and bed utilisation • Inability to meet national performance targets and ministerial priorities.

Controls (What has been implemented to manage the risk?)	**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**

7.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services. Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer. Maximising insourcing offer to ensure optimal performance standards are achieved. Implement as many Optimisation frameworks and 5 Goals for Planned Care as appropriate for a community-based provider	• Referral data into services from commissioning data sets and supplementary reports received from commissioned providers Best practice guidance from GIRFT and Welsh Government / NHS Exec	Reasonable	Finance & Performance
7.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Finance & Performance
7.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Finance & Performance
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Reasonable	Finance & Performance
7.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to the reliance on agency staff (particularly higher cost agency providers) and deliver expected cessation.	Various workforce and financial reports recording agency usage at ward and service level	Reasonable	Finance & Performance
7.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections	Reasonable	Finance & Performance

7.7	Development and implementation of integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and the expansion of Powys DigiFLO—to enhance system resilience and operational efficiency. This control supports delivery of the PTHB Six Goals for Urgent and Emergency Care, contributes to the NHS Wales People's Experience Framework, and enables a shift toward a prevention-based, value-driven model of care.	Task & Finish Group reports, baseline assessment against National SPoA Framework, operational data (Package of Care Delays, PoCD), pilot evaluations and implementation monitoring reports	Reasonable	Finance & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue series of regular meetings with service providers ▪ Monitor and manage delivery against performance improvement trajectories for our own services. ▪ Medinet contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed.	September 2026	On track

<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. ▪ A number of service reviews are being undertaken with several 'cases for change' having been approved by the Health Board and stakeholders.	Executive Director PCCMH	The first two cases for change were approved by the Board in October 2024, with overall case for change now available for second phase engagement.	September 2025	On track
There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	Executive Director PCCMH	A number of sub-indicator performance targets have been identified. These have been built into the IQPR and actions in train to further reduce risk	December 2025	On track
Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to mitigate delays, improve patient flow, and support timely discharge across the system.	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for September 2025. PoCD: Daily tracking and escalation in place; delays reduced by 6%. Daily 'huddle' to review patients in place. DigiFlo: Implemented on community hospital wards, expansion into MH has been scoped with rollout expected in Q2.	March 2026	On Track

		Trusted Assessment: Pilot completed in collaboration with PCC with early findings indicating positive impact.		

Additional information:

Rationale for current score:

Planned Care

- NHS Wales Ministerial standards
- Whilst services generally perform well against access targets, the fragility of some of the in-reach SLAs creates inherent operational risk to delivery.

Inpatient Beds

- At present capacity is part staffed by continued reliance upon agency staff. This is not a sustainable or affordable model.
- On any given day, over 40% of our beds can be occupied by patients that are clinically optimised and ready for discharge. They are delayed due to a lack of capacity in onward parts of the pathway. Elongated lengths of stay can have a detrimental impact to the long term needs for patients, and an increase to overall rehabilitation needs

Primary Care

- There are some recruitment challenges for staffing in primary care.
- Dental access and capacity required does not currently meet demand.

Minor Injury Units

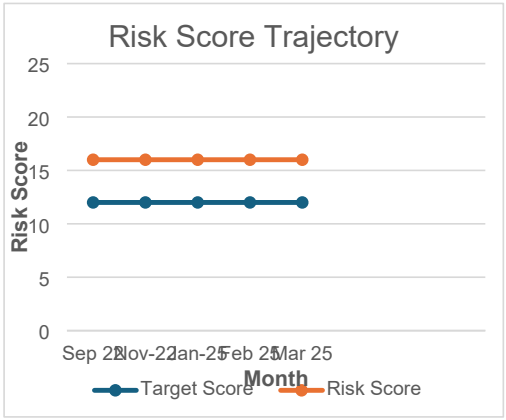
- Powys MIUs continue to performance well, in May (latest validated available) reported 100% compliance against 4 hour target and no patients waiting longer than 12 hours.

Mental Health

Elements of the service are currently in internal performance and scrutiny escalation

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 005	There is a risk that Primary Care is unable to respond to demand	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Primary Care, Community and Mental Health		**Assuring Committee:** Planning, Partnerships and Population Health Committee
Latest review date: July 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:** SP 4 and WBO 8		**Drivers/causes of risk:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures **Risk materialising would result in:** • Related workforce challenges may lead to services becoming unsustainable

Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1	Monitoring and liaison with GP practices to offer support including weekly review of the escalation tool, reviewing the sustainability matrix, and considering sustainability funding applications. Regular discussions with Cluster Lead and LMC regarding ongoing demands and additional actions to manage peaks. Additional national and local investment into GMS for 24/25. National 25/26 negotiations about to commence. Sustainability Assessment Panels being held following practice application submission. Targets discussions and action plans in place with specific practices. Implementing a local sustainability framework to consider supporting practices who do not meet the National Sustainability Assessment Framework criteria.	• Escalation Tool • Sustainability matrix score • National Sustainability Assessment Framework	Reasonable	Executive Committee
7.2	National Contract Assurance Framework embedded to support contract assurance. 23/24 CAF cycle completed, with a mixture of targeted Practice visits and action plans. Outstanding actions being picked up as part of the 24/25 review process	• Contract Assurance Framework • Annual Return • Supplementary Service Audits • Prescribing Data • Practice Declarations • GP Clinical Governance Self-Assessment Tool	Reasonable	Executive Committee / Finance & Performance

	24/25 evidence reviews commenced, including a comparison of clinical indicators across the 2 years for consistency/improvement assurance GMS Contracts Management Group meeting in mid July to confirm practice action plan requirements or targeted practice visits required as part of the 24/25 cycle.	• Information Governance Toolkit		
7.3	Implementation and maturity of Accelerated Cluster Development Programme and associated cluster projects of local pathways will support practice sustainability. Cluster IMTP plans agreed by RPB Executive Group – 09/01/25	Cluster Plan progress reported to RPB Executive Group	Reasonable	Executive Committee / Finance & Performance
7.4	OOH APMS contract is in place with Shropdoc from 01/04/25 to 05/01/26 (including extensions). The future long-term viability of Shropdoc continues to be a high-risk concern for PTHB. The long-term company viability review is currently under review by the Health Board. This is not having an impact on current service delivery, however, is an ongoing risk for PTHB. Resolve and secure current commissioning arrangements with SBUHB for 25/26 to ensure ongoing provision of OOH cover for Ystradgynlais patients and Ystradgynlais Community Hospital. Meeting dates being arranged/	• Weekly Rota (triage & base cover) • Monthly achievement against OOH Performance Standards • Quarterly Performance Review Commissioning Assurance Framework	Limited	Executive Committee / Finance & Performance

	Quarterly Performance Reviews continue to monitor out of hours services.			
7.5	Allocating patients from the Dental Access Portal is in place. DAP is fluid with regular 'on and offs' Patient urgent access demand has sufficient capacity in the system to address patient need and this is monitored very closely on a weekly basis. Urgent access pathways in place in all contract reform practices, further supported by the Community Dental Service pathway when needed. Mobile Dental provision, salaried PTHB service working well. Pathways in place to support patients following completion of course of treatment. Current location is Bronllys and from September onwards Gwynyfed High School. Non-Recurrent investment added to contracts in areas of need (geographical and service need) securing increased access provision.	• Dental Access Portal • Contract Reform new patient and historic patient metrics. • GDS monitoring Group	Limited	Executive Committee / Finance & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
To complete GP Practice visits following outcome of Desktop Reviews. These will take place in Q4	Assistant Director Primary Care (ADPC)	Desk top reviews to commence in July	October 2025	On track
Review and assess completion of General Practice Improvement Plans	ADPC	Not yet commenced - linked to desktop reviews above.	March 26	On track
To undertake GDS End of year review visits with all contract holders	ADPC	Arranged for July/August 25. Includes 3 face to face visits	August 25	On track

Undertake GDS Mid-Year Review visits	ADPC	Will be undertaken in October/November 2025	November 25	On track
Review of GMS sustainability matrix	ADPC	To be undertaken in Q2	November 25	On track
Relocate mobile dental clinic to Gwernyfed High School	Associate Dental Director/ADPC	Agreed implementation plan in place with the school	October 25	On track
Offer additional non recurrent GDS access opportunities across Powys	ADPC	3 non-recurrent ortho contracts being progressed. Also Clifton Dental Practice non recurrent CVN agreed	September 25	On track
Procure additional recurrent GDS access opportunities across Powys	ADPC	Crickhowell contract currently out to tender	April 25	On track
Assessment of delivery model of current GMS OOH service provision and future procurement options	Executive Director of Primary Care, Community and Mental Health (EDPCCMH/ADPC	GMS out of hours review and future model appraisal group with multiple stakeholder representation set up, to consider various options for the future OOH GMS service delivery and model across Powys. This will be presented to September Board for approval	September 25	On track
Complete Procurement for future provision of GMS OOH services	EDPCCMH/ADPC	Will commence following Board approval in September to proceed.	March 26	On track
Ensure future provision of general medical services for patients registered	EDPCCMH/ADPC	Procurement process being worked through with 2 bidders	July 2025	On track

at Rhayader Medical Practice post 30th September 2025		for Board approval of selected bidder (July Board)		

Additional information:

Rationale for current score:

- Current Shropdoc OOH contract due to end 30/06/25
- Sustainability assessment and escalation tool of GP Practices identifying consistently high-risk practices across Powys. Practices may not be able to provide sustainable GMS services. Approx. 50% of GP Practices reporting level 3/level 4 currently confirming the ongoing pressure. Appointment/contact activity data confirms continued high patient demand.
- Practice Sustainability support in place for Llanfyllin
- Practice Sustainability applications for support being prepared for Llanidloes and Knighton.
- Termination of Rhayader Medical Practice contract, effective from September 2025.
- Financial sustainability of practices may influence the termination of Local Supplementary Services
- Dental access continues to be challenging in areas with recruitment and workforce challenges. Mid cluster particularly affected currently.
- DAP waiting list currently at 3,710 patients on the waiting list.
- Orthodontic demand continues to exceed capacity across Powys.
- New Optometry Regulations and implementation of WGOS4 challenging due to complex secondary care pathways and implementation is further compromised by appropriately trained workforce.

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 006	There is a risk that the Health Board is unable to recruit and retain an appropriate workforce	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8	**Risk Category:** Workforce **Boards Risk Appetite:** **Cautious**
Executive Lead: Executive Director People & Culture		**Assuring Committee:** People & Culture Committee
Latest review date: July 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:** Cross-cutting risk relevant to all SPs and WBOs		**Drivers/causes of risk:** • Demographics of the workforce and within our communities leading to challenging labour market. • No university within the Powys footprint to provide regular supply of newly qualifying clinicians. • Rurality and commutability of sites. **Risk materialising would result in:** • Higher agency costs associate with variable pay spend • Inability to sustain high quality services and patient safety

Controls (What are we currently doing about the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
6.1	Safecare has been implemented to support and monitor safe staffing levels on wards.	Briefing at daily huddle between Community Service Managers and TSU.	Reasonable	Assistant Directors
6.2	A programmed schedule of staffing huddle meetings take place during the week between the TSU and services to plan and review rosters for the week ahead and prioritise areas requiring additional staffing.	Routine schedule published to include all relevant staff. It is managed by the resourcing team with a rota in place of TSU staff to attend.	Reasonable	Assistant Directors
6.3	A Variable Pay Group has been established and meets twice monthly. A range of performance measures have been developed to monitor variable pay levels.	Minutes and papers from meetings. Escalation of current vacancies within areas of high variable pay spend. Adult and MH Ward managers have been engaged to fully understand and agree existing vacancies and encouraged to actively advertise vacant posts. Wider vacancy 'deep dive' investigation completed and presented to variable pay group.	Reasonable	Deputy CEO
6.4	Workforce projections have been developed for all clinical staff groups with a detailed focus on Nursing (both Registered and HCSWs) across Adult Wards and Community teams and Mental Health Wards and Community Teams, projecting future staffing levels	Workforce performance reports produced routinely and shared appropriately.	Substantial	Lead Executive Directors

	against known recruitment pipelines, such as Grow our own and international recruitment.	Deep Dive Reports developed annually, or as required.		
6.5	Regular reporting of 'Time to Hire' and recruitment KPI's included within Workforce Performance Reports.	Workforce performance reports produced routinely and shared appropriately.	Substantial	Workforce & Culture Committee
6.6	Monthly vacancy reporting in place identifying vacant posts against the financial ledger.	Workforce performance reports produced routinely and shared appropriately.	Substantial	Workforce & Culture Committee
6.7	Workforce planning training delivered and an ongoing offer available.	38 staff have completed the training to date with MH, W&C, Digital and Corporate nursing receiving a 1-hour overview session.	Reasonable	Deputy Director People & Culture
6.8	Intranet page with information on Workforce Planning set up for managers.	SharePoint site: Workforce Planning (sharepoint.com)	Substantial	N/A
6.9	Wage stream available for Bank staff.	System in place and usage report included within the Workforce Performance Report. Programme recently re-publicised across ward areas, and reminded staff of availability of the service.	Substantial	Executive Committee

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**
Workforce Planning: Roll out the organisationally agreed workforce planning model by delivering	tbc	Ongoing support available to service leads in the development of workforce plans.	November 2025	On track

training which supports services to develop their resource plans.		HEIW funded role currently advertised – Workforce Planning Manager, to operationally support service areas in the development of workforce plans.		
Candidate Journey application to induction Review the end-to-end candidate journey from application to induction, identifying changes or omissions within the current process that are required to improve the candidate journey. To be extended to include local KPIs for recruitment to the Bank.	tbc	Heavily involved with All-Wales recruitment modernisation group, applying any learning to improve PTHB processes. End to End journey being reviewed to identify opportunities. No activity from NWSSP over this period. Recruitment Modernisation group, renamed as Recruitment Improvement and first meeting held in June 25. End-to-end review of Bank recruitment complete with changes immediately implemented. Weekly monitoring and escalation process in place.	31/09/2025	On Track
Increase bank supply: Targeted Recruitment Open days taking place at all Hospitals and will continue throughout the year.	tbc	5 Open Days held over June and July 2024 across Powys with multiple members recruited to the bank at each event. A further 5 held in	Ongoing	On Track

Rolling adverts and targeted Bank adverts for Registered Nurses and HCSW posts.		August and September 2024. Work continues to onboard the applicants successfully. Further targeted bank recruitment Open Days planned for Q4 2024-25. Specialist Bank Mental Health services Open Day held in February, with successful interviews held on the day. Rolling adverts out each week and shortlisting against applicants each Friday, alternating between RNs, HCSWs and both General and Mental Health fields.		
International Recruitment Continue international nurse recruitment to a target of 18 Adult nurses and 6 Mental Health Nurses	tbc	18 international nurse offers have been made, first cohort of 6 arrived in Newtown in August 2024, have now all passed their OSCE exam and have their NMC PINs. A further 6 arrived into Machynlleth on 20 November and are under-going their OSCE training. Final FY 24/25 General Nurse cohort of 6 staff arrived into Bronllys on 3 Feb, and will work across both Brecon	Ongoing	On Track

		hospital wards. In addition, 6 RMNs are expected in country by end of Q4. 24/25 International recruitment plan complete, totalling 18 Adult RNs and 6 RMNs, who have all now passed their OSCE exam. 25/26 International recruitment programme commenced, and 4 Adult RNs arrived in country in June 25, a further 4 Adult RNs due Oct/Nov 25. Paused RMN International recruitment pending student streamlining processes.		

Additional information:

Rationale for current score:

- The risk has been fully reviewed and assessed as a new risk in July 2024.
- As of 31st May 2025, the Health Board contracted vs budgeted establishment showed a vacancy rate of 13.87%. After the use of overtime, additional hours, agency, and Bank this fell to 7.65%.
- The challenges in recruitment are more pronounced in clinical roles with vacancies running at 17.70% for registered Nursing and Midwifery, 17.10% for Healthcare Scientists, 16.24% for Allied Health Professionals, 15.96% for Additional Clinical Services 14.62% for Medical and Dental and 10.02% for Add Prof Scientific & Technic.
- To support safe staffing levels there continues to be a need for reliance on agency staffing with the following WTE agency staff deployed in May 2025 from information held on the Health Roster/TSU systems:

- Additional Clinical Services: 25.01 WTE
- Nursing & Midwifery Registered: 22.65 WTE
- Allied Health Professionals: 7.84 WTE

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 007	There is a risk that the care provided in some areas is compromised due to the health board's estate being not fit for purpose.	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8	**Risk Category:** Quality **Boards Risk Appetite:** **Minimal**
Executive Lead: Executive Director of Finance, Capital, and Support Services		**Assuring Committee:** Finance and Performance Committee
Latest review date: July 2025 **Added to register:** January 2017 **Link to Strategic Priorities and Wellbeing Objectives:** SP 9 and WBOs 1 and 4		**Drivers/causes of risk:** **Estates Compliance**: (Risk Driver: Ageing Infrastructure, Underinvestment, Compliance Demands) • Powys has the oldest estate in NHS Wales with 38% of the estate infrastructure was built pre-1948, and only 5% post-2005, leading to higher maintenance needs and outdated systems. • Years of underinvestment have compounded deterioration and compliance risks across key areas (fire safety, water hygiene, electrical systems, medical gases, ventilation, etc.). • Backlog Maintenance stands at approximately £70M, significantly exceeding available budgets. • Revenue pressures due to rising energy costs and mandated cost savings are limiting the ability to invest in maintenance or modernisation. • Internal Audit (March 2024) issued a 'Limited Assurance' report citing the critical condition of the

		estate and shortfall in funding to address backlog and support future transformation plans. • Powys has the oldest estate in NHS Wales, compounding these issues. **Capital**: (Risk Driver: National Funding Constraints, Affordability, Prioritisation Pressures) • NHS Wales faces significant capital funding constraints which has seen the introduction of a new Capital Business Case Prioritisation Process from April 2024. This process will re-assess all current and planned projects against criteria for benefits and affordability, potentially impacting the PTHB capital programme / transformation agenda. • NWSSP-SSU audit (February 2024) reported a Limited Assurance rating, identifying a shortfall in WG Capital against backlog maintenance across the NHS estate. • Affordability challenges due to high overheads for contractors operating in rural areas like Powys are impacting the viability and attractiveness of capital schemes. **Environment & Sustainability**: (Risk Driver: Policy Ambition vs. Resource Gap) • The NHS Wales Decarbonisation Strategic Delivery Plan (2021) sets out ambitious targets to reduce carbon emissions. However, delivery capacity is limited due to limited funding/resource allocation. • The aging estate infrastructure is not well-suited to low-carbon adaptations without significant retrofit investment (Re:fit), further widening the gap between policy ambition and practical delivery.

		Risk materialising would result in: • Inability to sustain high quality services • Adverse impact on achievement of WBO 1 & 4 • Increased likelihood of infrastructure failure, non-compliance with statutory regulations, potential harm to patients and staff, and inability to deliver safe, modern healthcare services. • Escalating backlog costs may also lead to reputational damage and regulatory scrutiny. • Delayed or cancelled capital projects, inability to modernise or expand services, and failure to address critical infrastructure needs. • Possible impact on transformation goals, reduce service quality, and compromise long-term estate sustainability. • Failure to meet decarbonisation targets, missed national sustainability commitments, and rising operational costs due to inefficiencies. Also leading to reputational harm and reduced eligibility for future Environment and Sustainability funding streams.		
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
	ESTATES			
9.1	Specialist sub-groups for each compliance discipline	Structured meetings, risk-based approach, clear escalations lines	Reasonable	Estates Compliance Group
9.2	Risk-based improvement plans introduced	Highlight reports identifying and tracking risk mitigations, clear escalation lines	Reasonable	Estates Compliance Group

9.3	Specialist leads identified for key compliance areas	Authorised Persons independently appointed by NWSSP-SES	Reasonable	Estates Compliance Group
9.4	Estates Compliance Group and Capital Control Group established	Minutes, papers & work plans from meetings	Reasonable	Innovative Environments Group
9.5	Medical Gases Governance Group; Fire Safety Group; Water Safety Group; Electrical Safety Group; Asbestos Safety Group; Ventilation Safety Group convened with cross organisation & NWSSP-SES membership.	• Minutes and papers from meetings • Audits undertaken by NWSSP	Reasonable	Estates Compliance Group, Health & Safety Committee
9.6	Capital Programme developed for Compliance and approved capital programme	• Paper to Executive level meeting	Substantial	Delivery & Performance
9.7	Capital and Estates set as a specific organisational priority in the Health Board's Annual Plan	• Annual Plan	Substantial	Board
9.8	Address (on an ongoing basis) maintenance and compliance issues	• Compliance Highlight Reports, Audit plans, notes and papers from meetings	Reasonable	Delivery & Performance Group
9.9	Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards	• Compliance Highlight Reports, Audit plans, notes and papers from meetings	Reasonable	Delivery & Performance Group
9.10	30+ Specialist Maintenance Contracts in place to ensure appropriate specialist service provision over 3-5 year contract periods	• Contracts let via NWSSP-Procurement and contain Key Performance Indicator regime	Reasonable	Estates Compliance Group
	CAPITAL			

9.11	Capital Procedures for project activity	• Capital Procedures CP/D/1.00 document • Annual Capital Systems Audit reports from NWSSP	Reasonable	Innovative Environments Group
9.12	Routine oversight / meetings with NWSSP Procurement	• Notes from meetings • Annual Procurement Report	Substantial	Innovative Environments Group / Finance & Performance
9.13	Specialist advice, support and audit from NWSSP Specialist Estates Services / Authorising Engineers	• Notes from meetings • Designated Director role	Substantial	Innovative Environments Group
9.14	Audit reviews by NWSSP Audit and Assurance	• Audit reports and Action Plans	Reasonable	Audit and Assurance Group
9.15	Close liaison with Welsh Government, Capital Function	• Regular Capital Review Meetings. Notes and papers from meetings	Substantial	Innovative Environments Group
9.16	Reporting routinely to Finance & Performance Committee	• Notes and papers from meetings	Reasonable	Finance & Performance Committee
9.17	Capital Programme developed and approved	• Paper to Executive level meeting	Substantial	Delivery & Performance / Board
9.18	Detailed Strategic, Outline and Full Business Cases defining risk	• BJC, SOC, OBC, FBC documents / governance	Substantial	Executive Committee / Board
9.19	Capital and Estates set as a specific Organisational Priority	• Annual Plan	Substantial	Board

9.20	Capital projects developed for consideration for Welsh Government slippage in order to take advantage of any available funding	Capital proposals sheets Project sheets • SBARs	Substantial	Capital Control Group /Innovative Environments Group
	ENVIRONMENT			
9.21	ISO 14001 accreditation	SGS external body certification	Substantial	Finance & Performance
9.22	Environment & Sustainability Group	Notes and papers from meetings	Reasonable	Innovative Environmental Group
9.23	NWSSP-Specialist Estates Services (Environment) support and oversight	Meetings with Director NWSSP-SES	Reasonable	Innovative Environments Group
9.24	Welsh Government support and advice to identify and fund decarbonisation project initiatives	Presence on WG groups such as Community of Experts, etc.	Reasonable	Innovative Environments Group
9.25	Welsh Government Energy Service / Re:fit energy programme of works underway. Investment Grade Proposal (IGP) published to illustrate invest to save projects	WG Salix Framework arrangement	Substantial	Innovative Environments Group

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Implement the in-year Capital Programme and develop the long-term capital programme which is responsive to changes in funding availability and funding sources.	Associate Director for Capital, Estates and Facilities	Fluid nature of NHS All Wales Capital allocations and current WG/NHS funding challenges make future capital investment uncertain. All-Wales NHS Capital	In line with Annual Plan for 2025-26	On Track

		Prioritisation Review has 3 key schemes on 'green' list. Pressure on programme to divert capital to Transformation activity at short notice.		
Continue to seek Welsh Government capital funding to underpin investment to improve the estate / support Transformation.	Associate Director for Capital, Estates and Facilities	Consider alternative funding opportunities such as RPB IRCF, Targeted Estates Funding, etc. and have schemes 'on the shelf' in anticipation of Welsh Government 'end of year' capital slippage.	In line with Annual Plan for 2025-26	On Track
Deliver energy savings and decarbonisation benefits	Associate Director for Capital, Estates and Facilities	£4.2M Re:fit energy efficiency project works will complete in Q2	In line with Annual Plan for 2025-26	On Track
Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address establishment staff numbers in Works Team and recruitment challenges. Resource review undertaken by IEG in 2023 with proposal limited by financial position.	Associate Director for Capital, Estates and Facilities	Due to financial challenges within the Health Board, this item is on hold.	TBC	At risk
Additional information:				

Update including impact of actions to date on current risk score:
Estates: Estates compliance – team continues to support core statutory compliance and limited Reactive job requests using risk-based approach due to age of estate. Workforce challenges for recruitment and staff resource establishment level being reviewed at Innovative Environments Group. Organisational recruitment freeze ongoing.
Fire: Work to improve operational fire structure has been positive, but significant infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented but are dependent on capital funding.
Property: significant pressure on space with expanding staff numbers alongside implementation of new agile working approach. Rationalisation of space of health board and other public sector bodies underway. International Recruitment has introduced significant extra workload, which is affecting output of core activity. Better Together may have significant impact.
Finance: significant cost pressures related to energy and inflation are acting to increase pressure on Estates Revenue and Capital projects outturn costs and material / Supplier availability. Estates related pressure on revenue due to reactive failures of key building fabric and infrastructure.

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 008	**There is a risk that:** The Health Board is unable to shift to a primary prevention focused health care system	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L x I = 16 Inherent: L x I = 20 Target: L x I = 6	**Risk Category:** Innovation and Strategic Change **Boards Risk Appetite:** Eager
Executive Lead: Executive Director of Public Health		**Assuring Committee:** Planning, Partnerships and Population Health
Latest review date: July 2025 **Added to register:** July 2025 **Risk source:** SP 1 and WBO 1		**Cause of risk and rational for current score:** • NHS historically structured around acute and reactive care • The NHS is under immense pressure with escalating acute care demand; means it's a challenge to 'shift left' to reallocate resources to redesign care models around primary care and prevention • NHS Wales priorities and performance measures respond to rising health care pressures and are predominantly focused on activity and acute care rather than broader system change and population health outcomes. • Predominately community-based prevention services undertaken by the Health Board for tobacco control/smoking cessation and preventing childhood obesity is currently reliant on external grant funding.

		Risk materialising would result in: • Without increased focus and resources on prevention and shifting of healthcare system towards a preventative model risks: more people will develop avoidable chronic conditions, and live more years in poorer health, and further increased unsustainable demand on acute care/services and escalating healthcare costs • Preventable disease disproportionately affects disadvantaged communities and groups, widening health inequalities		
Controls (What are we currently doing about the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
2.1	The Health Board *Annual Plan 2025/26* contains a number of prevention focused activities under the strategic priority 'Focus on Wellbeing'.	PTHB Annual Plan internal performance reporting procedures.	Reasonable	Board/ Committee/Executive Committee/Group
2.2	The Powys Public Services Board *Wellbeing Plan* has the objective that 'People in Powys live happy, healthy, and safe lives' with the associated delivery step 'Taking a whole systems approach to healthy weight'.	Powys Public Services Board internal and external reporting requirements.		
2.3	The Powys Regional Partnership Board *Area Plan 2023-28* includes 'Priority 1.3 Population health improvement, including health inequalities'.	Powys Regional Partnership Board internal and external reporting requirements.		

2.4	PTHB is required to report against vaccination uptake and smoking cessation targets contained in the *NHS Wales Performance Framework 2025-26*.	NHS Wales Planning Framework reporting procedures.		

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
The *Better Together* consultation on adult physical and mental health community services in Powys contains the ambition that 'Together we want to create a future that helps people to stay healthy'.	Director of Improvement and Transformation	Phase 2 consultation underway until end July.	End of 2025/26	On track
A Population Health Framework for Powys (DPH Annual Report) will be published.	Executive Director of Public Health	In progress.	24/09/25	

Additional information:

Rationale for current score:
The controls currently in place are considered sufficient to reduce the inherent score to a current score of 16.

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

SRR 009	There is a risk that: The Health Board is unable to stabilise the growing implications of Continuing Health Care			
Current Risk Score: 16	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I3 = 9	**Risk Category:** Performance and Sustainability **Boards Risk Appetite:** Open		
Executive Lead: Executive Director of Primary, Community Care and Mental Health		**Assuring Committee:** Finance and Performance Committee		
Latest review date: **Added to register:** July 2025 **Link to Strategic Priorities and Wellbeing Objectives:** SP 6 and WBO 4		**Cause of risk and rational for current score:** • Demand is greater than available resource **Risk materialising would result in:** • The service is unable to remain within allocated budget • Failure to meet needs of vulnerable patients who are eligible for health services		
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**

9.1	HB wide Group established for Variable Pay, identified leads and clear expectation re delivery. Variable pay, CHC and Commissioning regular deep dive areas of focus at D&P Committee to track actions to improve.	Reports to Executive Committee and F&P Committee	Reasonable	Board
9.2	A Complex Care and Continuing Health Care (CCCHC) workstream is in place to monitor progression of identified key principles, escalate issues, and guide next steps through regular updates. This structured oversight supports early risk identification, informed decision-making, and contributes to meeting savings targets through improved processes, enhanced reporting, and strengthened assurance.	Reports to Executive Director for PCCMH and escalated if required to Executive Committee via committee papers/updates.	Reasonable	Executive Committee
9.3	Robust governance embedded through a multi-disciplinary panel and approval process, including Continuing Healthcare, to ensure consistent, transparent, and accountable decision-making	Reports into Variable Pay, DMT and CCCHC.	Reasonable	Executive Committee
9.4	Monthly Directorate Management Team (DMT) meetings include a standing agenda item whereby the Assistant Director for Complex Care provides an update incorporating Continuing Healthcare (CHC) via the DMT Highlight Report. This ensures regular oversight, facilitates early identification of risks, and supports timely decision-making.	Reports to Executive Director for PCCMH and escalated if required to Executive Committee via committee papers/updates.	Reasonable	Executive Committee

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**

Deep Dive Report on EMI numbers and costs	Assistant Director of Complex Care	Report submitted to Executive Director on time	Completed June 2025	On track
Recruitment to additional post to support MH Adults of Working Age with provision of commissioning support to Acute Care Pathway	Head of Mental Health Complex and Unscheduled Care	Draft JD is submitted to Workforce for job matching	Completed June 2025	On track
Private Provider Report identifying new governance processes in place	Assistant Director of Mental Health and Learning Disabilities / Assistant Director of Complex Care	Report submitted to Executive Director on time	Completed June 2025	On track
Complex Care Operational Management Group	Assistant Director of Complex Care	This bi-monthly meeting has a financial component. This is in addition to other regular meetings with finance to review budget changes/rationale.	July 2025	On track
Complex Care Workshop Series	Executive Director of Primary Care, Community and Mental Health	Working group addressing challenges through specific project work: • Implementation of Digital systems • Specific review high cost placements • Alternative arrangements with	Completed June 2025	On track

		providers to meet high need EMI placements		
New System to process Retrospective CHC Claims	Lead Nurse Complex Care and Care Home Governance	Implementation of an effective system to ensure process slippage is reduced when dealing with claims	Completed April 2025	On track
National Digital System delays	Assistant Director of Complex Care	There is no clear timeline for when a national system will be agreed. Welsh Government (WG) has agreed to fund the initial procurement cost of a digital system only but will not cover ongoing costs such as licensing and other system-related expenses. Health Boards will need to plan financially for future costs.	September 2025	Delayed
Additional information:				
Rationale for current score: It is early on in the financial year and full year demand is unknown. **Update including impact of actions to date on current risk score:** Remains the same.				
Associated organisational risks (ORR):				

- Organisational Risk Register under development Q2 2025/26.

SRR 010	**There is a risk that:** The Health Board is unable to respond in a timely, efficient, and effective way to a major incident, or critical incident	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: 4 x 4 = 16 Inherent: 4 x 4 = 16 Target: 4 x 3 = 12	**Risk Category:** Safety **Boards Risk Appetite:** Averse
Executive Lead: Executive Director of Public Health		**Assuring Committee:** Planning, Partnerships and Population Health Committee
Latest review date: July 2025 **Added to register:** July 2025 **Link to Strategic Priorities and Wellbeing Objectives:** Cross-cutting risk relevant to all SPs and WBOs		**Cause of risk and rational for current score:** • Due to emergency planning arrangements at both the corporate level and operational level not being sufficiently robust to respond to the incident or emergency. **Risk materialising would result in:** • Adverse impacts on delivery of care to patients • Inability to respond to a major incident to meet needs of those affected • Harm or injury to population, patients and/or staff • Health Board breaches statutory duties under the Civil Contingencies Act 2004 • Litigation & financial penalties • Reputational damage and loss of public confidence • Staff absence (injury, wellbeing)

Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
10.1	Major Incident and Emergency Response Plan and Corporate Business Continuity Plan are in place and updated on an annual basis.	• Plan approved by Executive Committee • Civil Continency Annual Report	Substantial	Executive Committee
10.2	Business Continuity Policy in place, with supporting 'Business Continuity Toolkit' available for operational services to develop service level business continuity plans.	• Policy approved by Executive Committee	Substantial	Executive Committee
10.3	PTHB Pandemic Framework is in place to guide the Health Board's response to a new or emerging pandemic. The Health Board is currently awaiting the publication of updated UK Pandemic Guidance, prior to completing a further review of the Framework.	• Framework approved by Executive Committee	Substantial	Executive Committee
10.4	PTHB Adverse Weather Arrangements is in place and is updated on an annual basis.	• Arrangements approved by Executive Committee	Substantial	Executive Committee
10.5	Internal protocols are in place for the management of patients self-presenting with a suspected High Consequence Infectious Diseases (HCID) are in place and are subject to regular review.	• Protocols in place	Substantial	Executive Director
10.6	PTHB Civil Contingencies Training Plan in place and updated on an annual basis.	• Plan approved by Executive Committee	Substantial	Executive Committee
10.7	Corporate level Business Continuity arrangements subject to internal audit 2023/24.	• Audit Report – substantial assurance (Dec 2023)	Substantial	Audit Committee
10.8	Operational level Business Continuity arrangements subject to internal audit 2024/2025.	• Audit Report – substantial assurance (May 2025)	Substantial	Audit Committee
10.9	The Health Board is fully engaged in Dyfed Powys Local Resilience Forum's planning and response structures.	• Minutes of meetings	Substantial	Executive Director

		• Training and exercise records		
10.10	The Health Board is fully engaged in the NHS Wales Emergency Preparedness, Resilience and Response planning structures.	• Minutes of meetings • Training and exercise records	Substantial	Executive Director
10.11	The Health Board has participated in a variety of exercises. Examples of these exercises are included below (not inclusive): • Exercise Mighty Oak (National Power Outage) • Exercise Pen Y Darren (Mass Casualty) • Exercise CYD (Communicable Disease) • Exercise Fad Fellin (Mpox/HCID) • Exercise Solaris (Pandemic) • Exercise Redstreak (Water disruption) • Exercise Wales Connect (Regular Pan Wales Response Plan activation test) • Walkthroughs of the operational response to major incidents/Mpox arrangements	• Exercise Reports	Substantial	Executive Director
10.12	Testing of internal major incident and business continuity response plans through response to incidents, including: Powys Train Collision (October 2024) Storm Darragh (December 2024)	• Debriefs from internal responses to incidents	Substantial	Executive Committee
10.13	Internal repository in place for all internal Response Plans	• Internal repository	Substantial	Executive Director

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**

Deliver programme of work in place to strengthen identified areas of risk.	Civil Contingencies Manager		31st March 2026	On Track
Complete cycle of work to ensure that PTHB internal response plans remain up to date.	Civil Contingencies Manager		31st March 2026	On Track
Continue to provide regular update reports to the Executive Committee on programmes of work in place to strengthen identified areas of risk	Civil Contingencies		October 2025	On Track
Complete internal operational review of clinical governance arrangements for operational major incident response arrangements	Civil Contingencies Manager/ Urgent and Emergency Care Clinical Transformation Lead		September 2025	On Track
Additional training and exercise opportunities to support PTHB's staff preparedness in response to an incident or emergency to be made available	Civil Contingencies Manager		31st March 2026	On Track
Continue to engage in, and actively promote preparedness activities (including planning, training, exercising) taking place with multi-agency partners, including NHS Wales Emergency Preparedness, Resilience and Response networks and Dyfed Powys Local Resilience Forum	Civil Contingencies Manager		31st March 2026	On Track

Continue to incorporate lessons identified from other incidents and exercises into internal plans and procedures to strengthen the Health Board's future response to incidents	Civil Contingencies Manager		31st March 2026	On Track
Additional information: The Executive Director of Public Health holds the overall responsibility for Civil Contingencies Planning within PTHB, however all Executive Directors are responsible for ensuring business continuity for the services that sit within their portfolio areas, as outlined within the PTHB Business Continuity Policy. Cyber resilience and response sits within the responsibility of the Executive Director of Allied Health Professions, Health Sciences and Digital				
Rationale for current score: There are a number of control measures in place, however further work is required to strengthen identified areas of risk and test internal response capabilities.				
Associated organisational risks (ORR): • Organisational Risk Register under development Q2 2025/26.				

SRR 011	**There is a risk that:** failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.	
Current Risk Score: **15**	**Risk rating detail:** (likelihood x impact) Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 3 x 4 = 12 *Risk scored based on health board wide failure.*	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite: Open**
Executive Lead: Executive Director of Allied Health Professionals, Health Sciences and Digital		**Assuring Committee:** Audit, Risk and Assurance Committee
The detail relating to this risk are considered In-Committee as some of the details are sensitive and confidential.		

SRR 012	**There is a risk that:** The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.

Current Risk Score: **15**	**Risk rating detail:** (likelihood x impact) Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 2 x 4 = 8	**Risk Category:** Reputation and Public Confidence **Boards Risk Appetite:** Open
Executive Lead: Director of Corporate Governance / Board Secretary		**Assuring Committee:** Finance and Performance Committee
Latest review date: July 2025 **Added to register:** July 2025 **Link to Strategic Priorities and Wellbeing Objectives:** Cross-cutting risk relevant to all SPs and WBOs		**Cause of risk and rationale for current score:** • The NHS is facing a very challenging period, including the waiting list backlog arising from COVID, the delays in strategic transformation exacerbated by the pandemic period, significant inflationary pressures. This is compounded locally by the challenges of service delivery in a rural area including for recruitment and retention, the need to take action to transform the model of health care so that it is safe and sustainable for the future, and the need for immediate action in response to the financial position. In this context there is a need for challenging decisions, sometimes short term in nature (e.g. waiting list measures). Given the comparatively small organisational leadership infrastructure in PTHB it is highly complex to engage meaningfully at a hyperlocal level with the many different community needs and expectations across our large county, particularly to contextual this to multiple secondary and tertiary care pathways. **Risk materialising would result in:** • Lack of public confidence could lead to erosion of trust; reduced engagement and discretionary effort by

		patients, public, staff and stakeholders; leadership and administrative burden in relation to responding to complaints, correspondence, FOI, enquiries, Senedd questions etc.; adverse impact on staff morale, recruitment and retention; potential loss of strategic momentum and/or financial inefficiencies due to delays, rework or crisis communications.		
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
2.1	Better Together programme in place in order to make lasting decisions about the permanent future shape of safe and sustainable health services, with Stage One engagement completed and Stage Two engagement nearing completion	Better Together Programme	Reasonable	Board
2.2	Communication and engagement team in place (substantive team = 4.0wte, additional temporary posts) with active management of priorities aligned with organisational priorities and risks	Quarterly E&C Team reports Directorate Review	Reasonable	PPPH
2.3	Weekly informal communications report to Board including reputation risk portfolio to support internal review and scrutiny	Copies of The Week	Reasonable	Chair
2.4	Quarterly Engagement and Communication Report supports ongoing review of capacity against opportunities and risks	Quarterly E&C Team reports Directorate Review	Reasonable	PPPH
2.5	Temporary strengthening of communications and engagement function including non-pay resources to support Better Together programme	Minutes of Executive Committee	Reasonable	Executive Committee

2.6	Procurement of additional engagement delivery and analysis support to Stage Two Better Together engagement	Contract in place. Reports to Portfolio Board and Executive Committee	Reasonable	Board
2.7	Procurement of additional consultation delivery and analysis support to Stage Three Better Together	Contract in place. Reports to Portfolio Board and Executive Committee	Reasonable	Board
2.8	Stakeholder Map in place	Stakeholder Map	Reasonable	Executive Committee
2.9	Priority stakeholder engagement mechanisms in place (e.g. regular MS/MP briefings, Board to Cabinet meetings with PCC, Joint Leadership Team meetings with PCC, RPB and sub-structures, PSB and sub-structures	Notes from meetings	Reasonable	Board
2.10	OD programme in place linked to Better Together transformational change programme	Notes of ODEC and Portfolio Board	Reasonable	Executive Committee
2.11	Channel strategy in place and kept under review (web, govDelivery, Facebook, NextDoor etc.)	Quarterly E&C Team reports	Reasonable	Executive Committee
2.12	Out of hours media protocol in place via Gold On Call but currently insufficient team capacity for on call comms	Major Incident and Business Continuity Plan arrangements	Limited	Executive Committee
2.13	Powys Engagement and Insight Network in place to support pan-organisational co-ordination of engagement and insight (joint sub-group of RPB and PSB)	Minutes 6-monthly insight reports	Reasonable	Executive Committee

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Procurement of consultation assurance for Stage Three Better Together	DCG/DoP&C	Procurement process due to conclude by 08/25 following some delays outside the health board's control in SSP	30/07/25	Delays by SSP have been escalated

Stakeholder engagement assurance included within TI support framework	DCG	Procurement process under way	08/25	On track
Identification of named Locality leads for each of the 13 Powys localities	DCG	Arrangements being finalised for implementation	08/25	On track
Establishment of continuous engagement programme following strengthening of engagement team from 06/25	DCG	Schedule of events being developed for implementation following	08/25	On track
Develop consultation plan for Better Together	DoP&C / DCG / DPPC	Consultation plan being developed through Better Together programme arrangements	08/25	On track
Establish annual Insight Report from community engagement activities for Board review and to inform annual planning	DCG	Pilot report created 2024/25 with aim to fully establish from 2025/26	31/03/26	On track
Further campaign to encourage govDelivery sign ups to increase subscribers so that residents can receive information direct from PTHB	DCG	Paid-for advertising campaign summer 2025	30/09/25	On track
Additional information:				
Rationale for current score: Significant challenges to public confidence remain possible, particularly given the pressing need for significant transformation of health services to ensure that they are fit for the future The scope for managing these challenges is reduced due to the highly complex environment in which the health board operates (very large rural geography, hyperlocal needs and expectations, complex				

cross-border commissioned pathways with both England and Wales). Trust has been further challenged by decisions the health board has needed to make in the context of in-year financial challenges (e.g. waiting list measures) and to address risks to safety and sustainability (e.g. temporary service changes).

Update including impact of actions to date on current risk score:

Temporary strengthening of the engagement and communication function is supporting the health board to establish mechanisms for continuous engagement, although decisions will be needed once temporary funding ends as the substantive permanent resource across all engagement and communication specialisms (strategic communications, digital and social media including website and intranet, crisis communications, graphic design and print, public and community engagement and consultation, press and PR, internal communications, stakeholder relations, reputation and branding) is 4.0wte.

Associated organisational risks (ORR):

- Organisational Risk Register under development Q2 2025/26.

Board Assurance Framework (BAF) Dashboard

PTHB Board– 30 July 2025

Board Assurance Framework Dashboard: Key

Key:

Adequacy of Controls
Are we doing enough to manage the risk?
GREEN: Multiple controls
AMBER: Some controls
RED: Limited/no controls

Effectiveness of Controls
Is what we're doing working?
GREEN: Controls largely effective
AMBER: Some control weaknesses
RED: Significant control weaknesses

Control Assurance
Based on what evidence?
GREEN: Assurance largely substantial
AMBER: Assurance largely reasonable
RED: Assurance largely limited
GREY: Insufficient assurance available

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Risk outside Board appetite

Board Assurance Framework Dashboard

Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls *Are we doing enough to manage the risk?*	Effectiveness of Controls *Is what we're doing having the desired impact?*	Associated Assurance *Based on what evidence?*
SRR 001: **Financial Balance** *EDoFC&E*	**20**	**20**	**8**	**Cautious** ⚠	Multiple Controls	Some control weaknesses	Assurance largely reasonable
SRR 002: **Transformation** *EDP&C*	**16**	**12**	**8**	**Eager** *In appetite*	Multiple Controls	Controls largely effective	Assurance largely reasonable
SRR 003: **Commissioning** *EDPP&C*	**20**	**20**	**12**	**Open** *In appetite*	Multiple Controls	Some control weaknesses	Assurance largely reasonable/limited
SRR 004: **Provided Services** *EDPCCMH*	**16**	**16**	**12**	**Open** *In appetite*	Multiple Controls	Some control weaknesses	Assurance largely reasonable
SRR 005: **Primary Care** *EDPCCMH*	**16**	**16**	**12**	**Open** *In appetite*	Multiple Controls	Some control weaknesses	Assurance largely reasonable
SRR 006: **Workforce** *EDP&C*	**16**	**16**	**8**	**Cautious** *In appetite*	Multiple Controls	Some control weaknesses	Assurance largely substantial

Board Assurance Framework Dashboard

Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls *Are there enough controls in place?*	Effectiveness of Controls *Are those controls working as intended?*	Associated Assurance *How do we know/evidence?*
SRR 007: **Estate** *EDoFC&E*	**16**	**16**	**8**	**Minimal** ⚠	Multiple Controls	Some control weaknesses	Assurance largely substantial/ reasonable
SRR 008: **Prevention** *EDPH*	**20**	**16**	**6**	**Eager** *In appetite*	Some controls	Controls largely effective	Assurance largely reasonable
SRR 009: **Continuing Health Care** *EDPCCMH*	**16**	**16**	**9**	**Open** *In appetite*	Some controls	Some control weaknesses	Assurance largely reasonable
SRR 010: **Emergency Preparedness/Incident Response** *EDPH*	**16**	**16**	**12**	**Averse** ⚠	Multiple Controls	Some control weaknesses	Assurance largely substantial
SRR 011: **Digital** *EDAHPHS&D*	**20**	**15**	**12**	**Open** *In appetite*	Multiple Controls	Controls largely effective	Assurance largely reasonable
SRR 012: **Public Confidence** *DCG*	**20**	**15**	**8**	**Open** *In appetite*	Multiple Controls	Controls largely effective	Assurance largely reasonable

Summary Position

- 9 of the 12 risks are operating within the Board's Risk Appetite
- **3 of 12 risks received are operating outside of the Board's Risk Appetite**
  - **SRR 001 – Financial Balance**
  - **SRR 007 – Estate**
  - **SRR 010 – Emergency Preparedness/Incident Response**
- *Is the Board willing to tolerate the current position outside of appetite or is action to identify and implement further controls needed to mitigate risks?*
- **8 of the 12 risks received have Inherent Scores the same as the Current Score, suggesting a need to review the effectiveness of controls and/or risk scoring.**

Scoring Matrix

Likelihood x Impact = Risk Score

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

Risk Appetite Summary

Strategic Risk	Main Risk Category	Appetite Level	Other associated risk categories
SRR 001 – Financial Balance	Financial Sustainability	Cautious	• Financial Governance, Financial Investment, Performance and Service Sustainability, Quality, Regulation and Compliance, and Reputation and Public Confidence.
SRR 002 - Transformation	Innovation and Strategic Change	Eager	• Performance and Sustainability of Services, Regulation and Compliance and Safety
SRR 003 – Commissioning	Performance and Service Sustainability	Open	• Quality, Safety, Partnerships, Performance and Sustainability of Services, Reputation and Public Confidence.
SRR 004 – Provider	Performance and Service Sustainability	Open	• Quality, Safety, Workforce, Performance and Sustainability of Services.
SRR 005 – Primary care	Performance and Service Sustainability	Open	• Quality, Safety, Partnerships, Performance and Sustainability of Services, Reputation and Public Confidence.
SRR 006 – Workforce	Workforce	Cautious	• Quality, Safety, Regulation and Compliance and Reputation and Public Confidence.

Risk Appetite Summary Cont.

Strategic Risk	Main Risk Category	Appetite Level	Other associated risk categories
SRR 007 – Estate	Quality	Minimal	• Safety, Regulation and Compliance, Reputation and Public Confidence and Financial Investment.
SRR 008 – Prevention	Innovation and Strategic Change	Eager	• Quality, Workforce and Reputation and Public Confidence.
SRR 009 – CHC	Performance and Service Sustainability	Open	• Financial Governance, Financial Sustainability, Partnerships, Quality, Reputation and Public Confidence and Regulation and Compliance.
SRR 010 – Emergency preparedness	Safety	Averse	• Reputation and Public Confidence, and Regulation and Compliance
SRR 011 – Digital	Performance and Service Sustainability	Open	• Quality, Safety, Regulation and Compliance and Reputation and Public Confidence.
SRR 012 – Public Confidence	Reputation and Public Confidence	Open	• Innovation and Strategic Change

Board Assurance Framework Dashboard: Analysis Principles

Adequacy of Controls (are there enough controls in place to manage the risk?)

Ratings provided:

Adequacy of Controls
Are we doing enough to manage the risk?
GREEN: Multiple controls
AMBER: Some controls
RED: Limited/no controls

Analysis principles:

Initial analysis will be completed by the Corporate Governance team which will be data based, the initial analysis will assess the number of controls provided within the SRR against the risk score and risk appetite category.

Broadly:

- 0-2 controls listed in SRR = Limited/No controls (RED)
- 2-5 controls listed in SRR = Some controls (AMBER)
- 5+ controls listed in SRR = Multiple controls (GREEN)

The Executive Committee will be given the opportunity to moderate this assessment, this is encourage to be a more reflective, feeling based review e.g.:

- *Does the number of controls feel sufficient?*
- *Is there more than could be reasonably done?*
- *How do the number/scope of controls feel in the strategic/organisational context and context of the Strategic Risks?*

Effectiveness of Controls (are there controls we have in place working? i.e. are they mitigating the risk?)

Rating provided:

Effectiveness of Controls
Is what we're doing working?
GREEN: Controls largely effective
AMBER: Some control weaknesses
RED: Significant control weaknesses

Analysis principles:

Initial analysis will be completed by the Corporate Governance team which will be data based, the initial analysis will assess the impact of controls listed within the SRR on scoring and will focus on whether the risk lead has identified that the inherent risk score (the unmanaged risk) has deceased as a result of the controls implemented (current score).

As the process matures consideration will also be given to the balance of preventative vs reactive controls to ensure sufficient balance.

This will then be assessed against the level of assurance currently available against those controls to make a draft assessment.

Broadly:

- There has been a recorded reduction in current risk score as a result of the controls in place, controls are balances and assurance is largely substantial or reasonable = Controls largely effective (GREEN)
- There has been a recorded reduction in current risk score as a result of the controls in place, controls are balanced but assurance is largely limited = Some control weaknesses (AMBER)

- The controls listed have had no impact on reducing the inherent risk score (the inherent and current risk score are the same), controls are balanced however assurance is largely substantial or reasonable = Some control weaknesses (AMBER)
- The controls listed have had no impact on reducing the inherent risk score (the inherent and current risk score are the same), controls are unbalanced however assurance is largely reasonable = Significant control weaknesses (RED)
- The controls listed have had no impact on reducing the inherent risk score (the inherent and current risk score are the same), controls are unbalanced and assurance is largely limited or there is insufficient assurance available = Significant control weaknesses (RED)

The Executive Committee will be given the opportunity to moderate this assessment, this is encouraged to be a more reflective, feeling based review e.g.:

- *Does is feel like there is grip and control over the risk?*
- *Are the controls ineffective or does scoring need to be revisited?*
- *Are Executive Leads comfortable with this assessment and feel its reflective?*

Control Assurance (what evidence is our assessment based on?)

Rating provided:

Control Assurance
Based on what evidence?
GREEN: Assurance largely substantial
AMBER: Assurance largely reasonable
RED: Assurance largely limited
GREY: Insufficient assurance available

Analysis principles:

Initial analysis will be completed by the Corporate Governance team which will be data based, this will draw on the data provided within the SRR and will calculate an average based on to assurance levels provided.

As the process matures, a more in-depth analysis of assurance available will be facilitated by the Corporate Governance Team and will make an assessment not only of availability but of balance across the Three Lines.

Assessment of Risk Appetite

Initial analysis will be completed by the Corporate Governance team which will be data based, the initial analysis will assess the risk score against the following basic matrix:

Risk Appetite	Description	Scoring
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry very limited or virtually no inherent risk.	Target current of: 1-8
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.	Target current of: 1-12
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.	Target current of: 1-15
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and	Target current of: 1-20

Risk Appetite	Description	Scoring
	value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Will tolerate risks of: 20+

This matrix will not be applicable to each individual risk, and is a rudimentary assessment. The Executive Committee will be given the opportunity to moderate this assessment, this is encouraged to be a more reflective, feeling based review e.g.:

- *Are we comfortable with the level of risk we are holding?*
- *Are we willing to tolerate a risk, despite a high score in context?*
- *Is it felt that the risk is untenable, and more action must be taken to manage/mitigate?*
- *Are we failing to manage the risk, is the position deteriorating/ the risk materialising? Can we tolerate that?*

AUDIT, RISK AND ASSURANCE COMMITTEE	7 OCTOBER 2025
Subject:	**Information Governance and Records Management Performance and Assurance Monitoring Report**
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Head of Information Governance, Records and Data Protection Officer, Corporate & Health Records Manager and Information Governance Manager
Other Committees and meetings considered at:	Executive Committee – 1 October 2025 who endorsed the report to the Committee.

PURPOSE:

To provide assurance of the arrangements in place to ensure the health board complies with its statutory obligations in relation to data protection legislation, national frameworks, and good practice.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **RECEIVE** the report and take **ASSURANCE** on areas of good compliance, acknowledging efforts and successes.
- **NOTE** areas of poor or non-compliance and take **ASSURANCE** a programme of work is in place to improve compliance.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	1. IG ensures that patient data is used effectively by securely sharing accurate information, healthcare providers can offer personalised and effective care, enhancing patients' overall wellbeing.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	

8. Transforming in Partnership	Y	2. Reliable IG practices enable timely access to data, supporting early intervention and proactive care. 3. IG embeds processes ensuring data is accurate and accessible, enabling healthcare professionals to develop and implement targeted interventions. 4. Good IG practices promote seamless information sharing across different care providers and sectors ensuring patients receive coordinated care, improving their treatment outcomes and experiences. 5. IG plays a role in training and supporting the healthcare workforce in IG and Records Management responsibilities. 6. Effective IG supports the adoption of new technologies and innovative practices ensuring data is managed securely and compliantly. 7. IG is fundamental to the digital transformation of healthcare ensuring digital solutions are implemented securely, protecting patient information while improving efficiency and accessibility. 8. IG facilitates the safe and secure sharing of information between different organisations, enabling effective partnerships and joint initiatives to improve patient care.

EXECUTIVE SUMMARY QUARTERLY SUMMARY:

This reporting period covers Quarter 1 April – June 2025/26, with a high-level overview of performance listed below, and more detailed breakdown provided in the detailed background and assessment section.

Freedom of Information (FOI) & Environmental Information Regulations (EIR) Requests:

- Total Requests Received: 113
- Compliance Rate: 92.04% (above ICO target of 90%)
- Breaches: 9 (longest delay: 42 days due to service-related issues; statutory limit: 20 working days)
- Quarterly Comparison: Figures remain consistent with the previous quarter
- Internal Reviews: 1 received; no further action taken by the requester
- EIR Requests: 1 received
- New Development – Enhancing Public Access to Information: The team is working with selected services to identify key information for inclusion in the Health Board's Publication Scheme. This proactive approach aims to reduce repeat FOI requests, saving time and resources.**Requests for Personal Information:**
- Total Requests Received: 171 (living and deceased)

- Compliance:
  - UK GDPR: 100% compliance; one extension applied due to complexity, met within revised deadline
  - Access to Health Records Act (deceased): 100% compliance
  - Medical Examiner (ME) Service: 2 disclosures exceeded the 72-hour target due to weekend staffing delays
- Overall Compliance Rate: 99% (consistent with Q4; above 90% local target)
- Trend: Request volumes decreased from 199 (Q1) and 188 (Q4)
- Operational Impact: Increasing complexity of requests continues to place significant pressure on team resources, particularly around detailed review and redaction, affecting capacity to progress other critical workplan priorities.

Datix Incidents (Breach Reporting):

- **63** Information Governance related incidents reported,
- **17** incidents were not reported within the UK GDPR regulatory 72 hours, mainly due to service delays in reporting.
- **2** of the recorded incidents were deemed reportable to the Information Commissioner's Office (ICO) due to the repeat nature of the incidents. No further action was taken by the ICO.

The top five themes identified during this reporting period:

- **10 incidents** – Records Management: Incorrect information recorded.
- **5 incidents** – Records Management: Wrong attachment containing personal identifiable information (PII) sent to an external recipient (via letter or email).
- **5 incidents** – Information Governance: Breach of sensitive data.
- **4 incidents** – Records Management: Wrong attachment uploaded to internal systems.
- **4 incidents** – Information Governance: Unintended external recipient (via letter or email).

Physical Security Incidents –increase in physical security incidents this quarter, **3** logged, specifically relating to insecure premises, including windows and doors being left open or unlocked outside of working hours. A reminder to staff will be issued in the next IG newsletter.

- New development since May 2025 – Strengthening IG Incident Review: To ensure all potential Information Governance incidents are appropriately assessed, Datix entries previously marked as 'Unsure' are now recorded as 'Yes' for specific incident categories. This targeted approach helps ensure no relevant incidents are overlooked.

- Operational Impact: Marginal improvement in the timeliness of services logging incidents within the 72-hour window, however delays are still proving a challenge. This would, should any of these incidents be reported to the ICO be picked up as a concern. Reminders continue to be issued out via several channels including Datix training sessions to try and reduce the numbers.

A significant number (**56**) of non-IG related incidents were received again this quarter into the team due to services incorrectly assigning the incident as having IG relevance. This has increased since the last quarter (**49**):

- April – Non-IG notifications - **17**
- May – Non-IG notifications - **14**
- June – Non-IG notifications – **25**

Top 5 Non-IG Incident Themes:

- Safeguarding children – **9** incidents.
- Slip, Trip & Falls - **7** incidents.
- Pressure Damage, Moisture Damage - **7** incidents.
- Aggressive/ threatening behaviour - **4** incidents.
- Patient/service user death - **4** incidents.

Operational Impact: Amending these incidents take un-necessary resource within the team. Reminders have been issued to staff highlighting this concern however high numbers continue to be received. National feedback is this is a common problem across Wales.

Audit and Monitoring:

Information Asset Register**:**

- **146** new assets have been added to the Information Asset Register since the June 2025 update, reflecting improved organisational engagement.
- Positive progress has been made, with several directorates submitting entries for the first time, including Corporate Governance, Dental, Digital Transformation, People & Culture, Mental Health, Public Health, and the Medical Directorate.
- Targeted engagement remains necessary, as a number of directorates have yet to submit any entries, posing a risk to full organisational compliance.
- Continued support and follow-up will be provided to ensure all areas are represented in the Register and that asset ownership is clearly defined.
- Operational Impact: approving assets in a timely manner due to sudden volume added

The National Intelligent Integrated Audit Solution (NIIAS):

- **1** notification of staff potentially accessing their own record (2nd offence)
- **7** notifications of staff potentially accessing a family member's record (Home Relations First Offence x 3 and Home Relations 2nd offence x 4).
- **Access investigations:** Of eight access-related incidents reviewed this quarter, seven were deemed appropriate by line managers for work-related purposes. One incident was found to be inappropriate, and the staff member was required to retake mandatory Information Governance training via ESR.
- **0** incidents reported to the ICO

NHS Wales IG Toolkit Submission:

- **IG Toolkit Submission:** The 2024–25 IG Toolkit response was submitted by PTHB at the end of March 2025 as required.
- **Improvement Plan:** An out-turn report and improvement plan for 2025–26 has been presented to the Executive Committee.
- **Ongoing Action:** The IG team will implement the improvement actions and provide quarterly progress updates to the Board.

New Development: On 1st July 2025, a new Power BI platform was launched to log and monitor Information Governance and Records Management activities. Enhanced reporting will be produced for future committee papers.

Training & Awareness:

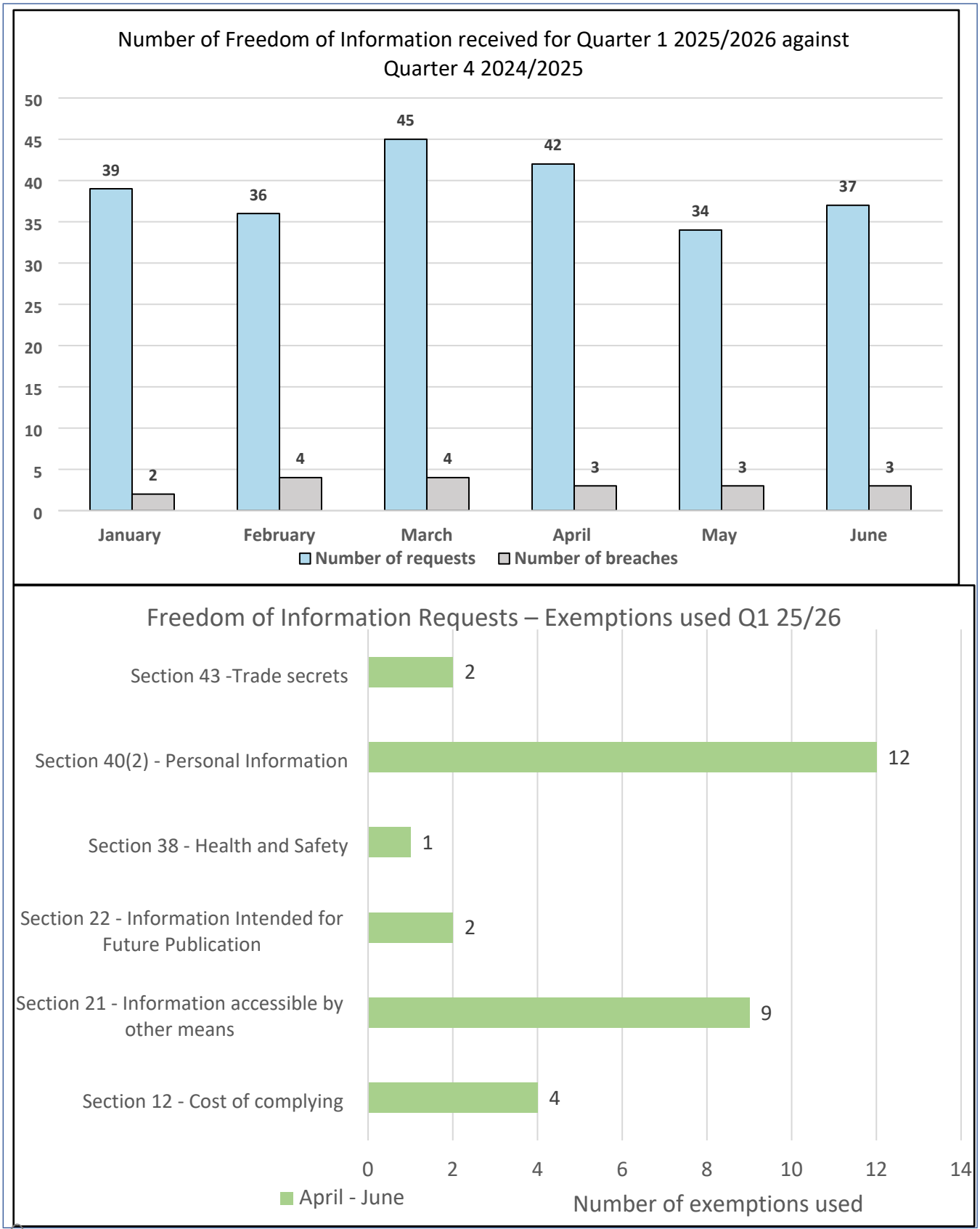
- Mandatory IG E-Learning (NHS Wales):
  - Compliance rate: 78.63%, slight increase from 77.3% last quarter
  - Now below the national target of 85%
  - the team have issued reminder emails to all non-compliant staff during quarter 1
  - bank staff remain area with lowest compliance 66%
- New Starters:
  - 76 of 99 did not complete mandatory IG training within the required 6 weeks
  - A targeted process introduced last quarter by the Team, to chase non-compliant starters, seems to have received positive response — no individual required more than two reminders.
  - Pro-active consideration still required how staff are targeted upon start date to complete their training within the 6 weeks.
- Internal IG Training Delivered:
  - 9 bespoke sessions provided, covering:
    - Information Asset Register
    - Introduction to Information Governance

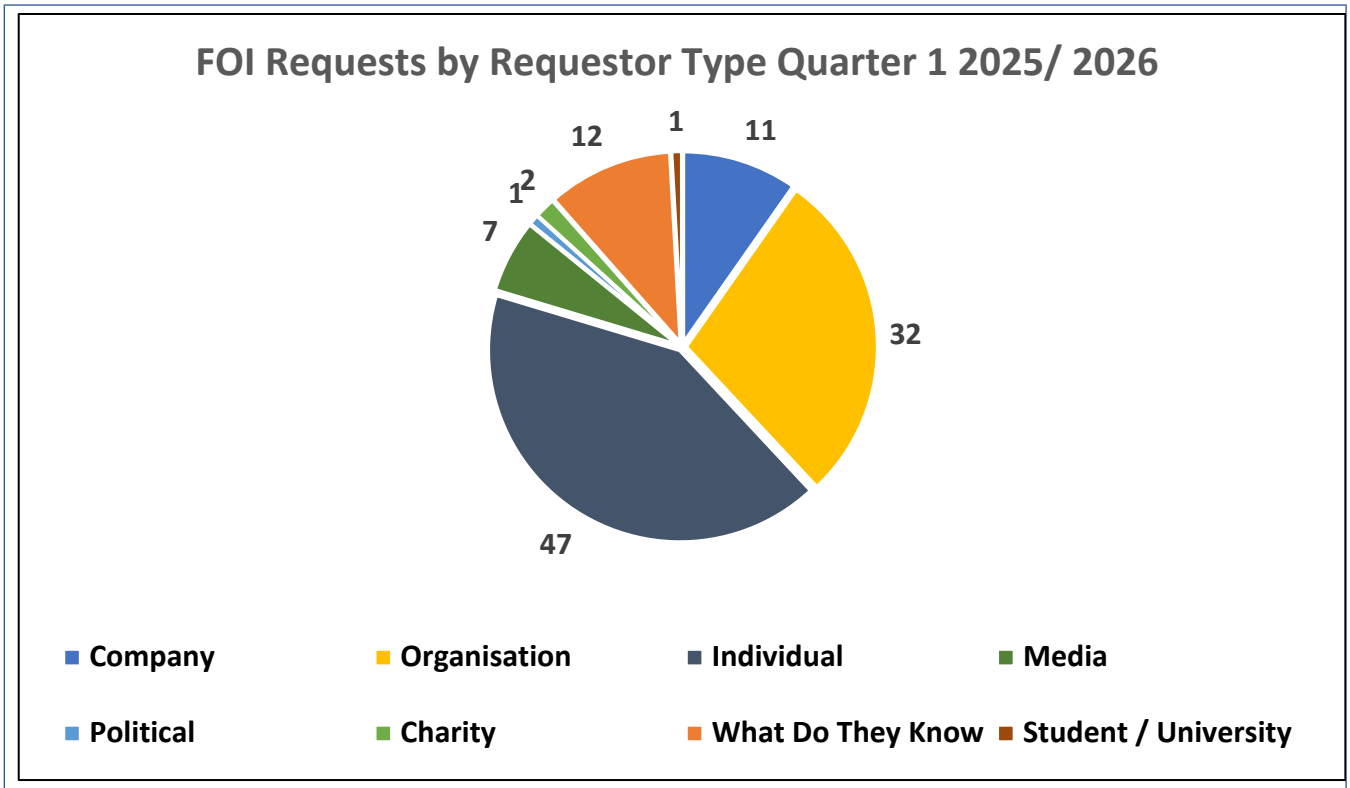
Records Management:
Storage Requests**: 4** requests received to assist services with the storage of their archive records, consistent with previous quarter (5 received).

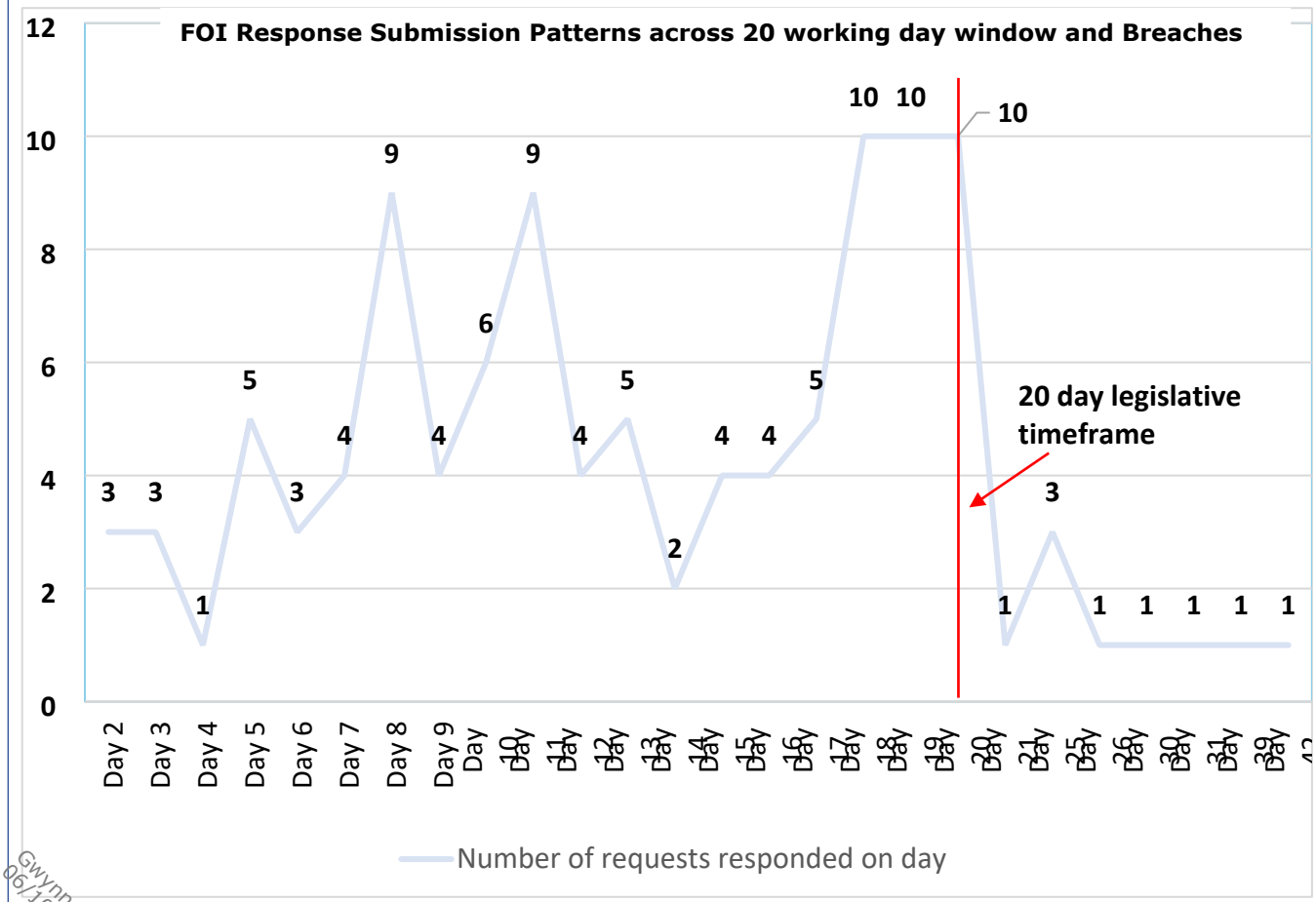
New Development: Work is due to commence to refurbish O ward in Bronllys in September 2025, which will provide the health board with additional storage availability and release pressure on local sites which are at, or nearing, records storage capacity.

DETAILED BACKGROUND AND ASSESSMENT QUARTERLY SUMMARY:

Freedom of Information (FOI) & Environmental Information Regulations (EIR) Requests:





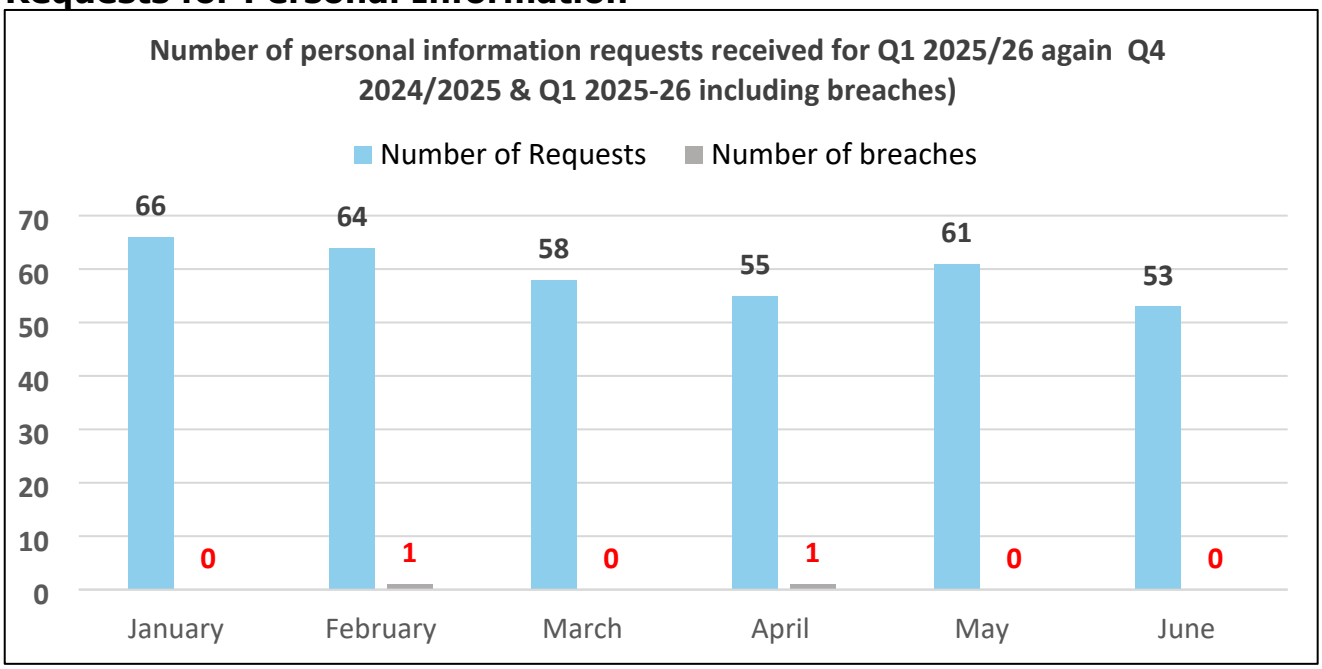


Note: The peaks at days 8, 11 and 17 correlate with chasers from the IG team to services reminding them of the 20-day deadline.

Service Areas that breached and reason**:**

Day responded	Service/s involved	Reason for breach
Day 21	Finance	Complex response; delay also due to annual leave and sign-off.
Day 25	Finance	Complex request.
Day 25	Finance & People and Culture	Complex request.
Day 25	Maternity, Sexual Health, Safeguarding & People and Culture	Service delay.
Day 26	Mental Health and Information Governance	Complex exemption-related request; IG Team contributed to delay due to research of legislation
Day 30	Women & Childrens service , ADHD Adults, Powys info and Finance.	Service delay and a complex request
Day 31	Concerns	Service delay.
Day 42	Continuing Healthcare (CHC) Mental health and CHC General	Service delay.
Day 39	Digital Transformation	Service delay.

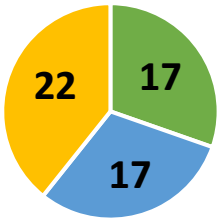
Requests for Personal Information



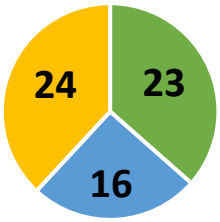
Datix Incident Notifications (Breach Reporting):

The graphs below show the number of notifications received and the top 5 notification types that do not relate to Information Governance or Records Management.

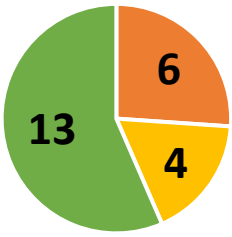
Number of IG/RM related Datix notifications received - Quarter 4 2024/2025



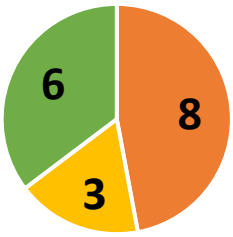
Number of IG/RM related Datix notifications received - Quarter 1 2025/2026



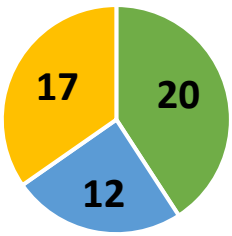
Number of incidents NOT reported within 72 hrs (including non PTHB incidents) (Q4)



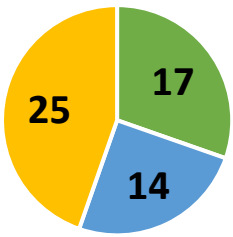
Number of incidents NOT reported within 72 hrs (including non PTHB incidents) (Q1)



Number of Non-IG/ RM related Datix notification received Quarter 4 2024/2025



Number of Non-IG/ RM related Datix notification received Quarter 1 2025/2026



Top 5 Themes - Non-IG/RM related Datix Notifications

- Safeguarding (Children) – 9 Datix notifications received.
- Slip, Trip & Falls – 7 Datix notifications received.
- Pressure Damage, Moisture Damage – 7 Datix notifications received.
- Aggressive/ threatening behaviour – 4 Datix notifications received.
- Patient/service user death – 4 Datix notifications received**.**

Service breakdown for IG/RM Datix notifications Received:

Service	**Number of incidents**
Support Services	**2**
Information Governance	**9**
Community Hospitals/ Nursing Services	**5**
Mental Health	**14**
Planned Care	**6**
General Medical Practice	**2**
General Dental Practice	**1**
Therapies & Health Science Operational	**4**
Women & Children	**13**
Public Health	**2**
Powys Living Well Service	**3**
People & Culture and Support Services	**2**
Total	**63**

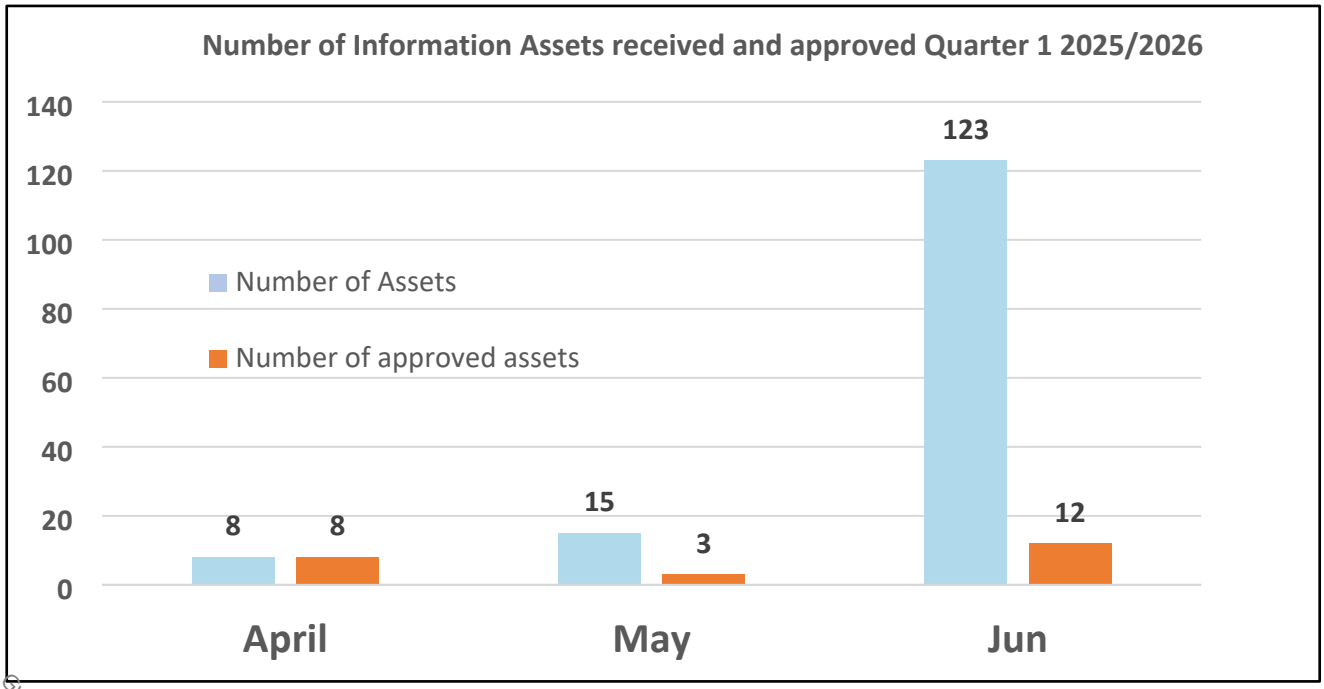
Theme breakdown for IG/RM Datix notifications received**:**

Datix Incidents Theme	No. of incidents
RM - Wrong attachment/data (containing PII) sent external	5
RM - Wrong attachment /data (containing PII) sent to internal	2
RM - Records Management - Documentation Lost	1
RM - Wrong information recorded	10
RM - Wrong attachment uploaded	4
RM - Lack of availability of information for clinical care	2
RM - Patient record misfiled	1
RM- Incorrect/inappropriate storage of documents	1
IG - Lost in post	2
IG - Unintended recipient external (letter, email)	4
IG - Breach of sensitive data	5
IG - Printer documentation	1
IG - Inappropriate disclosure (verbal) external	1
IG - Unintended recipient internal (letter, email)	2
IG - Patient record accessed inappropriately	1
IG - Communication issues	2
IT/System Security or Function - Missing laptop / Device	1
IT/System Security or Function - System not functioning as expected	2
IT/System Security or Function issue - No access to Internet/server issues	1

Non-PTHB Records Management - Wrong information recorded	1
Non-PTHB IG - Unintended recipient external (letter, email)	1
Non-PTHB IG - Breach of sensitive data	3
Non PTHB Damage during transit/ Post	3
Non -PTHB Records shared on Social Media	2
Non-PTHB Records Management - Wrong attachment/data (containing PII) sent external	1
Physical Security - Insecure premises	3
Physical Security - Access door codes	1

Audit and Monitoring:

Type of incident	National Intelligent Integrated Audit Solution (NIIAS)	
	Q4 2024/25	Q1 2025/26
Own Record - 1st offence	4	0
Own Record - repeated	1	1
Home Relations (Family) Record - 1st offence	4	3
Home Relations (Family) Record - repeated	7	4
Both home relations and own record accessed	0	0
Notification for Non-PTHB member of staff	0	0
Grand Total	**16**	**8**



Since the last update provided in the June 2025 Information Asset Register Committee paper, we have seen positive progress in engagement across

several directorates. The following areas have now submitted entries to the Information Asset Register, having previously had no recorded assets:

- Corporate Governance
- Dental
- Digital Transformation / Business Intelligence / Applications
- People and Culture
- Mental Health
- Public Health
- Medical Directorate

This marks a significant step forward in improving organisational oversight and accountability for information assets.

However, there remain several directorates that have not yet submitted entries, and continued engagement will be required to ensure full compliance and visibility across the organisation. These include:

- Complex Care
- Health Board Primary Care Team
- Health & Safety
- Improvement and Transformation
- Occupational Health
- Performance & Commissioning
- Powys Living Well Service
- Quality & Safety / Concerns
- Research, Innovation & Improvement
- Support Services
- Safeguarding
- Therapies and Health Services Directorate

Targeted follow-up will be undertaken with these areas to support completion and ensure alignment with the organisation's Information Governance framework.

Training & Awareness:

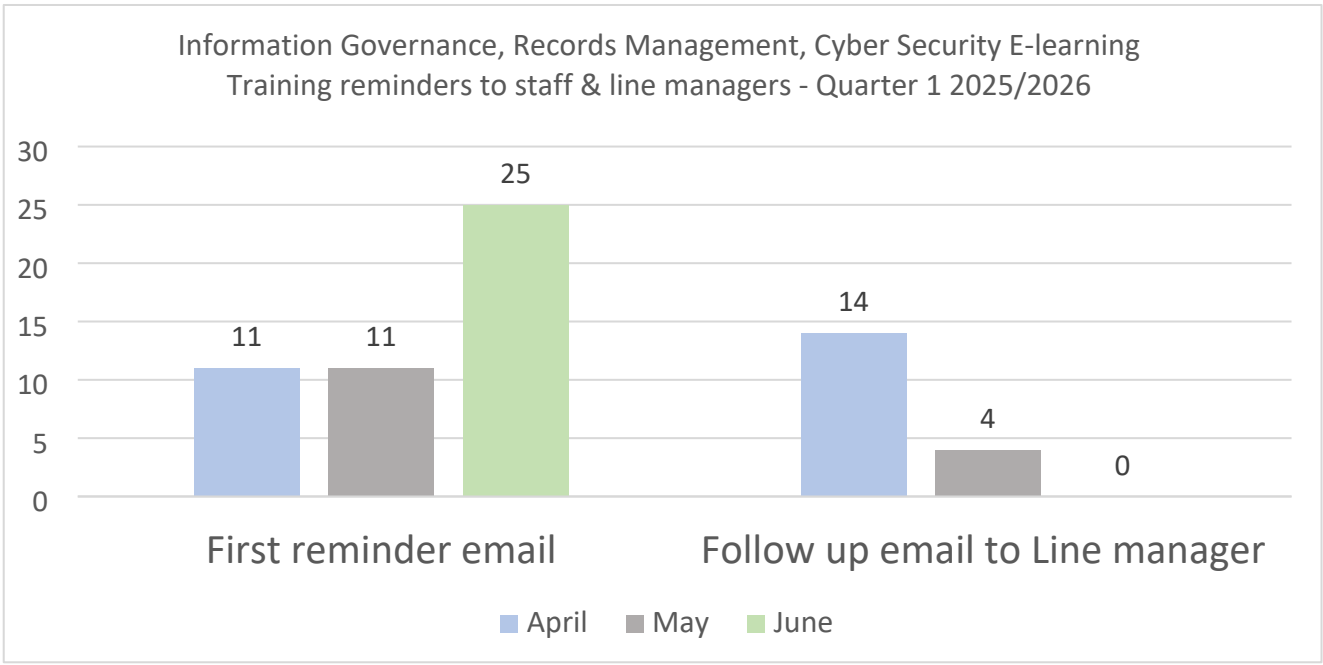
New starters Compliance Q1 2025/26:

Mandatory IG Module Completion	Q1 2025/2026	
	Headcount	Compliance %
Prior To Joining	16	15.84%
Not Completed	**74**	**73.26%**
Completed within 6 Weeks	7	6.93%
Completed after 6 Weeks	2	1.98%
Grand Total	**99**	**25%**

Detailed breakdown of PTHB wide training compliance by directorate as at 30 June 2025:

Directorate	Assignment Count	Required	Achieved	Compliance %
Bank Staff	1538	1538	945	61.44
Chief Executive Office	23	23	21	91.30
Community Care & Therapies	1108	1108	1001	90.34
Community Dental Service	71	71	64	90.14
Corporate Governance	26	26	25	96.15
Estates & Works	50	50	44	88
ESR	27	27	26	96.30
Finance Directorate	34	34	31	91.18
Facilities & Support Serv	192	192	153	79.69
HCRW	81	81	71	87.65
Medical Directorate	6	6	4	66.67
Mental Health	487	487	416	85.42
Medicines Management	38	38	36	94.74
Nursing Directorate	33	33	29	97.88
Public Health Directorate	96	96	89	92.71
Planning Directorate	17	17	15	88.24
People & Culture	70	70	59	84.29
Primary Care	20	20	19	95
Therapies & Health Sciences	65	65	64	98.46
Transformation Directorate	18	18	15	83.33
Women and Children	211	211	184	87.20
Grand Total	4211	4211	3311	**78.63**

The graph below shows the number of first time and follow-up reminder emails issued:



Internal training provided by team.

- Training Requests Received**:** 10 internal training requests were received from services during this quarter.
- Training Delivered**:** 9 sessions were delivered by the IG team, including 2 sessions originally requested in Q4 2024–25.
- Closed Request**: 1** due to no response from the requesting service.
- Forward Planning**: 2** sessions requested in Q1 are scheduled for delivery in Q2.

NEXT STEPS:

- Enhance organisational awareness of Information Governance and Records Management through targeted group sessions, digital learning tools, and ongoing training initiatives.
- Collaborate with People and Culture to strengthen IG awareness for new starters, ensuring early engagement and understanding of key responsibilities.
- Continue working closely with services to identify root causes of delays and breaches in information request processing and implement practical solutions.
- Conduct a detailed analysis of mandatory IG training compliance, focusing on new starters and directorates currently below the 85% threshold, with actions to improve uptake.
- Support directorates in improving compliance with the IG Toolkit through tailored guidance and follow-up.
- Maintain quarterly assurance reporting to the Committee, providing updates on progress, risks, and improvement activities. Exploring ways to

provide more detailed analysis post implementation of the new BI Activity tracker

IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe					A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial					
Corporate					
Operational					
Reputational					

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

Agenda item: 5.11

Audit, Risk and Assurance Committee	**7 October 2025**
Subject:	**Digital First Quarterly Monitoring Report**
Approved and presented by:	Claire Madsen, Executive Director of Allied Health Professionals, Health Science and Digital
Prepared by:	Chief Digital Data Officer Assistant Director of Digital & Data Operations, Head of Digital Programmes and Chief Nursing Information Officer
Other Committees and meetings considered at:	Executive Committee – 1 October 2025 who endorsed the report to Committee.

PURPOSE:

To provide a Digital First update and assurance relating to the delivery of the Digital, Data and Technology Services within Powys Teaching Health Board (PTHB).

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE** that we are progressing and delivering against the Digital Strategic Framework, to embed a clinically led digitally enabled service in support of Digital First as a Strategic enabler for transformation, improvement, quality, safety and efficiency.
- **NOTE** the key achievements.
- **NOTE** the key challenges.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	

6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

This report will provide an overview of progress, challenges and areas needed for improvement in the following key areas:

- **Clinical Informatics Progress Update**
  - Clinical Digital Systems Group
  - Digital Transformation Trainers
- **Digital Data & Technology Update**
  - integrated Medium Term Planning 2025/26
  - Expansion of the Target Operating Model
  - Digital Initiatives & Governance Management Group
  - Customer Satisfaction Survery
  - Team Performance Updates
    - Service Desk
    - Field Engineers
    - Infrastructure
    - Assets & Procurement
    - Data & Business Intelligence
    - Clinical Applications Support
    - Data Quality
    - Applications Development
    - Application Architecture & Integration
    - Digital Programme Management
      - Local Projects
        - Virtual Consultations
        - Integrated Medium Term Planning 2025/26
        - Whole System Review
        - Print Management
        - Digital Dictation
        - Cross Border
      - Ministerial Priority Digital Programme Updates
        - Digital Maternity Programme
        - Electronic Prescribing Medicines Administration (EPMA)
        - Welsh Community Care Information System (WCCIS) replacement
        - NHS Wales App
  - Appendix A – Digital Data and Technology (DDaT) Key Performance Indicator (KPI) Report
  - Appendix B – Data Corrections on Clinical Systems
  - Appendix C – Clinical Coding Performance

Please Note following feedback at the Executive Committee 01/10/2025 future reports for Digital First will be reporting in a format that is aligned to the Digital Strategic Framework 2023 – 2027 Key Strategic Themes.

PROGRESS UPDATE

Clinical Informatics Progress Update

Clinical Digital Systems Group

A clinically led, digitally enabled group (Clinical Digital Systems Group) has been established to convene clinicians and heads of service alongside other key representatives from digital and information governance. This group met for the first time in July (10th). It's purpose is to lead, oversee, and support the delivery of digital transformation in clinical services. The group is responsible for digital leadership and digital accountability in clinical areas and the optimisation and effective use of clinical digital systems across Powys Teaching Health Board. Its primary aim is to maximise the benefits of digital tools to enable safe, efficient, and standardised patient care, and to provide clinical leadership in setting the strategic priorities for digital development across the Health Board. This is recorded within our IMTP to embed digital accountability across Operational areas. Attendance will be monitored and measured, as well as improvement outcomes and actions. This group reports performance to the Investment Benefits Group, and via the Digital First Performance Quarterly Updates.

The key objectives of this initiative are:
1. Standardisation and Optimisation of Clinical Documentation and Digital Processes
Promote and support the widespread adoption of an 80:20 approach to clinical documentation, ensuring that the majority of forms and processes are standardised and shared across professions and systems, while allowing for a proportion to be tailored to specific needs. This enables the creation of a unified, person-centred patient record, not bound by system or professional silos. Efforts will include acting on insights from digital reporting and analytics to improve data quality and accuracy, system adoption and use, standardising clinical/digital processes and forms across multidisciplinary teams, identifying and addressing poor data input practices, and establishing protocols for safe, consistent, and standardised system usage and implementation.
Additionally, all improvements will be aligned with information governance requirements, and consideration will be given to the skill mix and workforce implications of digital adoption, including training and system integration needs.

2. Integration and Evidence-Based Use of Digital Systems
Promote the effective use of existing clinical systems by supporting their full integration into clinical workflows, with the aim of enhancing both patient care and professional practice. This involves strengthening collaboration with clinical and operational staff to ensure that digital solutions are meaningfully embedded in everyday clinical activities. It also includes fostering the consistent, evidence-based adoption of digital systems in alignment with clinical priorities and Health Board objectives, and ensuring continuous clinical oversight, review, and input

into digital transformation processes - including approval of business cases, policies, Service Operational Procedures (SOPs), Business Continuity and documentation.

3. Clinical Leadership and Alignment with Strategic Frameworks
Provide robust clinical leadership, scrutiny, and advice on digital priorities, implementation processes, and strategic plans. Ensure that all digital transformation initiatives are closely aligned with the Powys Teaching Health Board Digital Strategic Framework 2023-2027, addressing both clinical needs and priorities. Clinical leaders will contribute to the review and sign-off of digital-related policies and documentation, address information governance concerns, and support the development and implementation of digital solutions that are integrated and responsive to the evolving needs of the workforce and patient population.

In support of the Electronic Prescribing Medicines Administration (EPMA) implementation, the Clinical Informatics team have appointed two Digital Transformation Trainers on fixed-term contracts. Alongside this focused support, the team has introduced a series of concise 'Digital Top Tips' guides. These resources provide quick, practical solutions to common digital tasks and are designed to build confidence and promote consistency in day-to-day digital practice across all staff groups. This approach offers immediate, accessible support while contributing to the longer-term aim of strengthening digital capability across the organisation.

Clinical Safety Officer

Currently, Powys Teaching Health Board does not have a dedicated Clinical Safety Officer (CSO), as the formal standards from NHS England around clinical risk management in digital systems DCB0129 and DCB0160 aren't required in NHS Wales. Whilst there is currently no official expectation for Welsh Health Boards to appoint a CSO we recognise how important clinical safety is in digital health, so we are taking steps to review our current arrangements and develop a sensible approach for our needs. Recently, we provided a two-day "Proactive Clinical Risk Management in Health Information Systems" training for key clinical and operational staff working with digital systems. This is part of our ongoing work to support a safe digital environment and build clinical risk awareness right across our services and is monitored through our IMTP.

Digital Data & Technology Operations (DDaT)

Expansion of the Target Operating Model

A restructure of Digital teams in January 2025 has allowed the Target Operating Model (ToM) for business-as-usual workload to be strengthened and expanded

into Data & Application teams. This change will introduce improved process, reporting, communications and provide a universal single point of entry for every digital service, this simplifies KPI performance tracking and supports the development of demand and capacity forecast for digital teams. This work has been a significant undertaking for all teams and our users and has required significant changes to operational process in teams to align the support model. This transition was completed by July 2025, and reporting for these teams is now in progress. We expect to have a full quarter of data by the end of Q3.

Digital Initiatives & Governance Management Group

The Digital Initiative and Governance Groups first meeting took place in August. This group replaces the previous 'Digital Governance Board' following a review of the Terms of Reference and membership to align governance and alignment of resource for delivery of the initiative in one single process.

The previous Board provided robust cyber, information governance and procurement advice to ensure alignment with legislative and best practice processes from each area. However, the process did not then provide a clear route to implementation for submissions. The new group provides a clear path to delivery where it is appropriate or required to move the initiative or change request forward.

The progress and outcomes of submitted Digital initiatives is published for all members of staff to monitor on our intranet site Digital Initiatives & Governance Group . Alongside the adoption of the Target Operating Model across all teams this Group will be more transparent in surfacing demand for larger initiatives and allow more robust resource planning in line with our ongoing Demand and Capacity activities.

Integrated Medium Term Planning 2025/26

The 2025/26 Integrated Medium Term Plan is progressing as scheduled for Q2. Due to notable upgrades and modernisation of infrastructure, networking, data platforms, and local initiatives such as print management and telephony, the foundational systems are now more robust. The next phase will focus on measurable improvements in digital solution adoption and transformation, aiming to support collaboration with clinical staff and frontline teams through shared learning and joint efforts.

The expectations of delivery for both local and national programmes continue to increase during the financial year. The availability of local resource to support a

dynamic and growing significant programme of work for completion by the end of 25/26 continues to be a challenge. Due to late funding allocation letters, it is recognised that in some cases there is limited activity on programmes for Q1 and Q2, as we cannot resource/recruit until the funding letters arrive.

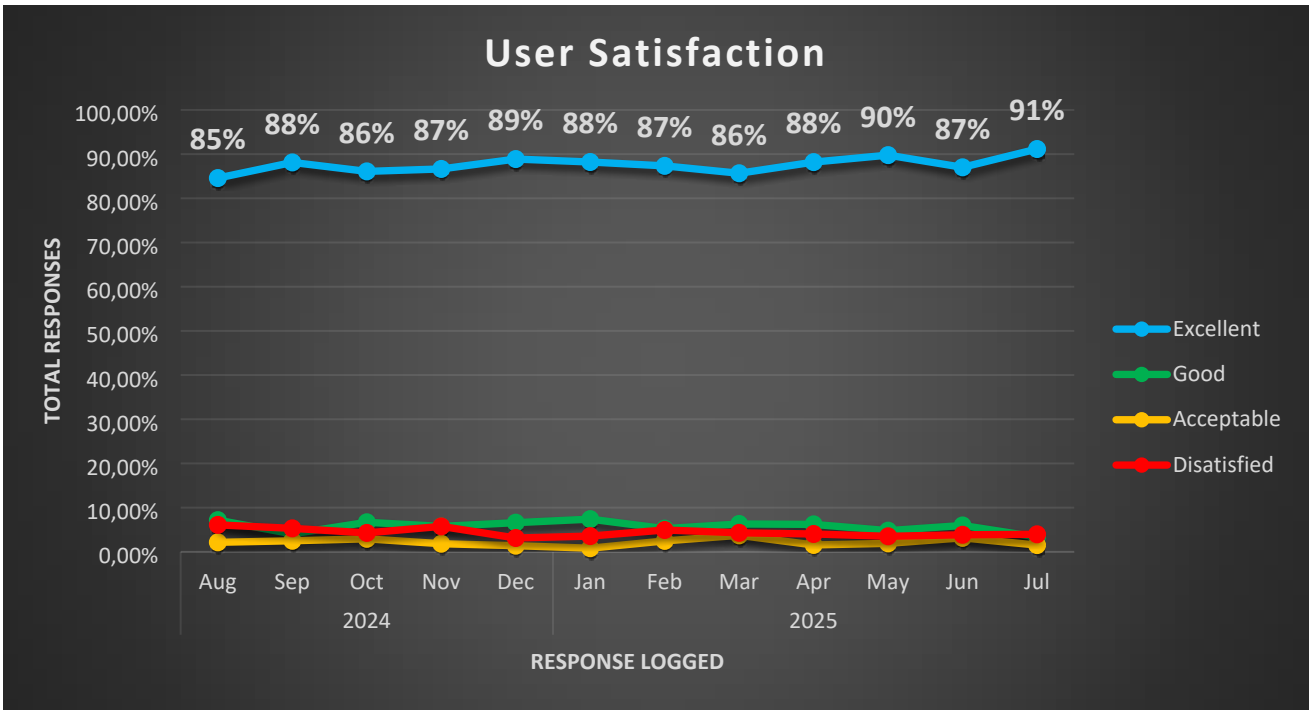
Exceptions to progress delivery as expected and planned are: The Cross Border Project, in partnership with DHCW, has experienced delays in meeting its intended milestones due to technical system issues. Similarly, the EPMA's initial go-live milestone for October has also been postponed because of technical system challenge with availability of the Testing Platform.

User Experience & Satisfaction Results

A key objective for the Target Operating Model for Digital is to increase a focus on user perception and experience. We measure feedback from colleagues upon completion of an incident or request.

Our ambition was to achieve over 90% excellent feedback. During July 2025 our focus is now to sustain that performance over time.

Overall, 94% of users provided a feedback score of Excellent or Good.

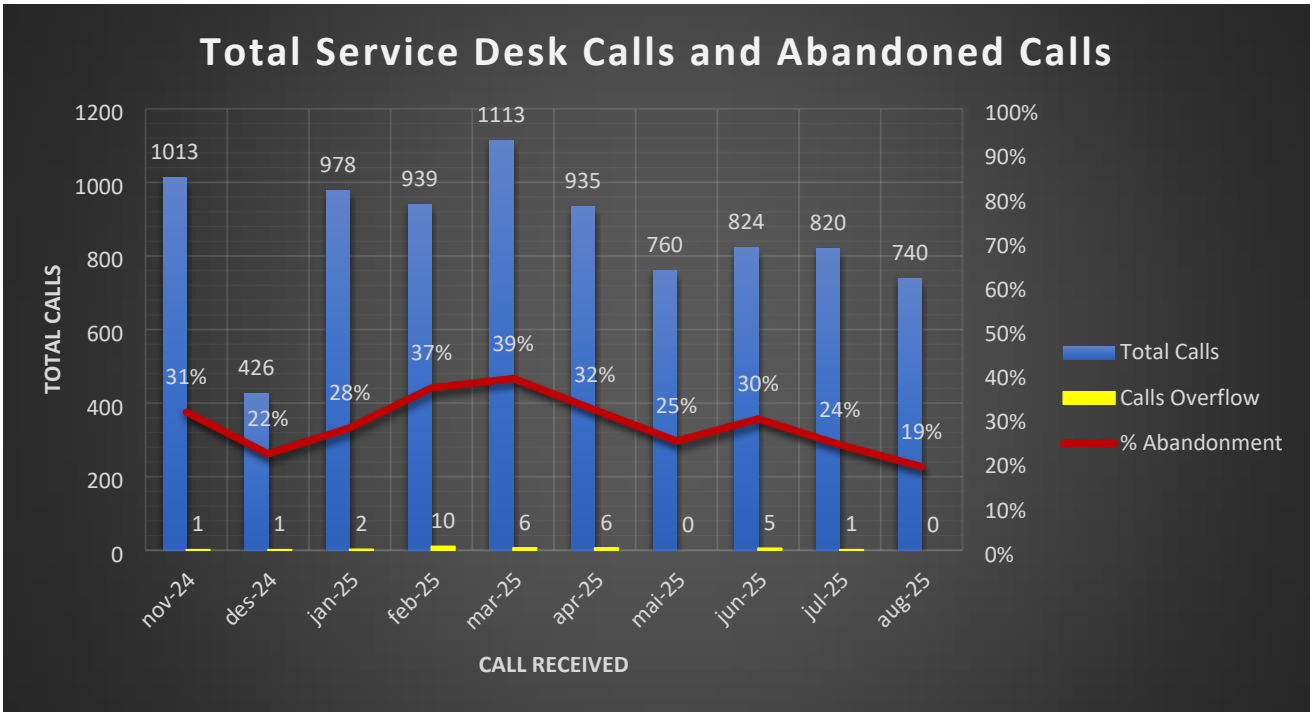


Service Desk

The service desk workload consists entirely of business-as-usual activity and performance is measured via defined key performance indicators.

Dealing with telephone calls from staff requiring digital support forms the largest part of the team's work. Alongside procedural and automation improvements a particular focus on reducing the number of abandoned calls (users hang up before their call is answered) is evidencing small but consistent improvement in performance.

In the last quarter we are aiming to embed the service desk as the Single Point of entry for all digital teams, this change ensures services and responses are provided in a consistent and managed way that aligns with the IT Service Management Industry Best Practice ITIL framework (Information Technology Infrastructure Library) that is at the heart of our Target Operating Model introduced in 2024. This also ensures we can report performance and KPIS in a standardised way.



Average call wait times have remained below five minutes for the last four months.

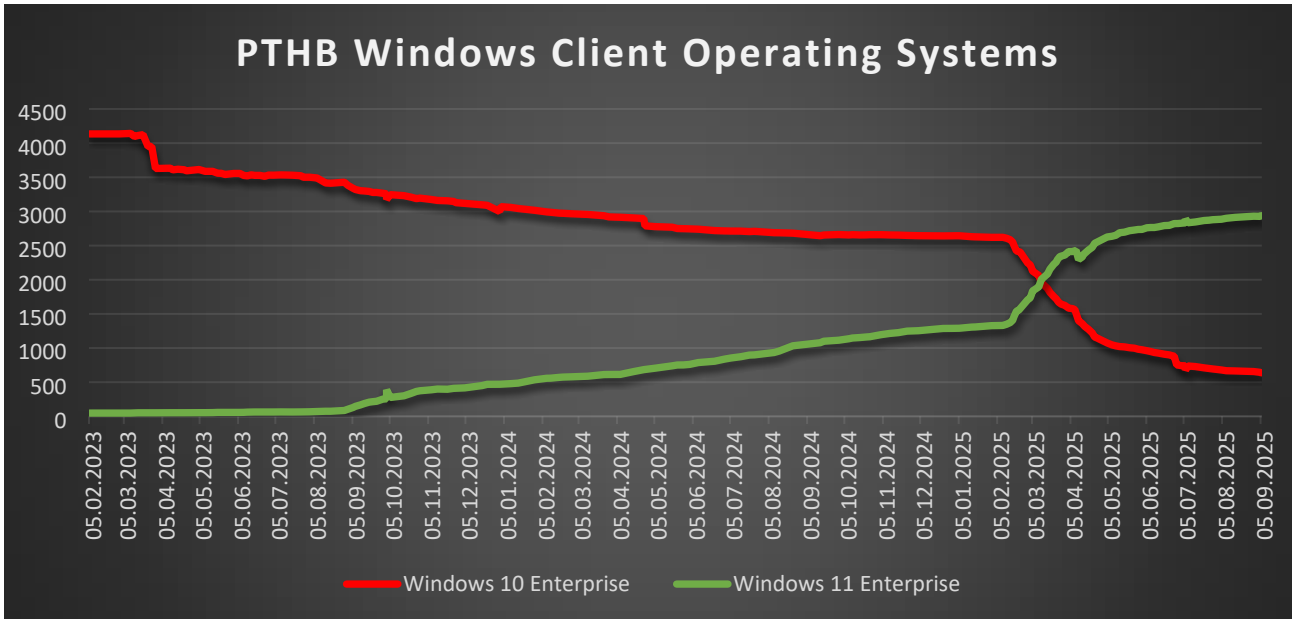
As part of our Continuous Service Review and in response to feedback from our user experience forums, we have evaluated the feasibility of extending the IT Service Desk's operating hours. To better support team handovers and clinical shift changes that occur outside the previous hours, we have extended the Service Desk's availability from 8:30 AM to 5:00 PM. This additional hour extension has been implemented without requiring additional resources or funding.

A more detailed analysis of all Digital KPI's with narrative is provided as Appendix A.

Field Service Engineers

Field Service Engineers (FSE) receive their work packages via escalation from the Service Desk. The performance of the FSE is also measured by KPI's for incidents & requests. This team are achieving 81% and 68% of KPI's for Requests & Incidents respectively.

This team is responsible for manually upgrading Windows 10 devices that cannot receive automated Windows 11 updates. The goal is to mitigate financial and cybersecurity risks linked to continued use of Windows 10 past October 2025. The project aims to remove all Windows 10 by October 2025.



Since June, FSE site schedules have been set. Staff appreciate knowing engineers' expected visits each week.

Infrastructure

The infrastructure team is responsible for maintaining the health boards digital infrastructure that supports the delivery & availability of all digital services and systems.

Network Equipment Refresh – Efforts to replace networking infrastructure continues to make progress. Network infrastructure and cabling have been completely renewed in Glan Irfon and Monnow Ward, Bronllys occurred during August. Work is being scheduled for Welshpool Hospital. This work is necessary to ensure that networking connectivity is supported by manufacturers, doesn't pose a cyber security risk and increases capacity where there are limitations to growth. Network refresh is expected to continue into 2026 where the work will need to start to replace infrastructure installed in 2022/23.

Datacentre Infrastructure Refresh – A project has commenced to replace

PTHB's datacentre Power and network infrastructure has begun. This refresh increases performance and availability of our core infrastructure. The backbone of our core datacentre network will be increased from 10GB throughput to 60GB throughput. This increase in capacity doesn't necessarily improve performance for end users, but improves our ability to backup and, more importantly, restore our services in the event of a device failure or cyber incident. As part of this work, we are commissioning completely new hosting, network and power infrastructure into our Spa Road site, replacing aging and unsuitable infrastructure that is currently in Brecon. This work is expected to complete by end of November.

The infrastructure team is also contributing to the technical implementation and Delivery digital projects which will include, but not limited to, EPMA & DMC projects.

Assets & Procurement

The Digital Asset Management Policy was finalised and approved during August, introducing clearer governance for asset lifecycle management, including acquisition, tagging, maintenance, and disposal. This policy aligns with ISO standards and WEEE regulations and addresses risks such as data breaches from lost devices.
The team has been operating on reduced capacity for the last quarter due to a vacancy gap, with the team achieving 66% against SLA expectations. A vacant position has now been recruited to, and we are expecting SLA compliance to increase after a period of training expected to be complete by November.

A focus on contract management for digital suppliers is having a positive impact on managing contractor expectations and delivery. During this financial year penalties for late payments have been eradicated with just one exception.

Alongside routine device replacement and digital equipment orders, the team are supporting procurement processes for EPMA & DMC Project activities.

This team is also responsible for managing the Digital Services IT Service Management Tool (HALO). This tool is helping increase performance of small teams through workflow automation, the investment in automation to support digital function through HALO is preventing a more significant drop in performance to allow capacity to support transformation / project function.

Data & Business Intelligence

The data and business intelligence team is responsible for collecting, validating, and analysing data from multiple sources within the Data Bricks cloud-based data platform. Achieving a single, accurate, and trusted source of data remains challenging due to the health board's reliance on commissioned services from other organisations.

Aligning with organisational priorities, the team continue to provide significant support to the Better Together, North Powys Programme and Business efficiencies is slowing our progress in completing the transition from our older reporting tools to our new cloud platform. The dynamic nature of these programmes is supported as a priority; it does however limit planning of other work.

Work continues to support the national data architecture as part of the National Data Resource (NDR) Programme which funds part of our Data Analyst function. PTHB remains the only health board in a position to transition data to and from the national platform using our local data repository (Databricks), and we continue to meet our defined objectives that support funding of our local data repository work.

Additionally, the demand from Better Together, Finance, Planning, and Performance has been significant. We have had to review the requests from services to help manage and prioritise them as part of our demand and capacity planning. This has resulted in some changes to the way in which requests for data are made to improve overall transparency, timely and consistent responses, and a route for escalation if needed.

Recently Developed Data Reports.

- Print Usage Report – Allows departments to monitor and address inefficiencies related to high volumes of printing within the health board. Despite the implementation of print management solutions, there are still challenges in reducing printing volumes. The report aims to facilitate collaborative discussions to tackle these inefficiencies.
- Vaccine Monitoring Dashboard - Dashboard to keep track of Powys contractors monitoring requirements for the central procurement of flu programme for 2025/26
- Hepatitis B&C Testing - Provide access the Hepatitis B & C testing data to identify where testing has currently taken place across Powys to support the Welsh Government goal to eliminate Hepatitis B & C by 2030.
- Safeguarding Strategic Group Report – Support a system wide approach to safeguarding in PTHB and demonstrate compliance with national Safeguarding Quality Priorities.

Clinical Applications Support

Following the merger of the PTHB WCCIS support team and Applications support team in February this year the team are currently cross skilling members of each team to achieve greater resilience with workload in support of our clinical applications.

Agreement to proceed on a replacement for the WCCIS platform will require the re-direction of resources from this team in 2026 calendar year to support a smooth and timely transition. A more detailed project update can be found below.

The team are meeting all SLA targets set, evidenced by the KPI report as Part of Appendix 1.

Data Quality

The data quality team is responsible for defining and co-ordinating the implementation of agreed national data standards. They are also responsible for defining methods of identifying and correcting incorrectly entered or processed data in our systems.

The number of records corrected across all digital systems in PTHB has been recorded since May 25.

Corrected Records	2025-05	2025-06	2025-07	2025-08
Monthly Total	2312	2195	3496	924

A more detailed table is included in Appendix B.

Efforts to minimise incorrect data in our clinical systems is targeting two distinct causes.

1) Training our clinical staff to support more accurate data entry.
2) Requesting changes to data input validation and verification at the point of entry.

Proposed changes to national systems pose a significant challenge seeking agreement of all organisations, and even if agreed, DHCW amongst other suppliers struggle to prioritise such changes.

Coding performance remains above national targets despite long term absences. Work is underway to explore capacity requirements for this team due to continued and prolonged achievement of targets during long term absence.

Coding performance table is included as Appendix C.

Applications Development

The application development team continue to contribute to applications development of DigiFlow & Silvercloud.

Several legacy applications developed in the last ten years that remain in use have been developed and deployed under sub-optimal circumstances. These

applications are in the process of being re-deployed or re-developed to ensure consistent service delivery, support and ownership is in place.

A review of current application development tooling is currently underway. This review is necessary to mitigate potential increases in costs for licencing because of the all-Wales Enterprise agreement renewal currently underway.

Application Architecture & Integration

The Application & Architecture team are responsible for providing technical design and integration assurance and documentation for the implementation of local and national clinical systems.

The team are contributing heavily to the implementation of all the project workflows that form part of our digital programmes. The team develop testing and process documentation to evidence systems are both safe and functional at the point of integration.

The team also act as a point of escalation for complex issues requiring support from the clinical application support team. KPI's for this element of the team's responsibilities will be available in October.

Digital Programme Management

The Digital Programme Management team supports the delivery and initial benefits realisation for the most complex digital projects where co-ordination of activity is required across several digital and clinical teams is key to a successful transformation agenda. Updates for each key project are included below.

The team supports Local & National Digital Projects to ensure that the overall transformation programme is managed within existing capability & capacity.

Welsh Government Priorities

The following projects are being managed as Ministerial projects by Welsh Government

Llywodraeth Cymru
Welsh Government

Eye Care – (Ministerial Priority)

The Digital Eyecare Programme commenced in 2020, following patient safety concerns highlighted in a Health Inspectorate Wales (HIW) thematic report. The scope of the programme was to digitise the referral process from primary care to secondary care ophthalmology settings (EPR), as well as introduce an electronic patient record (EPR). The intention was for the system to be live across health

board by March 2024, and for health boards to fund ongoing system and development as business as usual.

Due to ongoing cyber and IG concerns with the system hosted by Cardiff and Vale and following a review conducted by Digital Health and Care Wales, the project was put on hold.

Welsh Government have recently issued a funding letter (£50k for Project Management) and mandated that health boards introduce Open Eyes (EPR) by March 2026 through Cardiff and Vale's contract, and ERS when identified.

Planning and delivering project outcomes are difficult when funding letters are received late in the calendar year, as with Eye Care there is now only 6 months to roll out Open Eyes. By this point, key milestones and resource allocations have often been established in other priority projects, making it challenging to reallocate funding or recruit additional project resources at short notice. These changes may affect existing project timelines and resource distribution. There is an option to offer low to no confidence of delivery, and WG have advised if this is the case, they will request the funding be returned.

Llywodraeth Cymru
Welsh Government

Digital Maternity Programme (Ministerial Priority)

A national governance model has been established, featuring a Technical Advisory Board (TAG) and, pending formation, a Clinical Advisory Board (CAG), with BCUHB as our collaborative partner. This framework is designed to strengthen local governance, standardisation, encourage consistency, and reduce duplication of effort across Wales.

The Powys Clinical & Technical Operations Group is now fully operational, offering strategic oversight for the BadgerNet implementation. Meeting weekly, the group addresses issues related to integration, data migration, and reporting. In addition, regular weekly meetings are being held with the supplier, coordinated to align with the work of the Clinical & Technical Operations Group.

Summary:
Current Status: The national DMC programme, led by DHCW, officially concluded in August 2025. Local implementation is now underway, with Powys Teaching Health Board (PTHB) targeting a go-live date of 3rd March 2026 (set to be the first Health Board in the consortium to achieve this milestone)
Key Milestones:
Sep–Dec 2025: Local mapping & design, configuration (aligned to national data standards), and stakeholder engagement. Ongoing project board oversight and technical/clinical advisory input.
Jan–Feb 2026: Final system testing, user training, and readiness assessments.

3rd March 2026: Go-live for PTHB; other Health Boards to follow as per their local plans.
Dependencies/Risks: Alignment of clinical resources, data standardisation, and technical readiness are critical. Any delays in these areas could impact the March 2026 go-live.

Llywodraeth Cymru
Welsh Government

Electronic Prescribing Medicines Administration (EPMA) - (Ministerial Priority)

The project has experienced delays that now require the full implementation of phase 1 to be compressed into the period leading up to the financial year-end on 26 March. This has resulted in a significantly shortened delivery window, driven by financial and system constraints rather than operational readiness.

A business case presented to the Investment Business Group on the 15th September approved the case readiness for the Executive Committee seeking approval for stainable business as usual resources. Support for this business case is essential to ensure the system is properly supported pre and post go live, and subsequent phases of the project are feasible.

Summary:
Current Status: Configuration and testing of the ePMA system (Better Meds) are ongoing, with a development environment in place and user acceptance testing (UAT) scheduled for Autumn 2025. Rollout is planned to begin with an early adopter site in early 2026, followed by phased deployment to all inpatient wards.
Key Milestones:
Sep–Dec 2025: System configuration, UAT, and validation. Staff training and hardware deployment.
Jan–Mar 2026: Early adopter site go-live, process refinement, and phased rollout to remaining sites.
Beyond Mar 2026: Full implementation across all inpatient wards, with ongoing optimisation and support.
Dependencies/Risks: Supplier capacity, integration with existing systems, and clinical engagement are key. Any slippage in UAT or early adopter rollout could delay full implementation.

Llywodraeth Cymru
Welsh Government

Welsh Community Care Information System (WCCIS Replacement) the Connected Care Programme (Ministerial Priority)

The WCCIS Replacement case is approved through PTHB governance, we are working with NWSSP shared services for the procurement of a combined Mental Health and Community solution. DHCW have been supportive in guiding and offering support for our procurement approach.

We have successfully been awarded £299k DPIF funding (subject to WG funding letter) to support the procurement approach and supplier costs for Q3/Q4

Funding beyond this FY has not yet been confirmed but has been submitted to WG via DHCW as part of transparency of required costs.

There is a risk with the current platform as experienced with a recent outage Sept 4th (MI report to follow).

Summary:
Current Status: The existing CareDirector v5 platform will be unsupported after January 2026 due to Microsoft Dynamics end-of-life. National procurement for replacement solutions is progressing, with regional engagement and vendor demonstrations held in April 2024. The master services agreement with the current supplier cannot be extended beyond March 2027, but the focus is on re-platforming before that deadline.
PTHB are due to commence full procurement for a replacement solution.
Key Milestones:
Sep–Dec 2025: Market testing, procurement, and selection of new solutions for, Community and Mental Health services. Ongoing regional workshops and requirements gathering.
Jan–Mar 2026: Supplier contract award, initial implementation planning, and transition activities. Data migration and integration planning to ensure continuity of care.
Post-March 2026: Phased rollout of new solutions, with interoperability and data standards as core requirements.
Dependencies/Risks: Timely procurement, funding clarity, and technical migration are major risks. The transition must be completed before CareDirector v5 support ends.

Llywodraeth Cymru
Welsh Government

NHS App – (Ministerial Priority)

PTHB are working collaboratively with DHCW to provide data relating to prioritising onboarding of clinics to support reducing the wait times. This data has been provided to DHCW in the timescales set out by the Director General in a recent request to improve uptake and provide additional functionality for our population.

This will mean that the NHS Wales App will enable patients to track their place on a waiting list for planned care treatment, view and amend appointments, and access health management tools pertinent to the waiting list that a person is on.

There are activities taking place nationally with DHCW and NHS England to align the cross-border activity, however that is not currently a priority for the programme.
Summary:

Current Status: The NHS Wales App was relaunched in May 2025 with a 12-month roadmap focused on expanding functionality, improving access, and integrating with other national systems to reduce waiting lists. It is now positioned as the "digital front door" to NHS and social care services in Wales.
Key Milestones:
Sep–Dec 2025: Feature expansion, Priority Patient Pathway features live in Hywel Dda UHB (e.g. referral tracking, appointment notifications, cancellation requests)
Jan–Mar 2026: National Onboarding, Planned care clinics onboarded across Wales; integration with Swansea Bay Patient Portal; Welsh Identity Verification Service rolled out
Post-March 2026: Feature extension, Broadcast messaging, proxy/linked profiles, prescription-ready features, and curated digital resources portal
Dependencies/Risks: Awaiting confirmation from WG and NHS Wales Executive for extended roadmap delivery. Active engagement with Health boards and Primary Care to support local accelerated adoption and feedback loops.

High level Ministerial Digital National Priority Programmes.

Programme	Sep–Dec 2025	Jan–Mar 2026	Apr–Sep 2026	Oct 2026–Mar 2027
DMC	Local config, testing	PTHB Go-Live (Mar) Other HB go-lives	Optimisation/support	Benefits Realisation
WCCIS / Connecting Care	Procurement, planning	Transition/interim	New system rollout begins	Phased rollout continues
EPMA	Config, UAT, training	Early adopters go-live, rollout starts	Rollout to all wards/HBs	Full national coverage

NHS Wales App	Relaunch, early adopter features	National onboarding, ID verification	Feature extension, portal integration	Full integration and national coverage

Digital Eye Care Programme (DECP)

The Digital Eye Care Programme was launched in 2020 following serious patient safety concerns highlighted by Health Inspectorate Wales (HIW), particularly around delays in treatment for conditions like Wet Age-Related Macular Degeneration.

Its core aims are:

- Digitising referrals from primary care optometry to secondary care ophthalmology.
- Implementing a national Electronic Patient Record (EPR) and Electronic Referral System (ERS).
- Enabling shared care between community optometrists and hospital eye services

Programme Timeline (2020–2026)

Period	Milestone	Details
2020–2023	Initial rollout	Cardiff & Vale UHB deployed OpenEyes EPR; CTM piloted in one area, PTHB began config and testing, but due to Cyber Security gaps agreed nationally with HBs the programme paused as funding ceased.
2023–2024	Programme paused	Transferred to DHCW; paused for re-baselining and procurement review (given cyber issues and supplier concerns)
2024–2025	Contract extension	Cardiff & Vale funded by WG and extended contract to support national rollout

Apr–Sep 2025	Programme reset	New funding issued (£50k PM support to each HB); OpenEyes mandated to be implemented by March 2026.
Oct 2025–Mar 2026	Rollout phase	Health Boards expected to implement OpenEyes EPR; ERS pending procurement.
Apr 2026–Mar 2027	Full national deployment	NHS Wales aims to complete national rollout by early 2027

Risks & Challenges

Cybersecurity & IG concerns: Delays due to unresolved issues with hosting and data protection. Lack of documentation to provide necessary assurances.
Funding delays: Late funding letters from Welsh Government (August 2025) impact planning and resource allocation, £50k allocation is for project resource only, and will not cover the resource capacity required in the short timeframe.
Clinical Governance gaps: Current clinical pathways are not fully mapped.
Delivery confidence: Health Boards have flagged low confidence in their ability to deliver in line with other major programmes. CTM have not accepted the funding to roll out due to clinical governance mapping and decisions.

Health Board Local Priorities

Virtual Consultations

The Virtual Consultation service provided by Attend Anywhere has transitioned to business-as-usual support. The second phase of Virtual Consultations was to increase and sustain adoption to support business efficiencies and enhance the remote care experience. A target had been set via our IMTP to increase usage by 10% during 24/25 financial year, we have reached that target as planned.

1:1 Call Growth Forecast 25/26

13.52%

Group Call Growth Forecast 25/26

55.08%

There are still areas where adoption is low, however engagement has started to improve with the Planned Care and Secondary Care teams, and further demos have been arranged for September with visiting consultants to support uptake.

Since the contract was signed in March 2025, there has been an **increase** in individual consultations by **28%** with 9 new services onboarded, and an increase in group consultations by **65%** with 7 new services onboarded compared to Q1 2024/25.

A recent survey of 33 participants revealed that 78% were 'satisfied' or 'very satisfied' with the Attend Anywhere virtual consultation platform, 91% of respondents rated the platform as 'Very Satisfied' and 'Very Easy' to use, indicating strong user satisfaction and ease of navigation, and 79% expressed a strong willingness to use it for future consultations, highlighting its value in virtual consultations**.**

Over the last 6 months there has been a positive campaign to increase usage across the Health Board as agreed within our IMTP:

- A workshop held on 1 May, attended by 40 people, featured presentations from
  a. Powys Living Well Service (PLWS) who are 94% digital
  b. Foodwise for Life
  c. Psychology
  d. Primary Mental Health Service
  e. System demo on individual consultations
  f. Engagement with leads not utilising the platform to support onboarding them
- A programme of work to strengthen the wi-fi across Powys is complete
- Guest Wi-Fi has been updated
- A follow up workshop took place on the 15th July, attended by 20 people from 16 different service areas, which focused on group consultations and collaboration with health boards, which included presentations from:
  a. Speech and Language team – Cwm Taff HB
  b. Powys Living Well Service (PLWS)
  c. Powys Sleep Therapy Service
  d. System demo on group consultations

We consistently receive a positive and supportive service from the Attend Anywhere supplier. Their responsiveness and willingness to assist have contributed greatly to a smooth and productive working relationship; working with individual services to increase adoption and help us achieve our goal of a 10% increase.

Digital Dictation

A draft business case to consolidate the Digital Dictation system implementations is ongoing, this will be reported via the Business Efficiencies group. The challenges are to evidence license and usage from the contracts that are held across the organisation within service operational areas.

Cross Border

We are pleased to report that progress has been made over the Q2 period with Wye Valley Trust, with Clinic and Discharge Letters now being received within the Welsh Clinical Portal. The team are currently testing the pathology workflow which is expected to be live at the end of September.

Successful testing with each NHS England Trust has been completed to enable access to the GP Record via the Welsh Clinical Portal. Additionally, GP practices are now receiving discharge summaries from Robert Jones and Agnes Hunt (RJAH).

The project is scheduled for completion by October 2025, which has slipped from March 2025, at which time an evaluation and closure report will be submitted to the Executive Committee.

DHCW have however agreed to replicate the successes in WVT across SaTH for results into WCP, following positive engagement and collaboration for SaTH Pathology Services, this is subject to the same engagement necessary from SaTH IT Departments, which has not to date been as positive, and as a result is in escalation.

Welsh Emergency Care Data Standards (WECDS)

WECDS will replace the module currently used in Welsh Patient Administration System (WPAS) with a standalone application, aiming to facilitate data integration across healthcare and social care services. This will enable a comprehensive understanding of the patient journey through Urgent and Emergency Care (UEC) Services. The initial phase of WECDS implementation will prioritise Type 1 Emergency Departments (24-hour, consultant-led EDs), Minor Injury Units (MIUs), and Same Day Emergency Care (SDEC). In Powys, the change will only apply to Minor Injury Units, with implementation expected to take effect by March 2026.

Planned Care Transformation

Supporting Planned care transformation from Paper to Digital aligns with the Digital First approach in PTHB's Digital Strategic Framework and supports national priorities outlined in "A Healthier Wales" and the NHS Wales Planned Care Programme. The aim is to address challenges such as workforce pressures, increasing demand, and fragmented patient pathways.

Key Workstreams & Actions:

- **Referral Optimisation**: Standardise referral templates and triage protocols, implement digital referral pathways integrated with NHS Wales App and ERS, and use dashboards to monitor referral volumes and outcomes.
- **Outpatient Transformation**: Introduce digital booking and follow-up systems, reduce unnecessary follow-ups through virtual consultations and modern outpatient models, and pilot digital letters and reminders to reduce DNAs.
- **Clinical Documentation**: Design and Deploy electronic patient records across planned care specialties and integrate diagnostics, pre-assessment, and theatre documentation into a single digital workflow.
- **Patient Communications**: Procure a secure solution for digital appointment letters and reminders via SMS/email, ensure accessibility and auditability of all communications, and reduce carbon footprint and postal costs.
- **Workforce & Training**: Develop a digital skills framework for planned care staff, provide training on new systems and digital tools, and engage clinical champions to support adoption.

CHALLENGES:

- Ever increasing digital projects that are ministerial priorities are proving to be a challenge for Digital Operations teams based on existing internal commitments and business-as-usual.
- Digital Inflation continues to put pressure on digital budgets; we are expecting an increase in the cost of our contracts and SLAs with Digital Health and Care Wales (DHCW). The industry is suggesting this may be between 10% and 15%, depending on the specific technology and pricing metric used, with some reports showing increases in hardware like laptops and servers reaching up to 20% in price hikes; software prices are also seeing significant inflation, with increases around 15-20%.
- Upcoming negotiations regarding the all-Wales enterprise agreement may result in increased costs. Reallocation of current significant discounts from the power platform poses a sustainability risk to our application development approach.

NEXT STEPS:

Planned Work
Continue with the planned programme of work and ensure the Integrated Medium- and Long-Term plans align to the delivery of the Digital Strategic Framework 2023-2027.

Demand & Capacity Exercise
Following on from significant enabling process changes across all teams, conduct a Demand and Capacity exercise across the whole digital services directorate and review the current structure for efficiency, capacity and capability to support future requirements.

Ministerial Priorities

Sustain momentum on ministerial digital initiatives and providing clear reporting of progress against ensuring clarity on constraints.

Clinical Process Efficiencies

Enhance Clinical Practices and Patient Care: Conduct comprehensive analyses of performance dashboards to identify opportunities for the enhancement of clinical practices and patient care through digital solutions. This will be measured by the number of identified opportunities and their subsequent implementation.

National Programme Updates
Progress with the Digital Maternity Programme, Electronic Prescribing Medicines Administration (EPMA), and the Welsh Community Care Information System (WCCIS) replacement. This will be measured by the number of national programmes in and their successful phased completion.

Infrastructure
Continue to utilise funding opportunities to refresh digital infrastructure. The aim would be to completely refresh all legacy infrastructure before 2027. Plan for the replacement of significant infrastructure procured in 2023 as it reaches end of life in 2027.

Cyber Security
Maintain current technical cyber security posture and assurance of new digital initiatives. Explore resource opportunities to complete documentation expectations of external audits.

Reporting
Continue to provide robust and transparent report that provide assurances and escalations as appropriate.

Appendix 1

Digital Technology Key Performance Indicators - August 2025

Contents

Report Introduction

This report provides a comprehensive overview of service levels and compliance in managing digital services. It details various aspects, such as service level targets, overall compliance in handling requests and incidents, and compliance breakdowns by team. The document also examines top incident-generating services and user experience monitoring.
The goal is to monitor and improve the efficiency and effectiveness of digital service management.
The report is aimed at managers who want to understand how the demand on and performance of the Digital Services team could impact their team.

Executive Summary

August was predictability quieter than previous months, owing to annual leave across the Health Board. However, it is not the quietest month with shorter holiday periods and other months showing a lower number of tickets. Based on ticket volumes, the Clinical Applications and Procurement & Assets team saw the most notable drops in tickets during August.
SLA compliance in July improved for Service Requests (I Need Something) but decreased for Incidents (Something is Broken). Teams that showed increased performance for Service Requests showed decreased performance for Incidents.
This month is the first report to include the Data and BI team who have migrated their ticketing system to Halo.
There were 2 significant events in August. One involved a certificate expiration and impacted the corporate Wi-Fi. Another random error resulted in the corruption of a storage server and loss of several legacy or non-critical services. This event is ongoing at the time of writing.
The top 5 related services remain largely the same. Changes have been made to provide more granular reporting regarding user devices, and these will be shown in the September report.

Digital Tickets

Tickets are used to structure, prioritise, and track work completed by the Digital Services. These tickets are generated through several methods:

- Email – An email is received from a staff member or supplier that generates a new ticket (this does not include emails that are matched to existing tickets)
- Portal – A ticket is created by using the forms available from the Self-Service Portal https://powysthb.haloitsm.com/portal/home
- Auto – A ticket is created automatically by Halo as part of an automated ticket process i.e. tickets in the New User Process, kit installation requests after equipment has arrived
- Manual/Phone – These tickets are created by a member of the team, usually by the Service Desk.

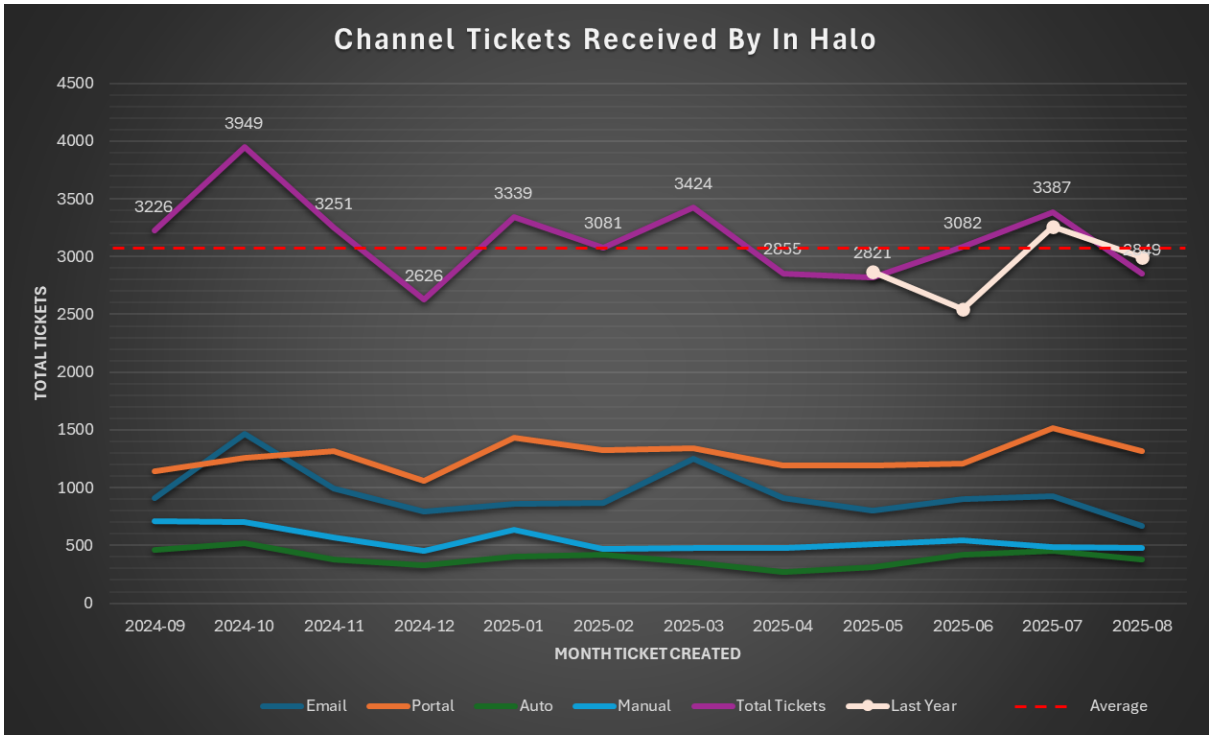


Figure 1 - Ticket generation by method the ticket was received.

The graph above depicts the number of tickets and the method by which they were received.
In August, ticket numbers dropped by 18.9%. This drop was primarily seen in a 38% drop in emails and a 15% drop in tickets via the portal. This drop is anticipated during the summer holidays and coincides with a period of leave for the Digital teams.
Analysis of team tickets shows specific teams benefitted from this drop in tickets. The following teams saw a drop in tickets greater than the average drop:

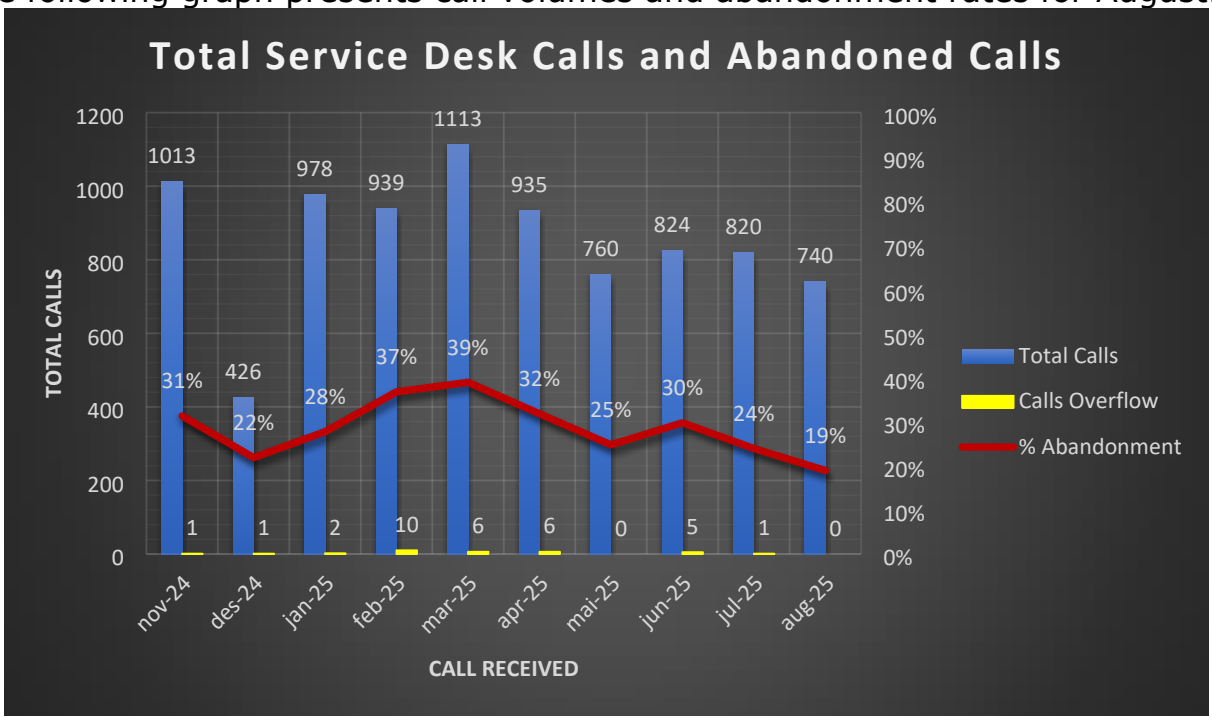
Team	Tickets Opened	

	July	August	% Decrease
System Architecture and Integration	36	19	47%
Clinical Applications	1532	1170	24%
Infrastructure	77	53	31%
Procurement & Assets	309	246	20%

This data provides further evidence that last month's sudden increase of tickets was caused by anticipation of leave. Further, it also provides evidence that email is still the preferred route for requests regarding clinical applications.

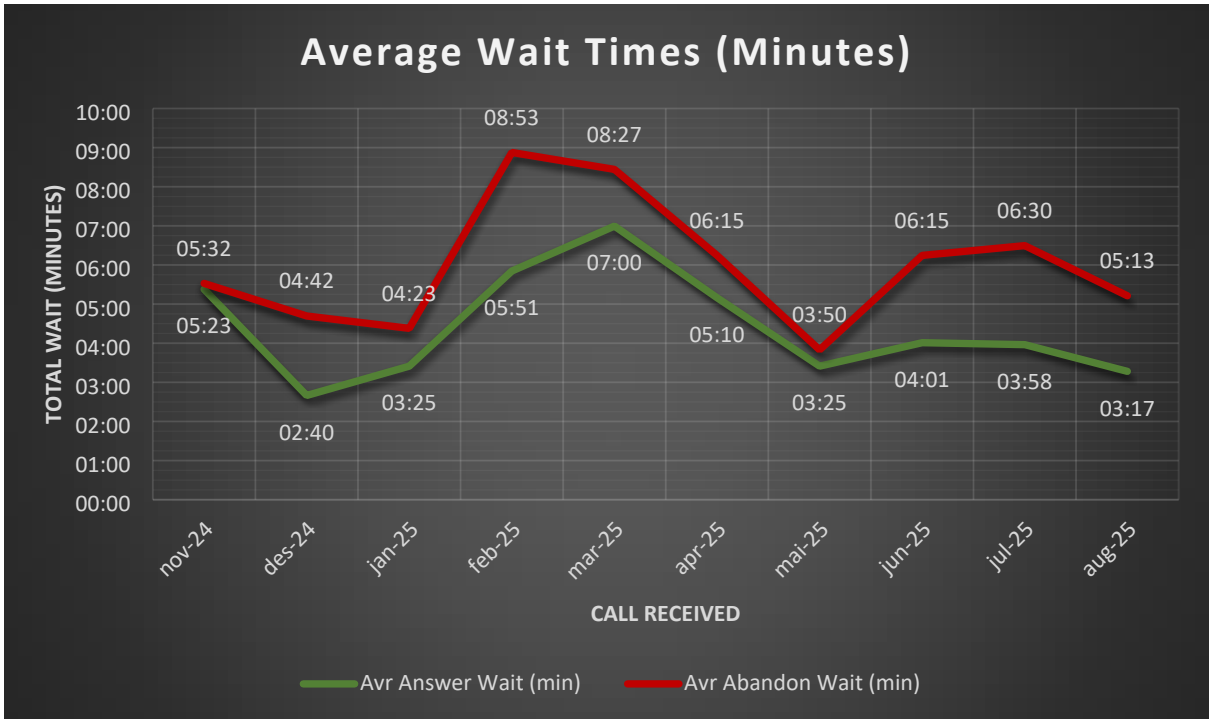
Service Desk Calls

The following graph presents call volumes and abandonment rates for August.



In August, Service Desk calls decreased, and abandonment rates decreased by 5%. However, the total number of tickets created manually remained relatively the same. This suggests that most calls resulted in a ticket and were not chases for existing tickets.

No calls was disconnected, overflowed, or was queued with no agents available.



This month, average wait time decreased by 17%. This average wait time decreased by 20%, suggesting staff were not prepared to wait as long in August. This may be driven by staff absence and more pressure on staff not on leave.

The wait times before answer are within the the 2-3 minute targets set by Operational Level Agreements (OLAs) and Service Level Agreements (SLAs) with Health and Care Research Wales (HCRW).

Incident & Request Trending

Service Requests range from requests for new equipment and software licences, to information requests.
Incidents indicate a failure, fault or problem with our digital services that impacts staff productivity or their ability to deliver care.
Both these ticket types represent a productivity cost to the health board and efforts are required to ensure the total number is reduced as well as the total time it takes to resolve them.

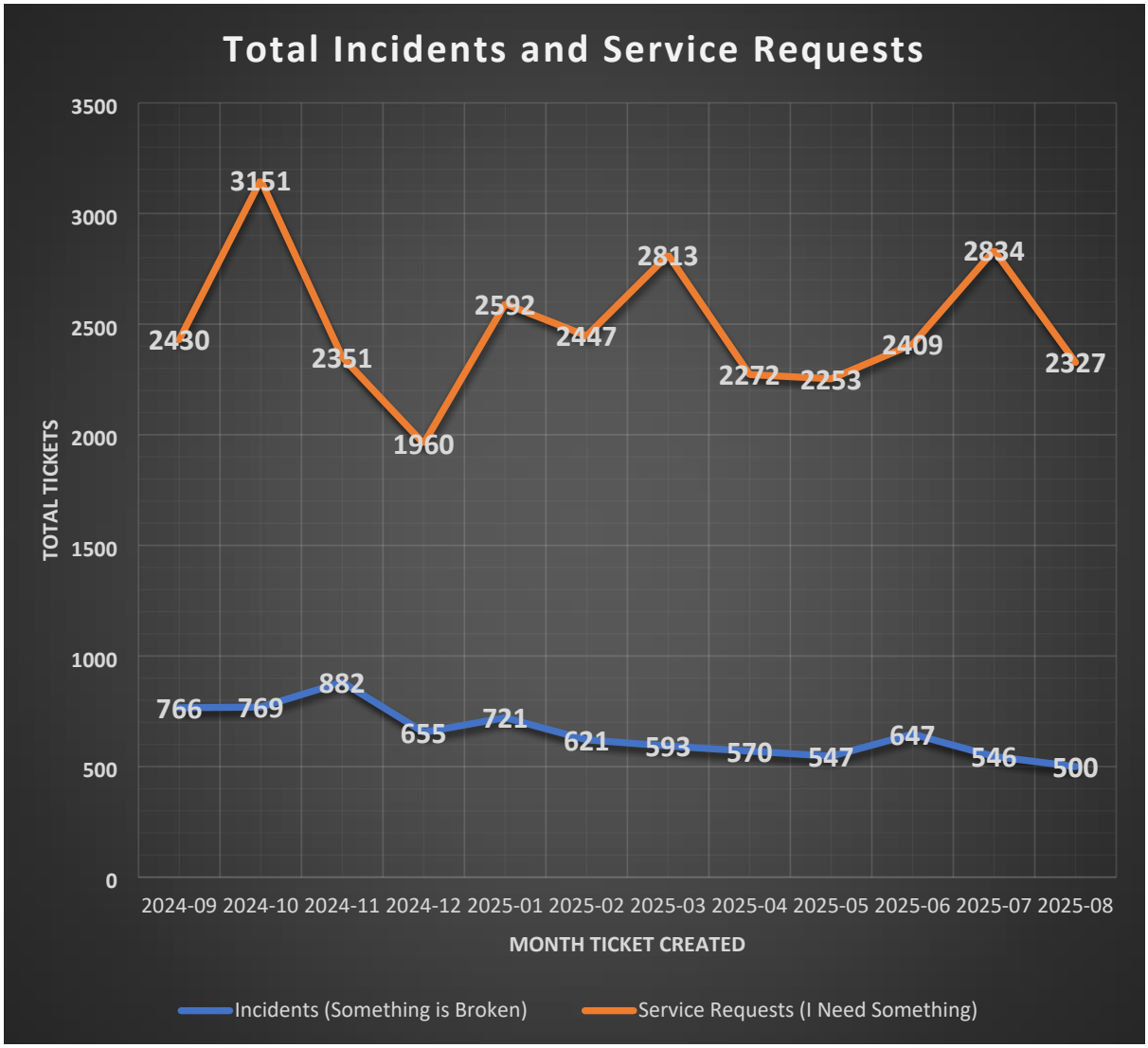


Figure 2 - Total incidents and requests by month

Service Requests Trends

The total number of service requests decreased by 17.9%. This is expected with less staff working in August. However, the total number of requests is not the lower value for the past 12 months. This is, in part, due to more teams using Halo to manage their workload and would align the volume with other holiday periods such as Easter.

Incidents Trends

The number of incidents decreased by 8.4%, returning to an equivalent number of tickets seen in May. This confirms the total number of incidents continues to fall because of improvements to various areas of the digital ecosystem.
Our aim is to reduce the frequency of incidents over time. We'll look to achieve this by: -

- Maintaining sustained investment in the removal of legacy infrastructure and client devices from our estate.
- Continue the expansion of automatic problem detection and remediation. Fixing problems before users are even aware of them.
- Sustained efforts to remove single points of failure in our infrastructure and digital services.

The data indicates that current efforts have successfully curbed the rise in the number of incidents and that we are in fact reducing the likelihood of an incident occurring. However, we expect this decrease to stop with the introduction of more applications to the ecosystem.

Service Level Targets

Digital Services set the following service response targets.

Requests

Priority	Resolution Target
Expedited Request	3 Days
Standard Request	5 Days
Low Priority Request	10 Days

Incidents

Criticality	Response Target	Resolution Target
Emergency Healthcare Impact across Health Board	1 Hour	2 Hours
Critical Healthcare Impact at a single site	1 Hour	4 Hours
Major Departmental Impact	2 Hour	8 Hours
Normal User Impact	4 Hour	12 Hours
Low Limited Impact / Annoyance	8 Hour	16 Hours

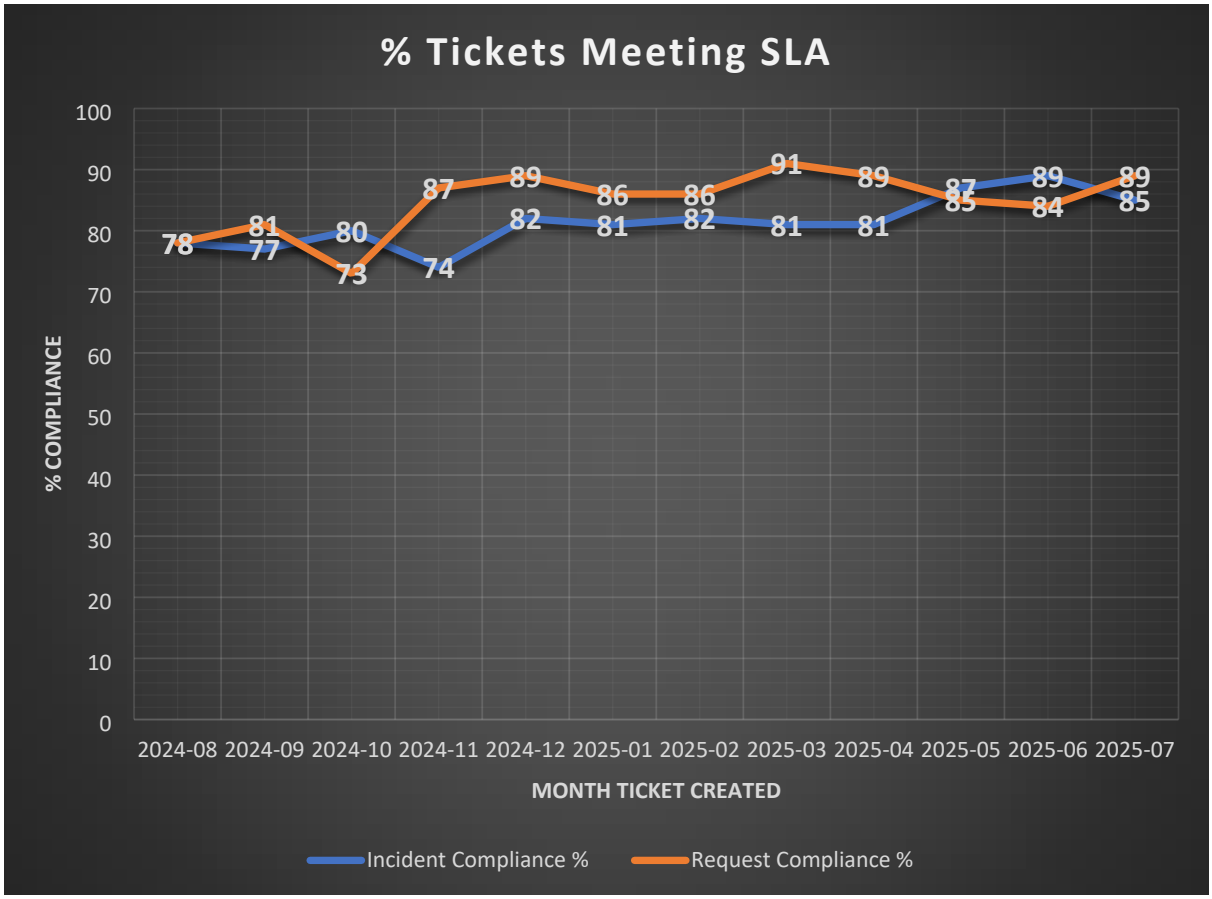


Figure 3 - SLA compliance by ticket for tickets closed as of 4th July.

Requests Overall Compliance

Service Request compliance in July increased to 89%, from 84%. This has been driven by the introduction of the Data & BI team, and several teams making gains in their SLA compliance.

Incidents Overall Compliance

Compliance fell in July, mainly due to fewer tickets resolved by the high-performing Service Desk. Teams that improved service request compliance saw lower incident compliance, indicating ongoing difficulties in balancing workloads.

Request Compliance Breakdown by Team

The graph below shows the level of compliance by different teams in the Digital Services. Compliance is not consistent across the teams, possibly identifying gaps in resource to meet demand within the set SLAs.

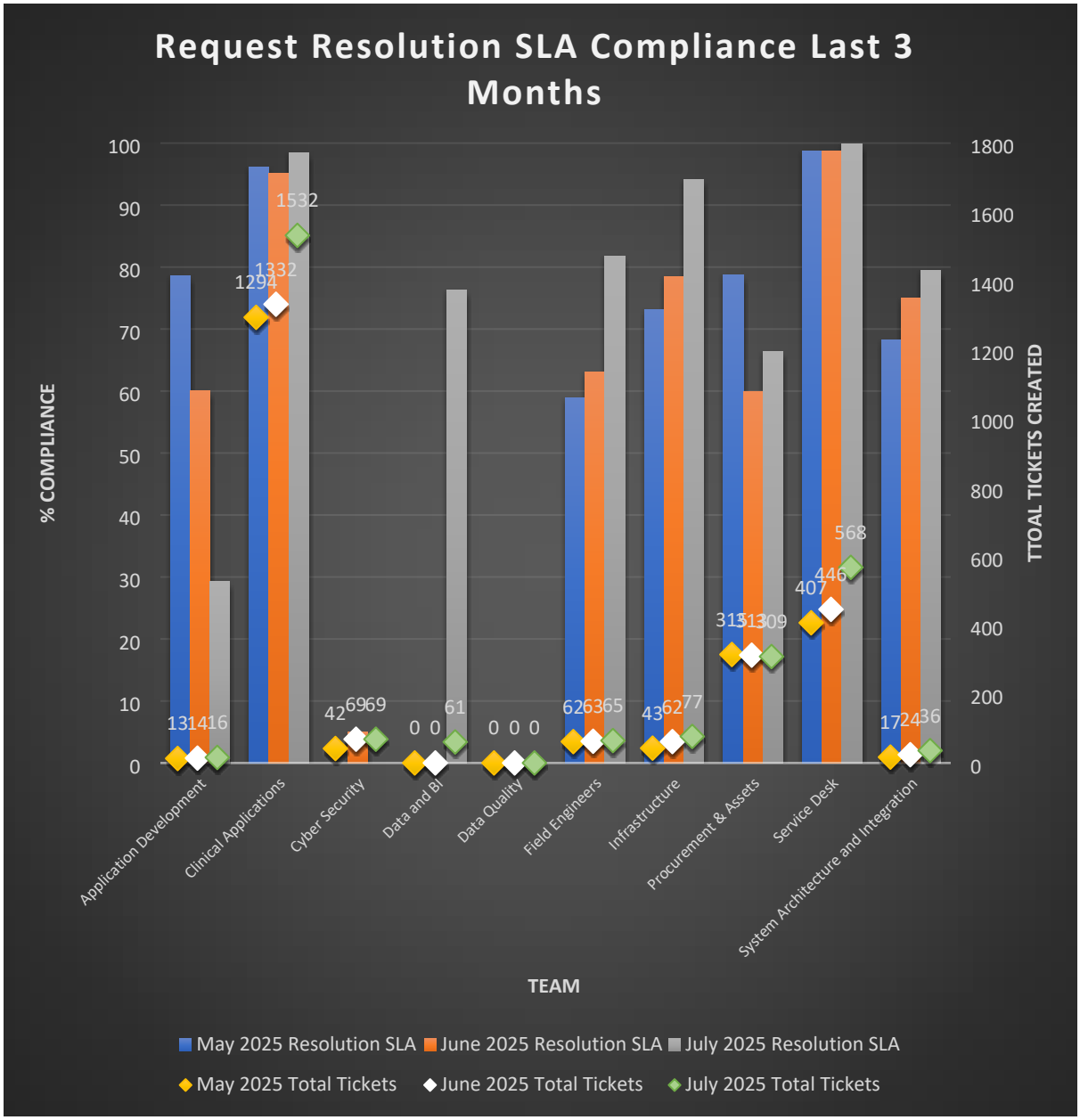


Figure 4 - Request SLA Compliance by Team for the last 3 months

SLA Achievers (>90%)	Notable improvements in SLA (+10%)	Non Compliant (<90%)
• Clinical Applications • Service Desk	• Field Engineers • Infrastructure	• Application Development • Cyber Security • Data and BI • Procurement & Assets • System Architecture and Integration

Both Clinical Applications and Service Desk achieved their respective SLA targets. Of note is the Clinical Applications team increasing their SLA compliance rate despite receiving 200 more ticket than June.
The infrastructure team and Field Engineers have both increased their request compliance by over 10%. This is despite receiving a similar number of requests. However, as described later, this improved compliance has come at the cost of incident resolution.
The Procurement & Asset team has consistently maintained SLA compliance within the 60-80% range. With the addition of a new team member in August, we anticipate further improvements in compliance toward the end of the calendar year.
July marked the first month that the Data and BI teams utilised Halo, achieving a commendable initial compliance rate of 76%. Greater utilisation of the portal for work requests will improve data accuracy and more accurately reflect team demand and capacity.
Similar to the Infrastructure team, the System Architecture and Integration team generally receives tickets only after the Clinical Applications team has made an initial attempt at resolution. This process often results in the smaller team having limited time to address more complex issues.
Cyber Security faces challenges in maintaining compliance due to being staffed by a single team member.
Finally, the Data Quality team was newly integrated into Halo as of August; thus, there is currently no ticket data available for this group.

Incident Compliance Breakdown by Team

The graph below illustrates the compliance levels of various teams within Digital Services. There is a noticeable inconsistency in compliance across these teams, potentially highlighting resource shortages to fulfil demand within the established SLAs.
The Incident Response SLA refers to the time taken for a team to acknowledge receiving an incident reported via email or the portal. At this stage, the incident is prioritised and forwarded to the appropriate team, which must resolve the ticket within the resolution SLA.
The Incident Resolution SLA is the time taken for a team to resolve the issue reported. At this stage the ticket has been triaged. The total resolution time is the time that the team can provide a fix. If the ticket is escalated to a supplier or a meeting is arranged to discuss the issue, then the timer is placed on hold.

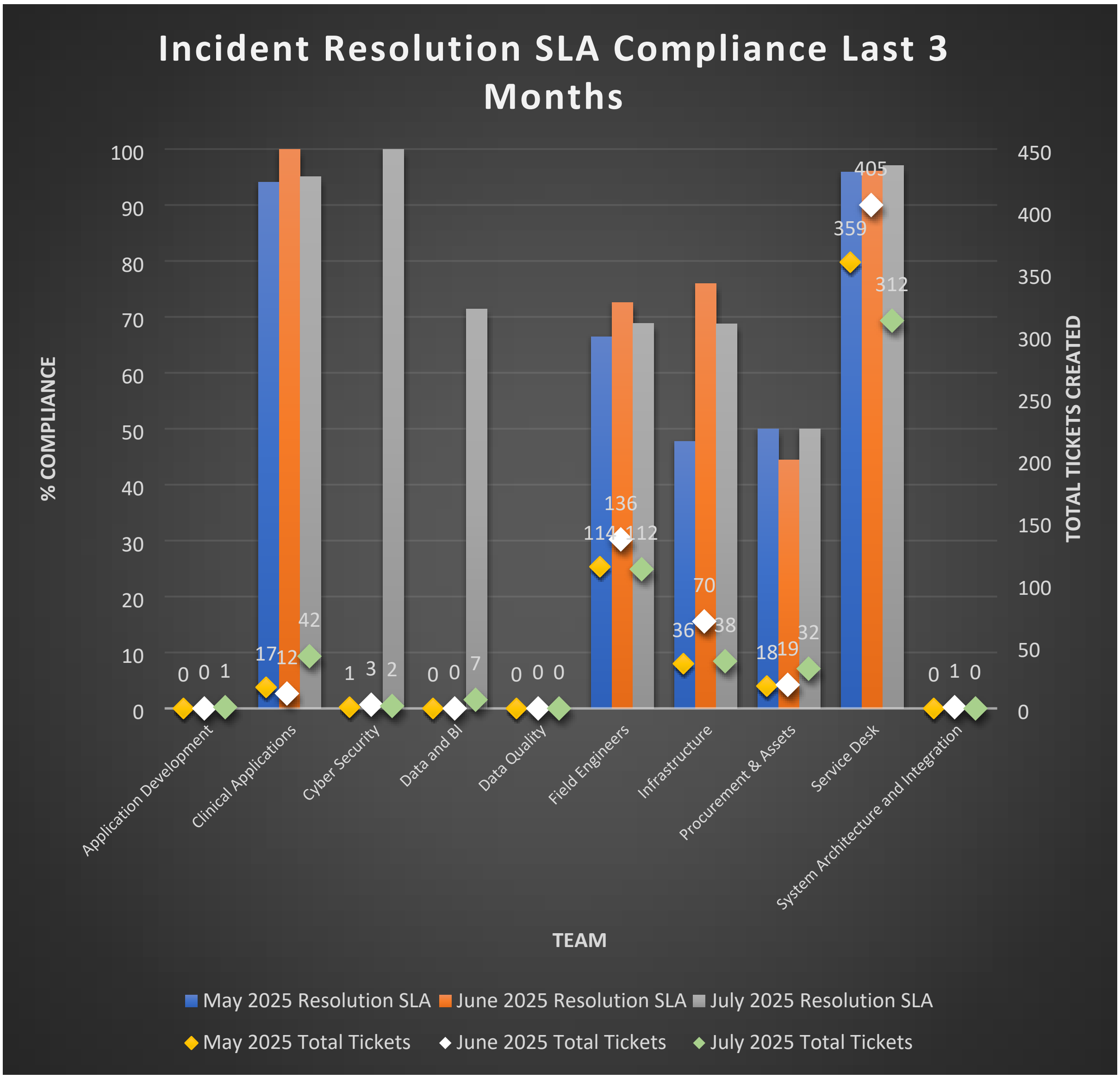


Figure 5 – Incident SLA compliance by team for November

SLA Achievers (>90%)	**Notable improvements in SLA (+10%)**	**Non-Compliant (<90%)**
• Service Desk • Clinical Applications • Cyber Security		• Application Development • Data and BI • Field Engineers • Infrastructure • Procurement & Assets

The Clinical Applications team has maintained their compliance with the SLA. The Service Desk, interestingly, saw a significant reduction in incidents in July. This dip in tickets could be related to anticipation of annual leave. Staff maybe putting off reporting issues until they are back from leave where the issue does

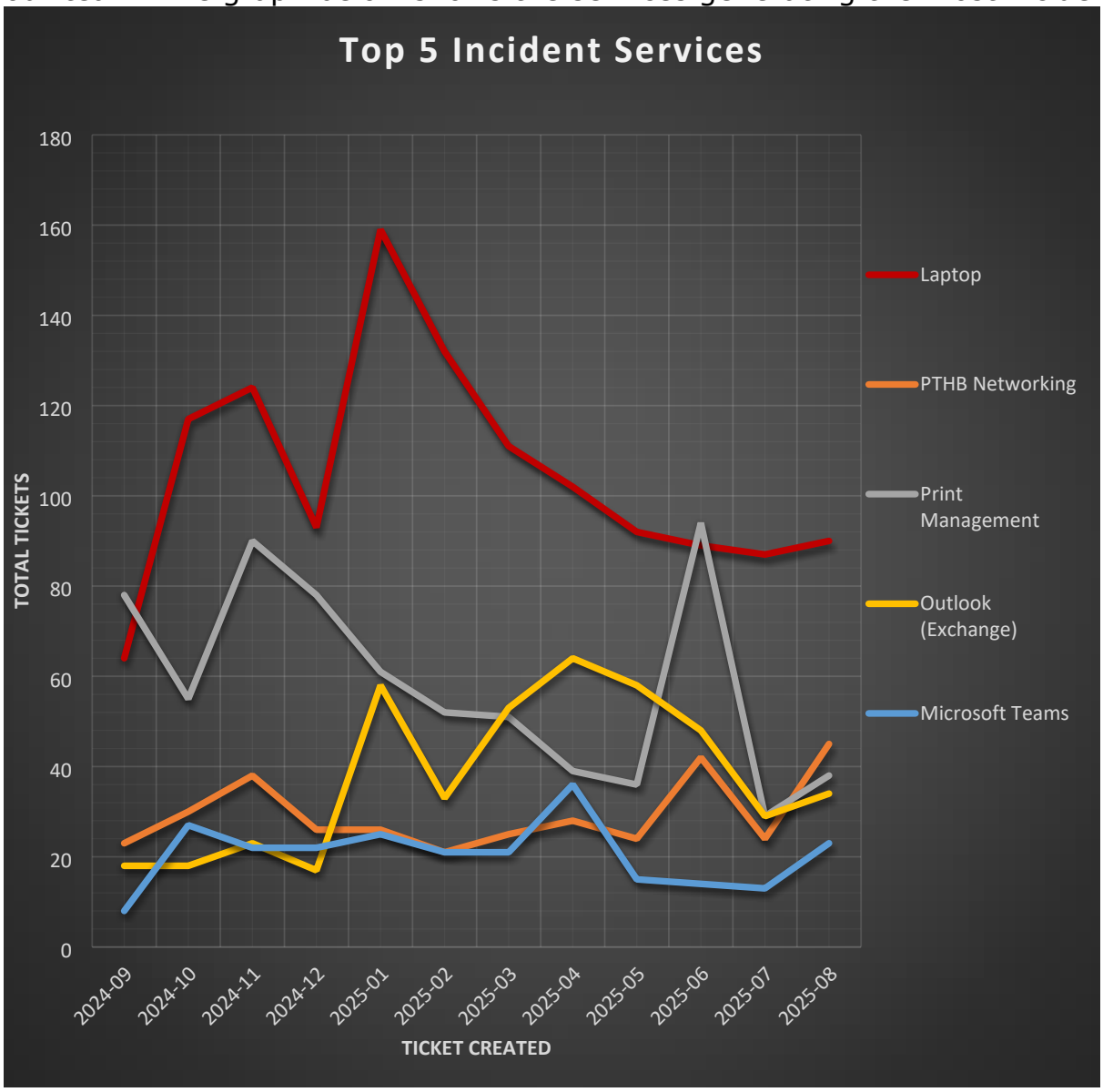
not prevent them completing certain critical tasks. This could result in an unmet demand that is seen later in August, or September.

Implications

Certain teams experience challenges with demand and capacity that impact their ability to comply with one or both types of tickets. Introducing additional systems without increasing staffing resources may exacerbate these challenges. As a result, it may be necessary to adjust compliance targets to more accurately reflect current team capacity.

Top Incident Generating Services

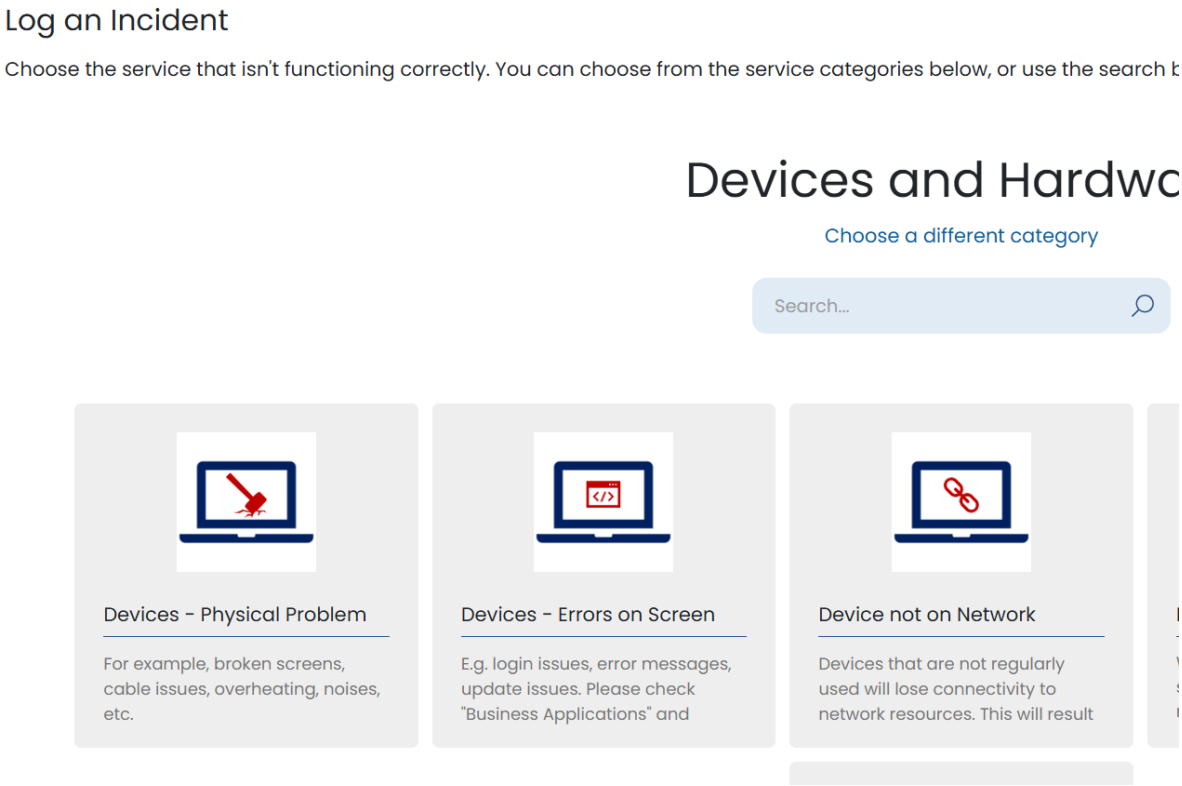
Identifying the services that cause incidents helps us target issues impacting our team. The graph below shows the services generating the most incidents.



Laptops and PCs

18 tickets (20%) were associated with devices that were not in use and unable to connect to Wi-Fi.

17 tickets (18%) were related to potential software issues rather than physical problems with the device; of these, 4 tickets pertained to specific software and were misclassified under this service.
The remaining tickets (62%) involved physical issues with devices, including overheating, performance concerns, peripheral problems, and devices not running Windows 11.
To enhance data quality, Halo has been updated with new service categories to differentiate between common issues and requests. Details are provided below.



Although "Device not on Network" is now categorised as a service request, it remains listed in the incident catalogue to assist staff in locating the appropriate form. Halo will automatically redirect users to the Service Request form, eliminating the need for additional input from staff members.

PTHB Networking

In August, two significant events affected PTHB Networking. One event involved the Corporate Wi-Fi, while another affected multiple services. As of this report, the latter event remains unresolved. These incidents account for 43% of tickets related to this service.
On 8 August, a significant event occurred due to the expiration of a certificate on servers responsible for authenticating connections to the Corporate Wi-Fi. The issue was addressed by requesting a new certificate from DHCW. It was determined that establishing a scheduled ticketing process for timely certificate renewal could help prevent similar issues in the future.
On 25 August, a second significant event took place when an unknown error led to hard drive corruption within a cluster storage server, causing several services to become unavailable. Attempts by Dell and Microsoft to determine the root cause were unsuccessful, and services are now operating on alternative

hardware. This incident resulted in permanent unavailability of the ICE pathology system.
Additionally, 11 tickets (24%) were for devices that had disconnected from the network due to inactivity and were mistakenly associated with this service. Fifteen tickets (33%) addressed other networking issues, such as intermittent internet connectivity or support needs for specialised systems. For instance, connection difficulties were reported with a new Moodle system being implemented for the Powys Living Well Service as a replacement for their Community Training Platform.

Print Management

Tickets for this service contained a variety of issues with both the physical hardware and the software on the device. There is still too little information of interactions between the Service Desk and the supplier to understand root causes for issues.
Resolution of tickets appears to have either been:

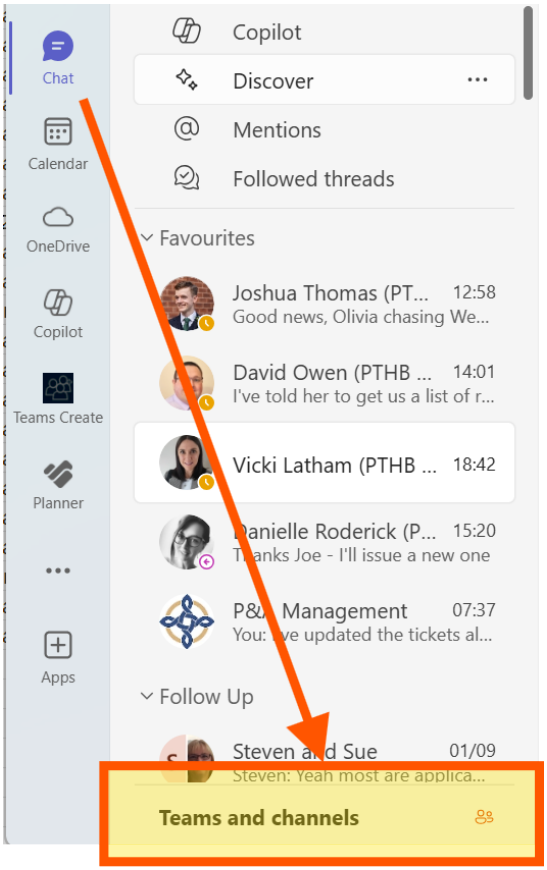
a) Update drivers on the laptop/PC
b) Restart the printer by turning on/off at the wall
c) An engineer coming from Apogee to resolve physical problems

Outlook (Exchange)

The main email issue involved synchronising shared mailboxes, including calendars and emails, leading to problems when multiple users managed the same mailbox. For instance, a fix applied to one user had to be repeated for 17 others. Additional tickets concerned trouble opening PDF attachments due to a global Outlook issue, now resolved by Microsoft. Other queries involved less common problems that required the Service Desk to repair or rebuild Outlook profiles.

Microsoft Teams

35% of tickets related to a Microsoft Teams update. Microsoft have chosen to update the “Chat” and “Teams” windows into a single condensed view. This moves the Teams list to below the chat, as shown below.

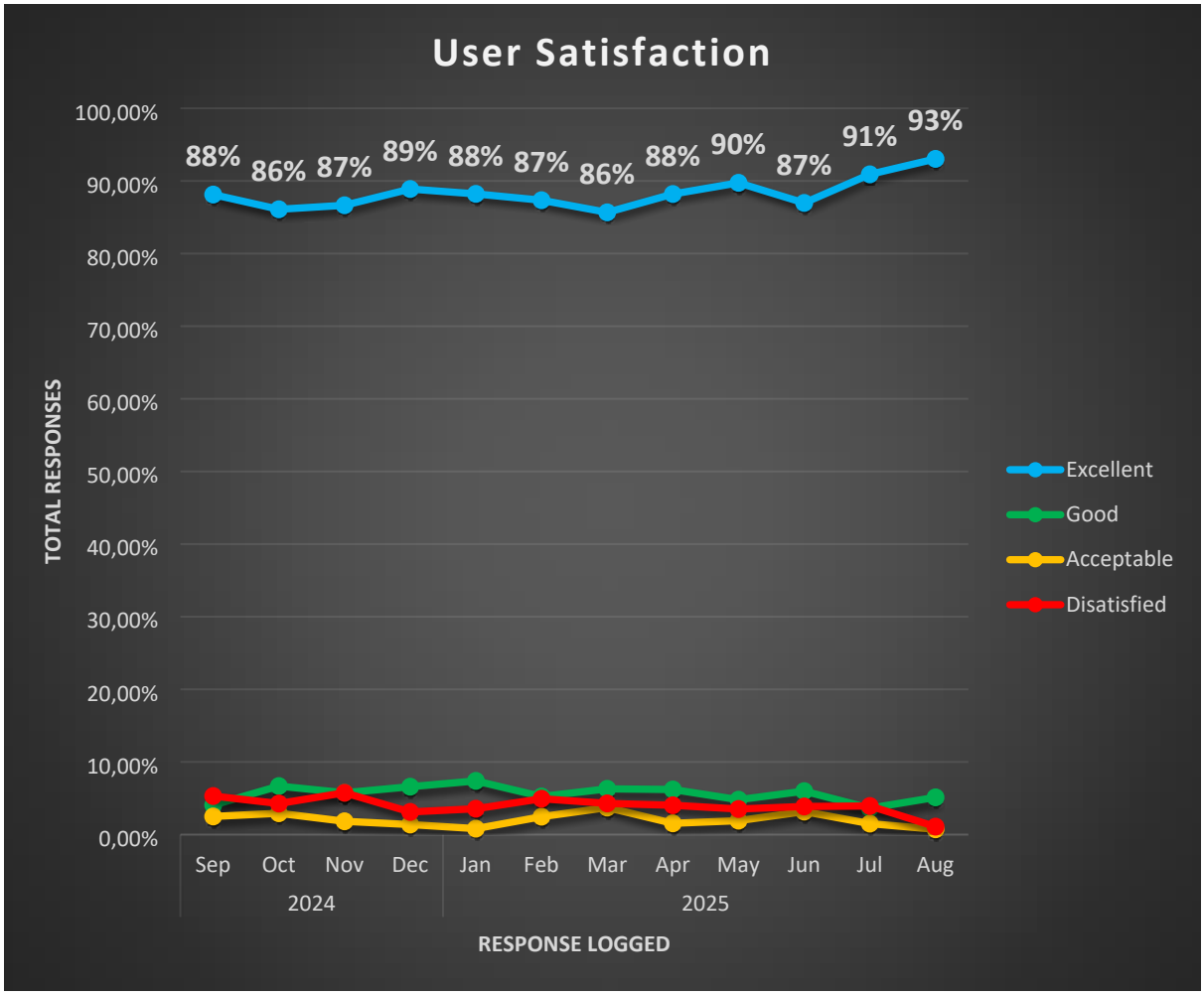


Remaining tickets were often mislabelled as the user was experiencing a larger issue with their device, and it was impacting their use of Teams. Usually this is the performance capability of their laptop.

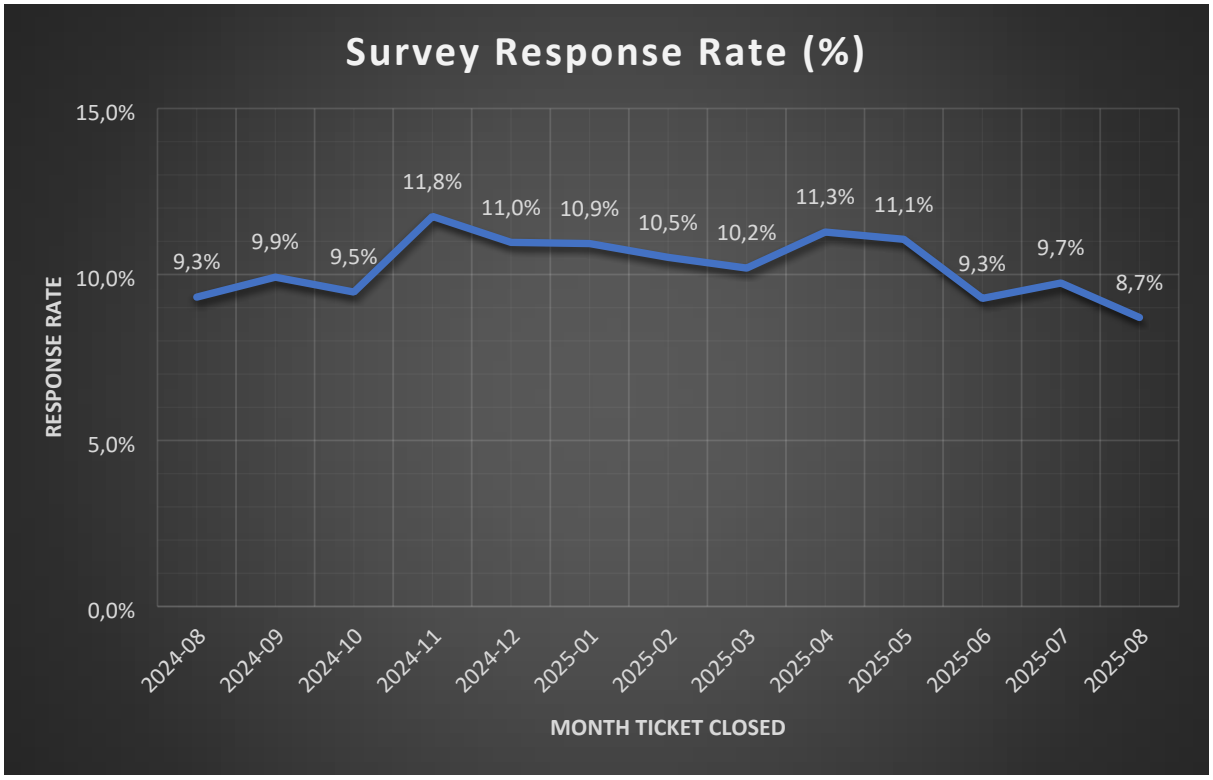
User Experience Monitoring

Digital Services are keen to ensure that any interaction with us is positive, and a such we offer staff to provide feedback on their experience throughout their ticket being resolved.

The data below demonstrates that most members of staff who took the time to rate their experience with digital as positive. This month saw the highest user satisfaction score to date.



User engagement is dropping. This is a result of the changes to the number of opportunities to provide feedback.



Some examples of feedback:

Excellent
With it being a worry when these things go wrong. The both gentlemen that I spoke to were great in trying to do everything they could. Failing arranged for someone to come out. This was quick and was messaged first thing on the Tuesday morning by Marcus and was there and sorted quickly. Will know to try and wipe the connections next time.
Thanks to the team with setting me up with a laptop that meetings my working requirements. everyone has been really helpful and responsive. Much appreciated. Jason
timely and helpful response to ensure clinical services can run safely & smoothy - during essential maintenance work

Dissatisfied
This was a case where I had done some work which hadn't saved, I repeated the work being very careful to check that autosave was one but again when I went back to it, it hadn't saved. I contacted the service and it it despite efforts it was not possible to recover the work. I therefore effectively did some of the work three times. It has dented my confidence in trusting sharepoint and our systems. I have confidently used shared directory's for very many years but what is happening now with some of the systems seems to be going backwards and it is really frustrating. So this dissatisfaction isn't with the team member, who tried to help but with the unreliable systems.
The problem is still not resolved yet. Can someone help?

Report Introduction

This report provides a comprehensive overview of service levels and compliance in managing digital services. It details various aspects, such as service level targets, overall compliance in handling requests and incidents, and compliance breakdowns by team. The document also examines top incident-generating services and user experience monitoring.
The goal is to monitor and improve the efficiency and effectiveness of digital service management.
The report is aimed at managers who want to understand how the demand on and performance of the Digital Services team could impact their team.

Executive Summary

The report shows there was a sudden and unexpected increase in service requests to Digital Services. These were primarily for the Clinical Applications team. This increase in tickets was also experienced on the portal which saw an increase in the number of tickets being logged on it.
Performance of the Service Desk has stabilised with a new trend emerging that appears to explain why there was an increase in the number of requests via the portal.
SLA compliance continues to decrease for service requests as teams struggle to meet the increase in demand recently. However, improvements in SLA compliance for things that are broken has improved.
The top 5 related services remain largely the same. This month, there were more individual issues rather than specific events that caused incidents. The exception to this is 2 national outages of WCCIS and a contract migration for mobile phones.

Digital Tickets

Tickets are used to structure, prioritise, and track work completed by the Digital Services. These tickets are generated through several methods:

- Email – An email is received from a staff member or supplier that generates a new ticket (this does not include emails that are matched to existing tickets)
- Portal – A ticket is created by using the forms on https://powysthb.haloitsm.com/portal/home
- Auto – A ticket is created automatically by Halo as part of an automated ticket process i.e. tickets in the New User Process, kit installation requests after equipment has arrived
- Manual/Phone – These tickets are created by a member of the team, usually by the Service Desk.

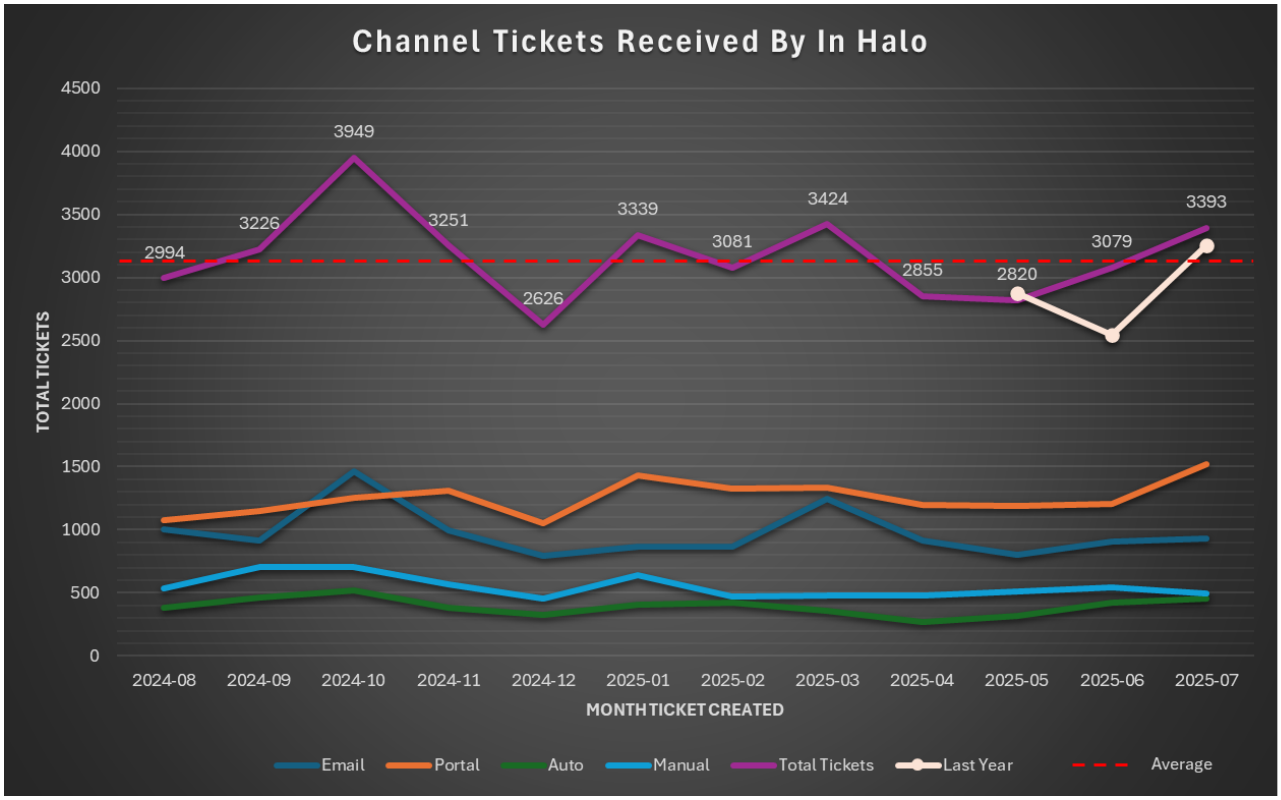


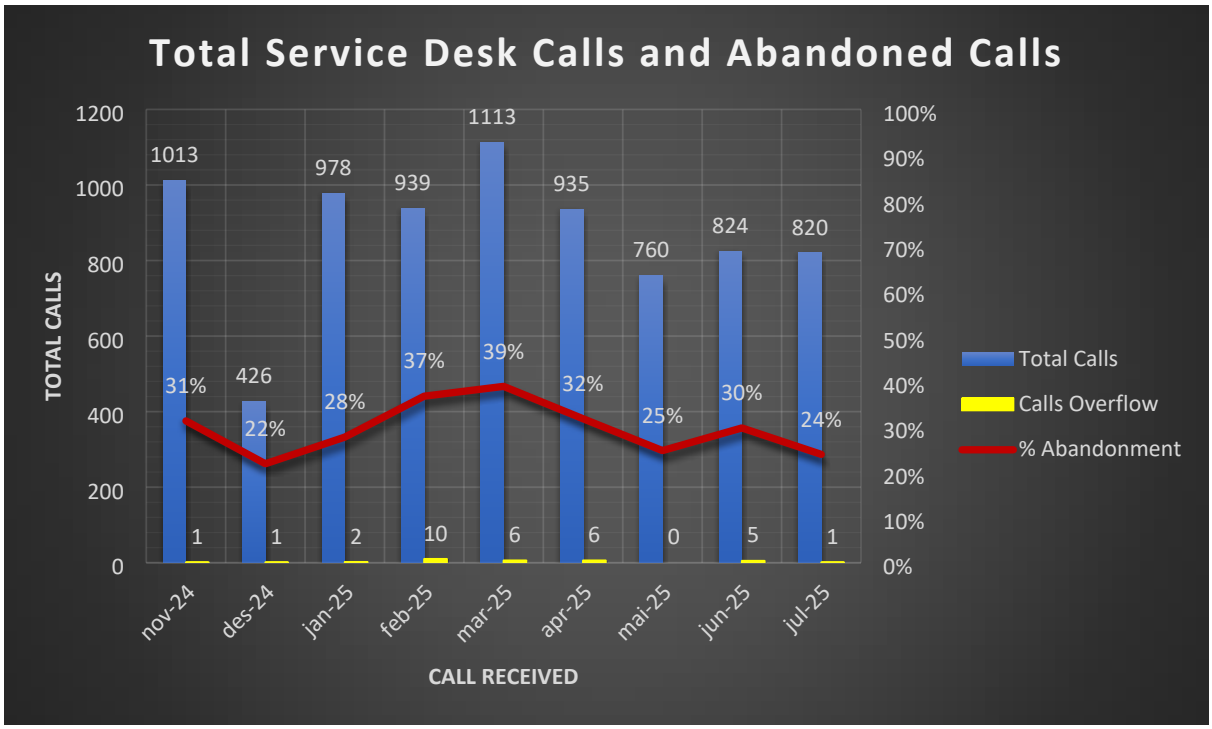
Figure 6 - Ticket generation by method the ticket was received.

The graph above depicts the number of tickets and the method by which they were received.
In July, ticket numbers rose by 9.3%, mainly due to a 20.5% increase in tickets logged in the portal. There was a 10.8% decrease in ticket created by the Service Desk.
The analysis indicates that Clinical Applications were predominantly affected by an increase in ticket volume, reaching a total of 314 tickets. This represents an additional 229 tickets compared to the previous month. Upon review, no distinct

trends were identified; rather, the data reflects a general rise in standard demand.
Portal tickets rose by 312, with around 206 related to Clinical Applications. Of these, 87 were data amendment requests in WCCIS. Additionally, clinic creation or amendment requests increased by 155%, from 20 to 51. This may be indicative of staff trying to get requests in before going on summer leave, or request for changes as a result of leave being taken.
There is an opportunity for developing forms further on the portal to improve the flow of tickets and ensure the required information is captured on ticket creation. The ICT Service Delivery Manager will explore this with the Clinical Applications Team Leader.

Service Desk Calls

The following graph presents call volumes. Modifications have been applied to the graph to enhance the visual representation of call abandonment relative to the total number of calls.



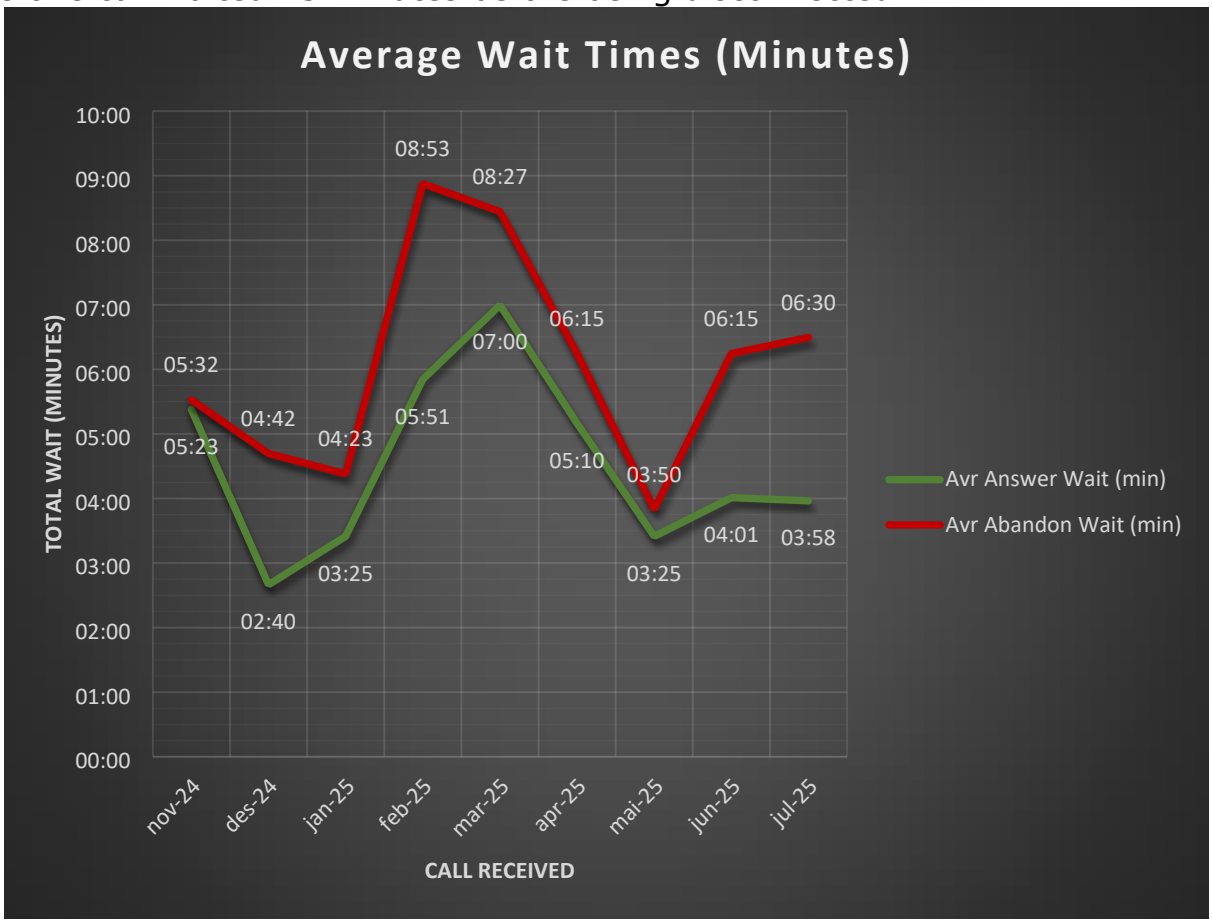
In June, Service Desk calls remained the same, and abandonment rates decreased by 6%.
1 calls was disconnected, overflowed, or was queued with no agents available. These events occurred at the following times:

Date	Time	Total Disconnected	Total Volume	Agents Available*
15/07/2025	12:00	1	10	2 available agents until 12:40 then only 1 until 1pm where we back to 2.

				Fully staffed with 3 from 2pm

**This only includes substantive Service Desk staff and excludes the Client Services Lead*

The one call waited 45 minutes before being disconnected.



This month, average wait time remained the same, or within 5%. Like June, the abandonment wait is now significantly greater than then average answer wait. Unlike other months, the ratio of answered calls per ticket to total calls per ticket is remarkably close. This suggests that the waiting times are less influenced by

The wait times before answer are outside the the 2-3 minute targets set by Operational Level Agreements (OLAs) and Service Level Agreements (SLAs) with Health and Care Research Wales (HCRW).

Implications

Last month, we reported uncertainty regarding whether the change in call trends was due to significant events or the revised welcome messaging promoting portal usage. The ongoing trend suggests an increased likelihood that the updated welcome messaging has contributed to greater portal engagement. This shift has resulted in more tickets being logged without affecting the desk's capacity to manage them.

Incident & Request Trending

Service Requests range from requests for new equipment and software licences, to information requests.
Incidents indicate a failure, fault or problem with our digital services that impacts staff productivity or their ability to deliver care.
Both these ticket types represent a productivity cost to the health board and efforts are required to ensure the total number is reduced as well as the total time it takes to resolve them.

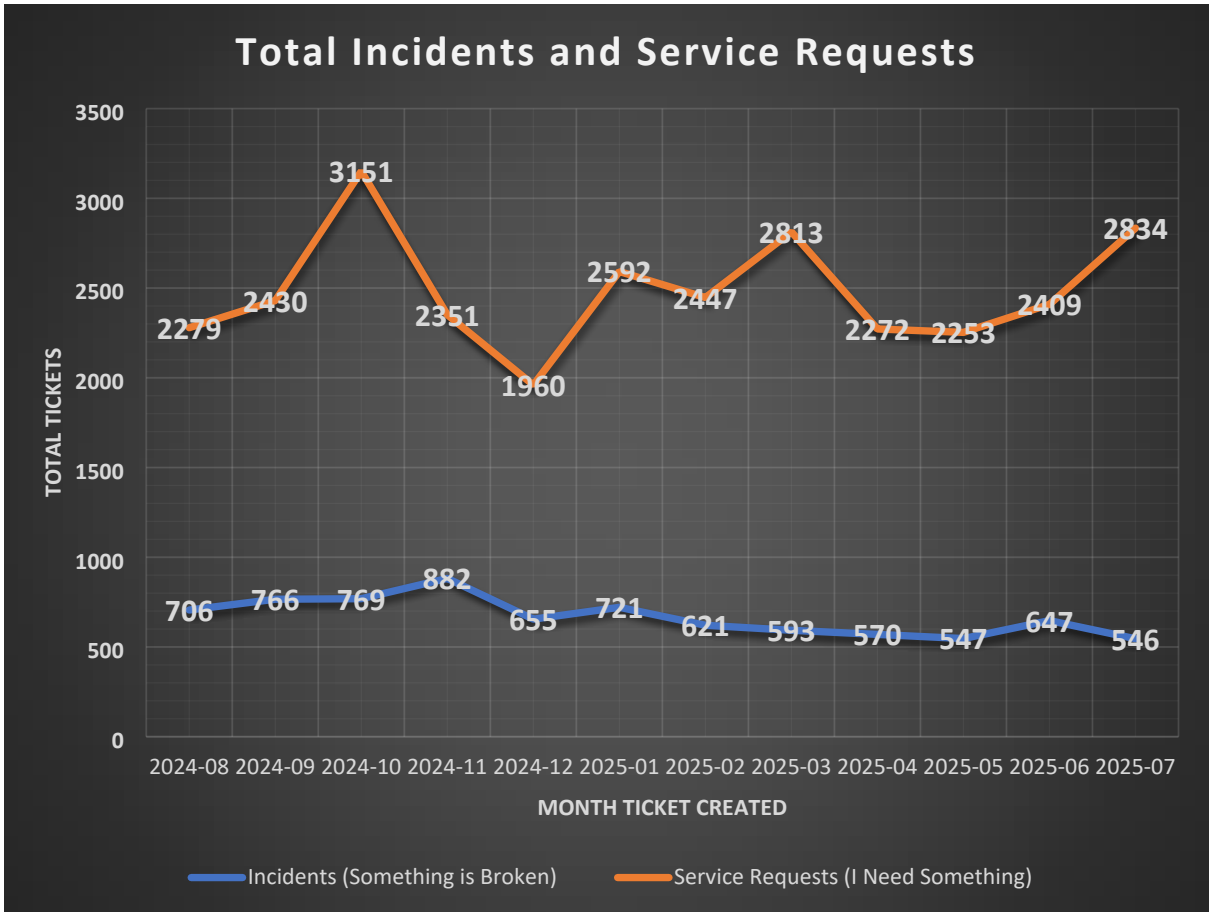


Figure 7 - Total incidents and requests by month

Service Requests Trends

The total number of service requests increased by 17.6%. This indicates the increase in tickets was related to things people needed rather than a service failing.

Incidents Trends

The number of incidents decreased by 15.6%, returning to an equivalent number of tickets seen in May. Next month we will be able to assess if this is a new baseline of incidents or if the prior decrease in incidents continues.
Our aim is to reduce the frequency of incidents over time. We will look to achieve this by: -

- Maintaining sustained investment in the removal of legacy infrastructure and client devices from our estate.

- Continue the expansion of automatic problem detection and remediation. Fixing problems before users are even aware of them.
- Sustained efforts to remove single points of failure in our infrastructure and digital services.

The data indicates that current efforts have successfully curbed the rise in the number of incidents and that we are in fact reducing the likelihood of an incident occurring.

Service Level Targets

Digital Services set the following service response targets.

Requests

Priority	Resolution Target
Expedited Request	3 Days
Standard Request	5 Days
Low Priority Request	10 Days

Incidents

Criticality	Response Target	Resolution Target
Emergency Healthcare Impact across Health Board	1 Hour	2 Hours
Critical Healthcare Impact at a single site	1 Hour	4 Hours
Major Departmental Impact	2 Hour	8 Hours
Normal User Impact	4 Hour	12 Hours
Low Limited Impact / Annoyance	8 Hour	16 Hours

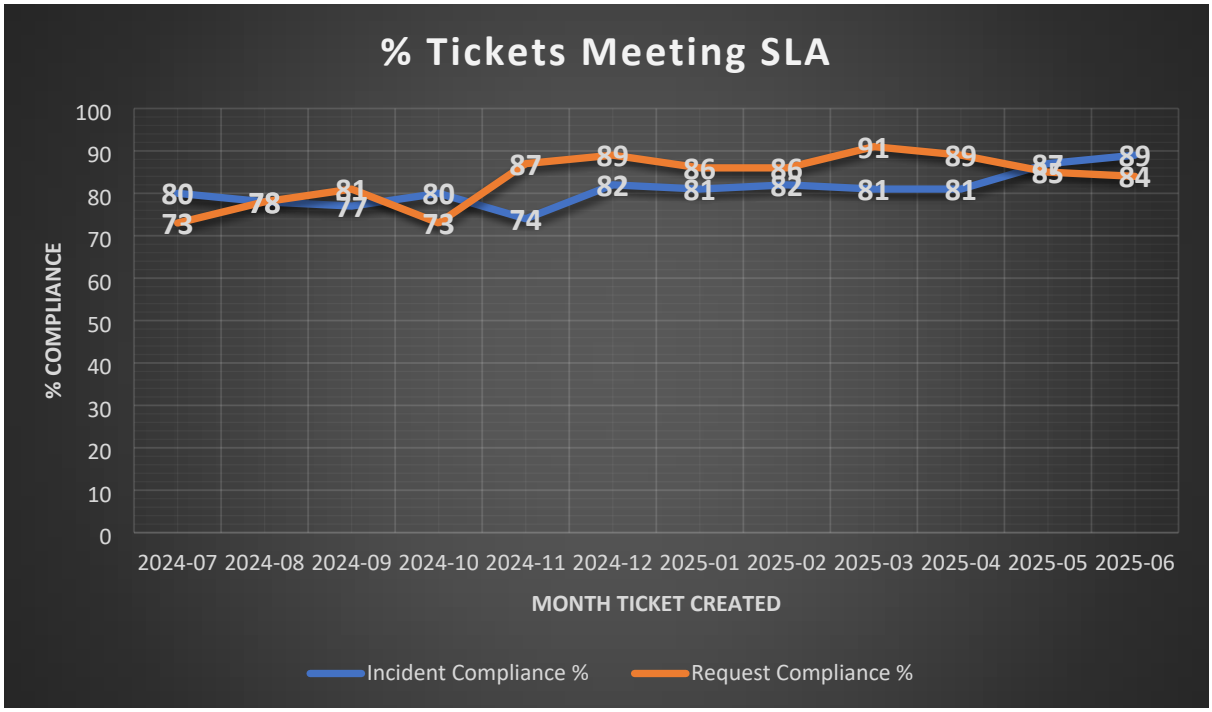


Figure 8 - SLA compliance by ticket for tickets closed as of 4th July.

Requests Overall Compliance

As the number of service requests increase, the SLA compliance has decreased from a previous high of 91% to 84%.

Incidents Overall Compliance

Compliance continues to increase with teams making efforts to better manage tickets to improve compliance.

Request Compliance Breakdown by Team

The graph below shows the level of compliance by different teams in the Digital Services. Compliance is not consistent across the teams, possibly identifying gaps in resource to meet demand within the set SLAs.

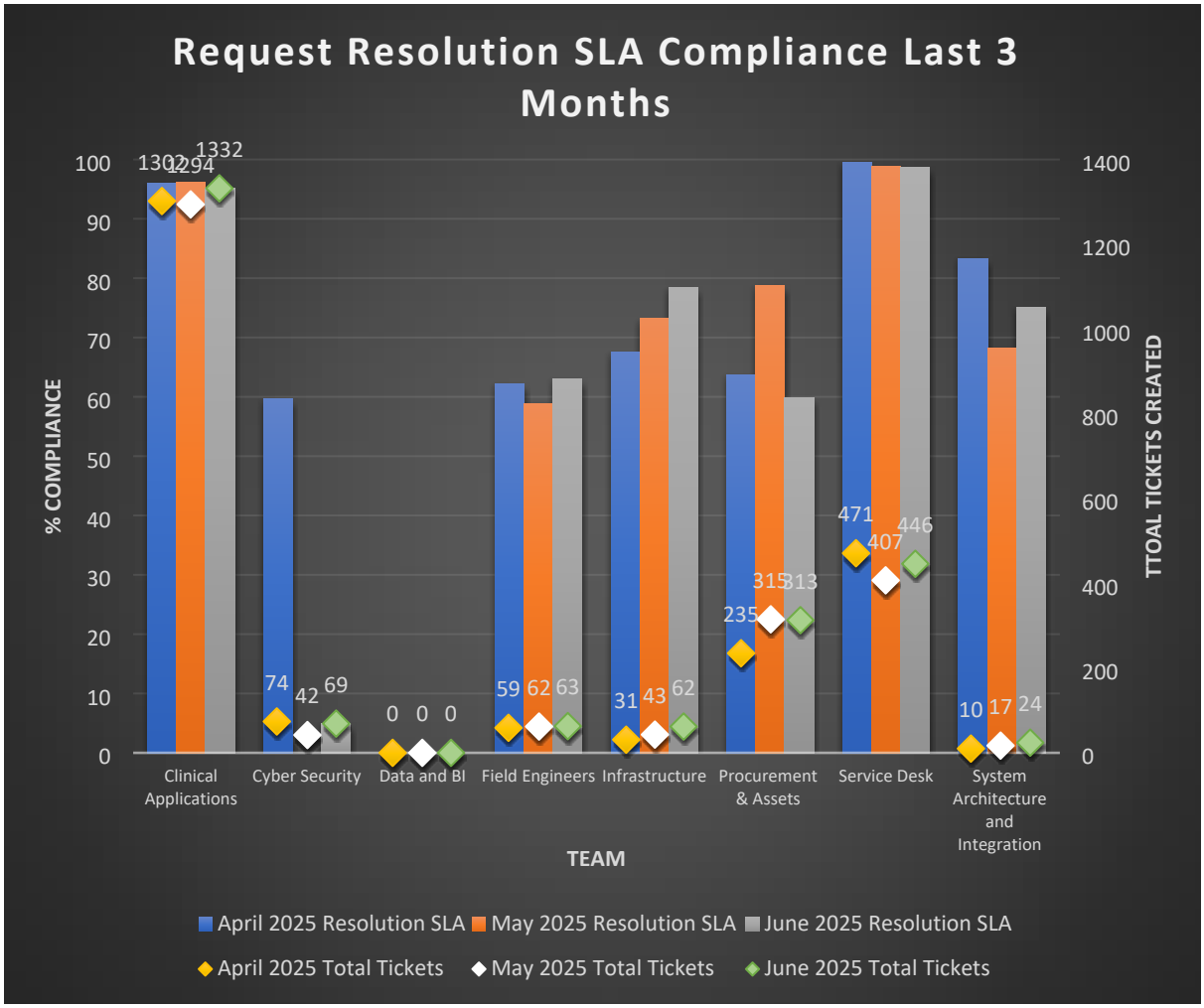


Figure 9 - Request SLA Compliance by Team for the last 3 months

SLA Achievers (>90%)	Notable improvements in SLA (+10%)	Non Compliant (<90%)
• Clinical Applications • Service Desk		• Cyber Security • Field Engineers • Infrastructure • Procurement & Assets • System Architecture and Integration

Both Clinical Applications and Service Desk achieved their respective SLA targets.
The Infrastructure team has maintained compliance over the past three months. Due to the type of requests handled by this team, the SLAs will be reviewed. Typically, tickets are first triaged by the Service Desk and addressed initially by the Field Engineers. Therefore, when a request is escalated to this team, a sizeable portion of the allocated SLA time may have already elapsed.

Absences in the Procurement & Asset team have affected SLA compliance. With only two core staff, there is limited resilience. When the Band 5 was off for two weeks and the Band 4 replacement had yet to start, coverage was provided by the Digital Business Manager and ICT Service Delivery Manager.
Like the Infrastructure team, the System Architecture and Integration team receive tickets after a first attempt being made by the Clinical Applications team. Therefore, a 3rd line SLA will be investigated.
Cyber Security continues to struggle to maintain compliance as there is only one staff member in the team.

Incident Compliance Breakdown by Team

The graph below illustrates the compliance levels of various teams within Digital Services. There is a noticeable inconsistency in compliance across these teams, potentially highlighting resource shortages to fulfil demand within the established SLAs.
The Incident Response SLA refers to the time taken for a team to acknowledge receiving an incident reported via email or the portal. At this stage, the incident is prioritised and forwarded to the appropriate team, which must resolve the ticket within the resolution SLA.
The Incident Resolution SLA is the time taken for a team to resolve the issue reported. At this stage, the ticket has been triaged. The total resolution time is the time that the team can provide a fix. If the ticket is escalated to a supplier or a meeting is arranged to discuss the issue, then the timer is placed on hold.

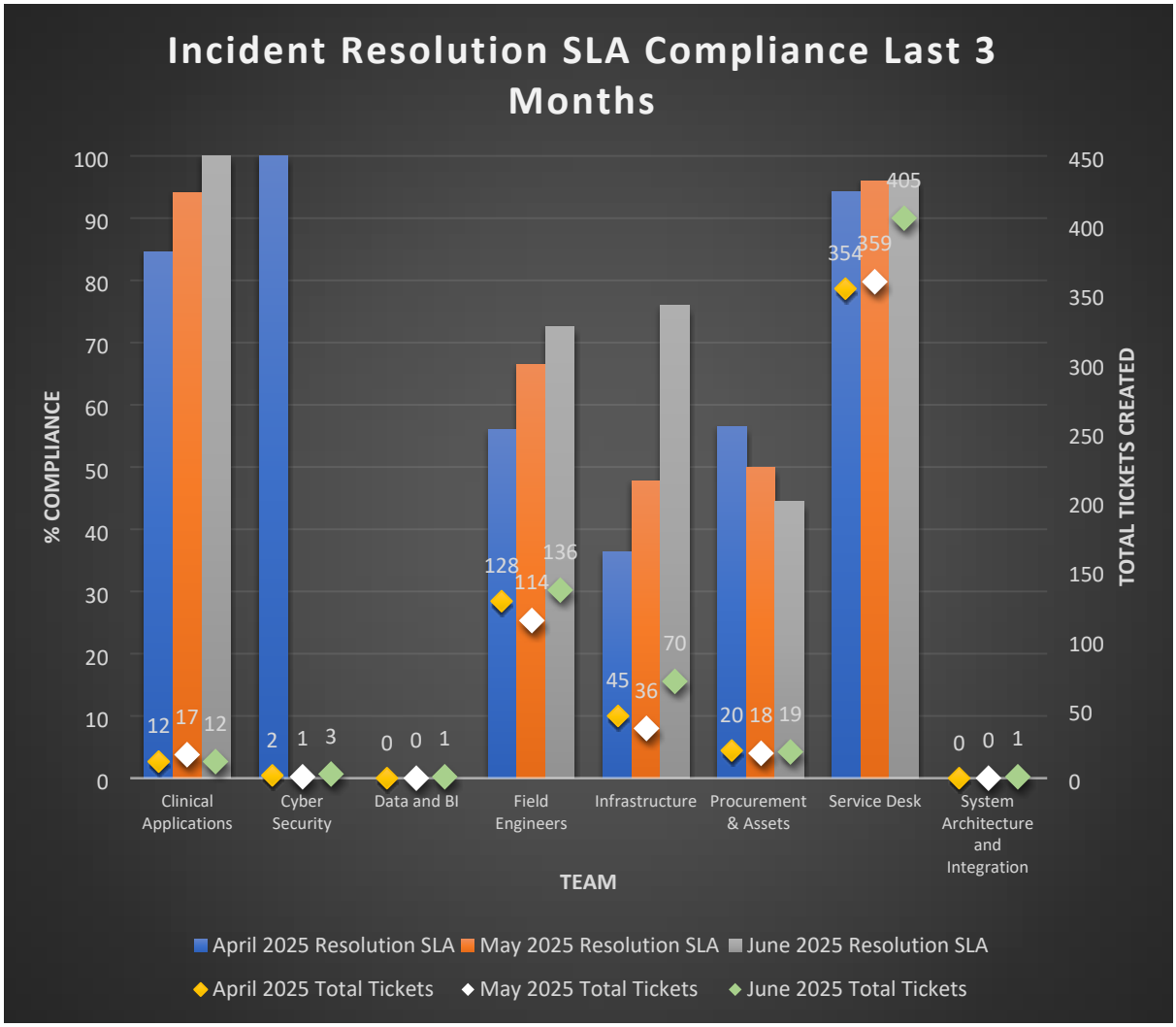


Figure 10 – Incident SLA compliance by team for November

SLA Achievers (>90%)	Notable improvements in SLA (+10%)	Non-Compliant (<90%)
• Service Desk • Clinical Applications	• Infrastructure	• Cyber Security • Field Engineers • Procurement & Assets

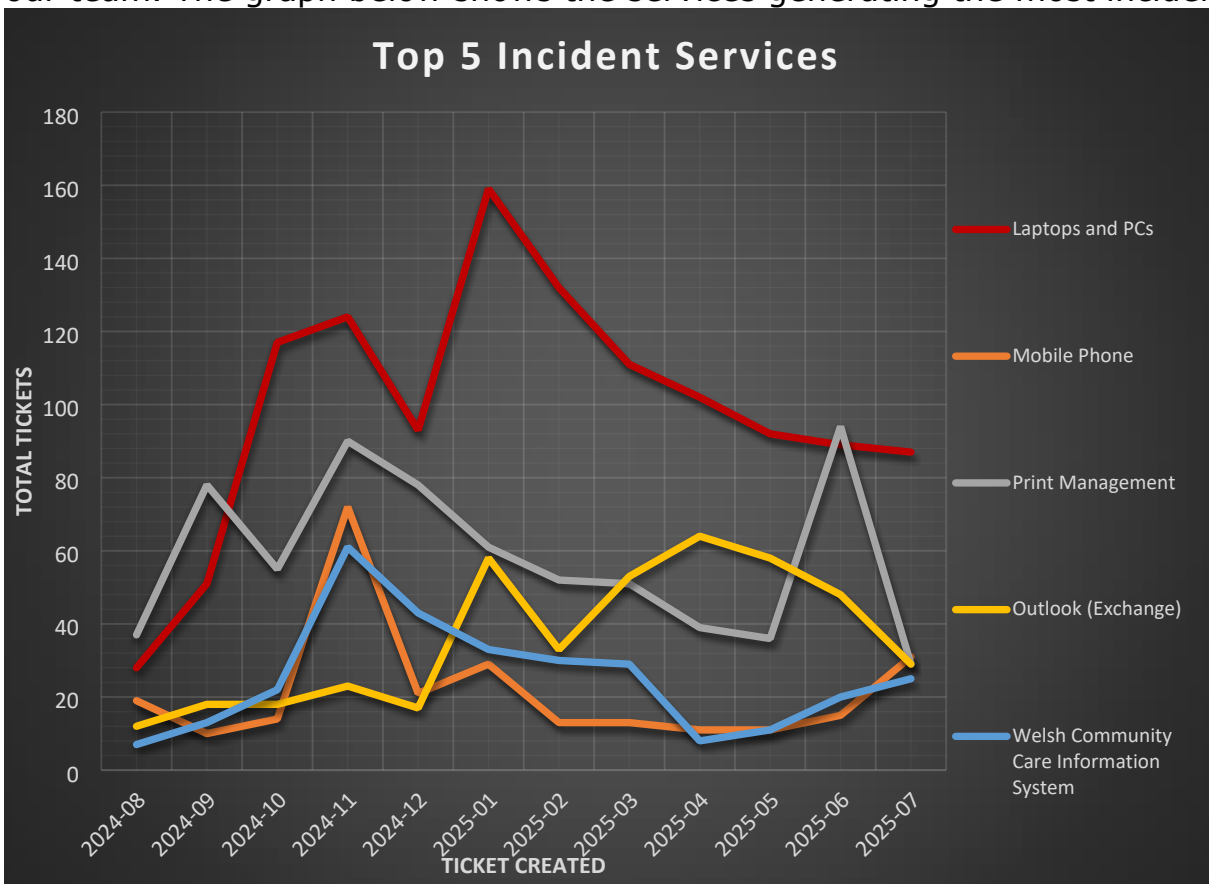
The Clinical Applications team has reached 100% compliance with 12 tickets. Comparatively, this was ~85% in April. The Service Desk, despite receiving significantly more tickets in June, improved on compliance. This will be driven, in part, by Significant Events being managed and large numbers of tickets being closed off in bulk. This has the advantage of reducing the administrative burden that can contribute to tickets breaching SLA.

Implications

Some teams face demand and capacity issues that hinder compliance. Improvements have been made in the ITSM and this is contributing to teams improving their performance.

Top Incident Generating Services

Identifying the services that cause incidents helps us target issues impacting our team. The graph below shows the services generating the most incidents.



Laptops and PCs

14% of tickets related to devices that had fallen off the network. Amendments have been made to the new user process to start to challenge teams to explain why they do not have equipment to pass onto new staff if an existing role is being filled. During this scrutiny we are advising teams with equipment to reallocate to ensure the device is reconnected to the network.

20% of tickets relate to performance issues. Where it is not possible to improve the device performance, new devices are being used to replace these devices. We are currently under 50% of original stock level purchased using Welsh Government funds in the first quarter of this year.

The remainder of tickets relate to an array of specific issues with the device itself and only occur for one or two staff members.

Mobile Phone

On the 8th July, we switched to a new contract with O_2. This contract is substantially cheaper than the previous, with calling plans dropping from £4.63 to £0.28. To complete the contract switch, SIM cards needed to be moved to a new tariff.

It is suspected that during this migration, several contracts lost their tariff for calls and SMS messaging. Incidents were raised for roughly a fortnight after the migration but inconsistently reported the day the issues occurred. Therefore, the migration is only a tentative explanation. In most cases, phone service was restored with 24 hours.
There is an average of 15 tickets each month for this service. The increase was therefore 16 tickets and represents a failure rate of 1.28% during the migration.

Print Management

There were no significant outages with this service in July.
The evidence does not suggest an issue specifically with the service. Faults are common printer issues such as error relating to how printer paper is being added or toners not being installed correctly. Where Apogee have been contacted, an engineer has been able to restore functionality within the expected timeframes.

Outlook (Exchange)

There were no reports of mailboxes being full this month.
Many of the issues described were resolved by restarting the machine, indicating a software issue. A couple of issues required configuration changes by the Service Desk and Infrastructure teams.

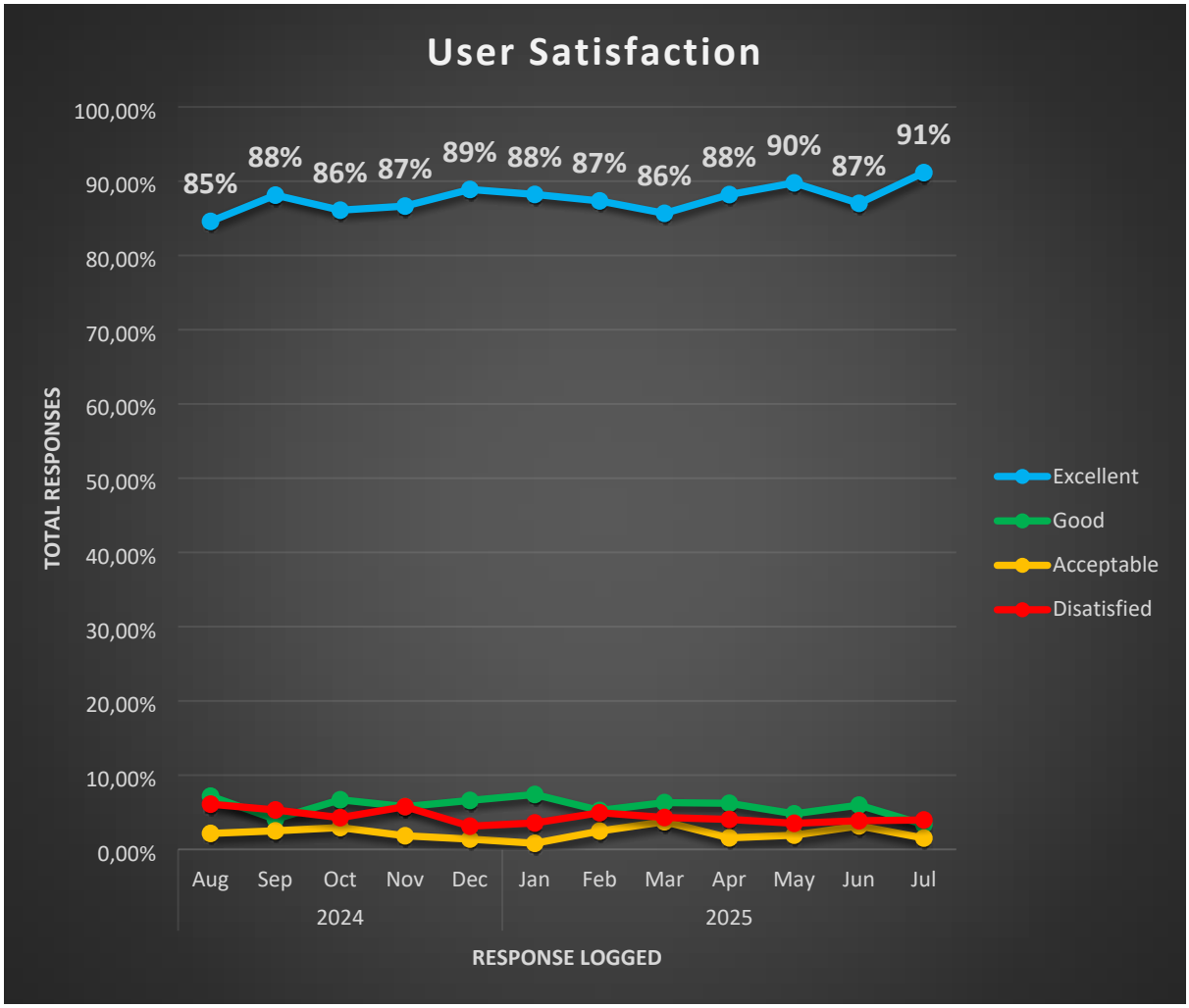
Welsh Community Care Information System

1st July – There was a national outage of the system. 4 tickets were logged by PTHB teams.
23rd July – There was a national outage of the system. 9 tickets were logged by PTHB teams.
All other tickets were specific user issues related to accessing the system.

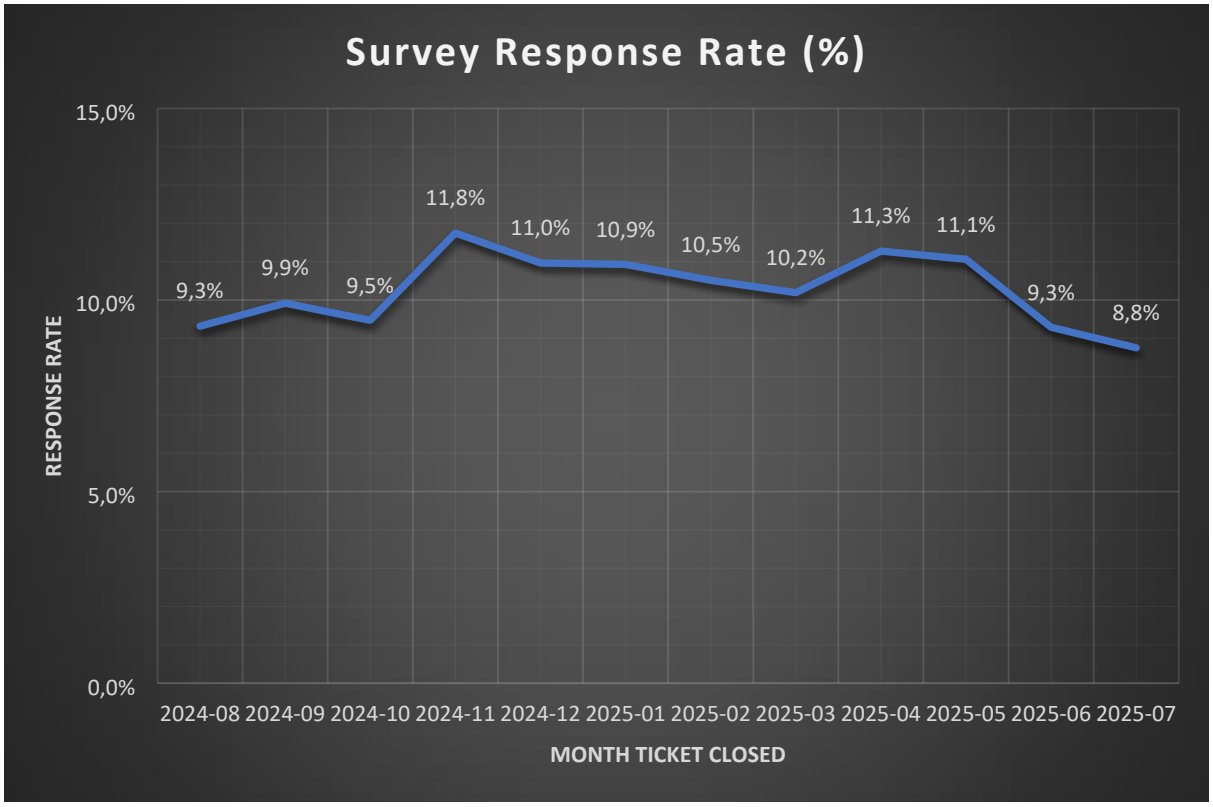
User Experience Monitoring

Digital Services are keen to ensure that any interaction with us is positive, and a such we offer staff to provide feedback on their experience throughout their ticket being resolved.

The data below demonstrates that most members of staff who took the time to rate their experience with digital as positive. This month saw the highest user satisfaction score to date.



User engagement is dropping. This is a result of the changes to the number of opportunities to provide feedback.



Some examples of feedback:

Excellent
Brilliant, thanks so much Marcus completely appreciated.
Stuart Bond as always was calm and patient. He explained things so I could understand what was going on and he resolved my laptop issues. I am very grateful. *Thankyou Stuart*
You were excellent as always. I uploaded a document on the wrong file and asked for it to be deleted. This was handled promptly and effectively without any problems. Great to know Digital Services are always there to support our clinical work.

Dissatisfied
The password was requested at about 10.30am on Wednesday 16th of July ahead of a clinic that afternoon. *I had been issued with a password previously and clicked the 'Save log in information' button.* *This had not happened, so I was unable to gain access. I was definitely using the correct password.* *Because the password wasn't received, we couldn't print the visual fields assessment paperwork for the Dr to review.* *He was also unable to access Zeiss forum as his log in details would not work.*
We have to work cross border in a timely manner. We double check email addresses to consultants, and they do not have time the other end to

access secure files. Emailing a letter is no different to sending a physical letter in the post., in fact it is more secure than sending a physical letter in the post so we really need a secure email to email set up like the nhs.net accounts so we can ensure timely urgent email transaction for the sake of the patients.
I went to ESR initially as I was told she could not have a P60 without accessing ESR. They told me she needed an email address, and I went to the digital link for requesting an email address which asked questions I am unable to answer as there is no position number and no Trac reference as she's been in the position for several years - way before TRAC was in place. *The person has worked for the Health Board on an ad-hoc basis for several years (she is not retired from the Health Board, but is a senior aged person) but is not able to access ESR as she only has a payroll number (No Nadex and no PTHB email).* *See needs a copy of her P60, and I need to know how I advise her what to do in order to get this.* *Please can someone help me to sort this out.* *Thank you*

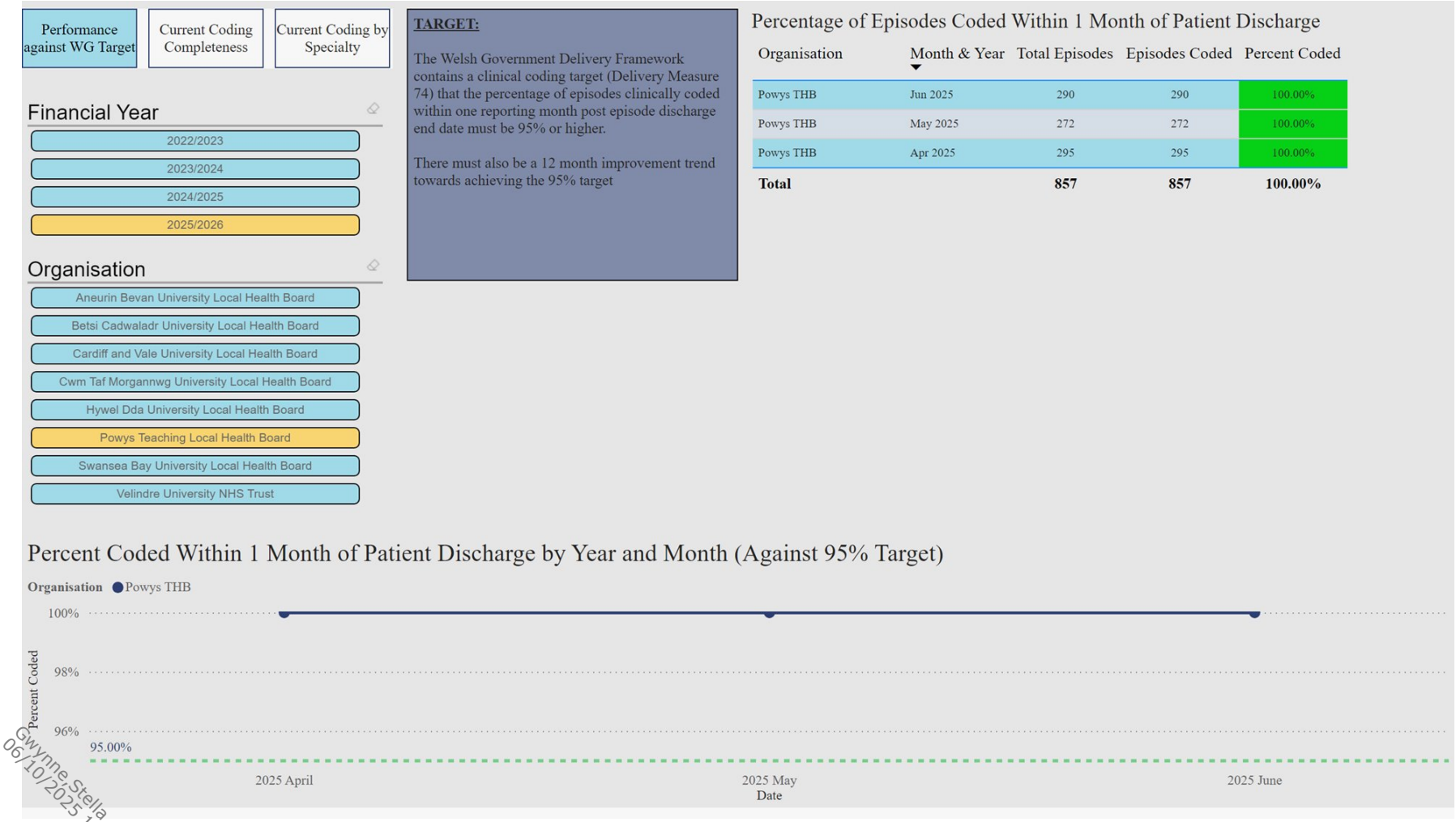
Appendix B

Clinical System Data Corrections

Report/Check Name	2025-05	2025-06	2025-07	2025-08
Update Power BI Monthly VASS Error Report				
WCCIS & WPAS Differences - Missing Dates of Birth	1	0	0	0
WCCIS & WPAS Differences - Patients With Different Dates of Birth	5	13	11	10
WCCIS & WPAS Differences - GP Practice Status			6	
WCCIS Patients With An Incorrect Registered GP Practice	5	7	12	10
WCCIS Missing Clinician Professional Registration Codes	12	18	11	16
WPAS Clinician Professional Registration Code Check		6	1	1
WPAS - GP Reference Data Updates				
WCCIS Patients With No Registered GP Recorded	38	167		45
Update GP reference data				
WCCIS & WPAS Differences - WCCIS Patients With No Date Of Death Recorded	77	80	136	32
WCCIS Open Involvements On Active Referrals Of Deceased Patients	4	9	5	5
WCCIS Open Activities On Active Referrals Of Deceased Patients	5	38	21	18
WCCIS Open Forms On Active Referrals Of Deceased Patients	20	39	98	48
WCCIS Active Referrals on Deceased Patients	27	101	162	78
WCCIS Patients With No GP Practice Recorded				
MPI Recent Incomplete Registrations	26	63	73	47
MPI New Duplicate Records		88	13	6
MPI New Potential Duplicate Records			37	
WCCIS GP Updates	1519	0	1586	
WIS Duplicate RSV Vaccines		7	8	8
WPAS Outstanding TCIs	424	683	510	
WPAS Hospital Cancellations With Blank Local Reasons	134	149	147	74
WPAS Virtual Appointments with an Invalid Virtual Type		242	304	81
WPAS Virtual Appointments Recorded As Procedures	15			13
WCCIS Deactivated People				
WCCIS Core Demographics - NHS No (blank or error)			26	15
WCCIS Core Demographics - Postcode (blank or error)		152	21	60
WCCIS Core Demographics - GP Practice (blank or error)		146	42	55
WCCIS Core Demographics - Duplicate NHS number				12
WCCIS Core Demographics - Death Date (error)			77	3
WCCIS GP History - Invalid Lookup			172	44
WCCIS GP History - Invalid Dates			0	1
WCCIS GP History - Overlapping GP Dates		91	10	3
WCCIS GP History - Multiple Active GPs		96	4	0
Clinical Coding Errors			3	4
Monthly LTA Validation				235
Monthly Total	**2312**	**2195**	**3496**	**924**

Appendix C

Clinical Coding Performance 025/2026



Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.12

Audit, Risk and Assurance Committee	**Date: 07 October 2025**
Subject:	**Standing Financial Instruction (SFI) Executive Financial Delegations (non-pay expenditure)**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Director of Corporate Governance
Other Committees and meetings considered at:	N/A
Appendices:	N/A

PURPOSE:

This report provides the Committee with a series of proposed changes to the Standing Financial Instructions, including Executive financial delegation levels.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **DISCUSS** the proposed changes to the Standing Financial Instructions and **RECOMMEND** the following proposed changes to the Board:
  - Executive authorisation levels are increased to £500k for the CEO, £250k for the Director of Finance and to £100k for Executive team
  - A series of administrative updates are applied to the SFIs including executive and other job title changes, Board committee names and external agency names changes where appropriate.
- **NOTE** that the Chief Executive will complete a review of the Executive portfolio scheme of delegation in readiness for the November Board.

Approve/Take Assurance	Discuss	Note
√	x	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The SFIs are a core control for all activities across the organisation.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	

7. Put Digital First	Y	
8. Transforming in Partnership	Y	

STANDING FINANCIAL INSTRUCTIONS

PTHB if required to have in place a set of Standing Orders (SOs) for the regulation of proceedings and business. The Standing Orders for PTHB and Glossary of Terms, including the Standing Finance Instructions and Scheme of Reservation and Delegation of Powers are available via the attached link:
Board Governance - Powys Teaching Health Board

With regards to non-pay financial approvals, the organisation currently has four key limits in operation for the approval of expenditure. These are as follows:

ORACLE REQUISITIONS	Authority Delegated to
Up to **£10,000**	Nominated Budget holder for specific cost centres
£1,000 to **£25,000**	Assistant Directors
Up to £50,000	Executive Directors
Up to £100,000	Chief Executive

As outlined in the Financial Controls paper, having relatively low values to Assistant Director level at £25k means that the Executive team have sight of all significant purchases or contracts. However, a comparatively low delegation level for Executive Directors means that a high volume of orders require Chief Executive or Chair or Board approval for relatively low values in the context of the organisational turnover.

A review has taken place and changes are recommended to ensure the organisations scheme of delegation is in line with modern day practice and can support the requirements of efficient, effective and appropriately controlled delivery of organisational business.

Comparison with other NHS Health Boards

Following review of a selection of other NHS Wales organisations SFIs, a summary of delegations for Non-Pay expenditure are summarised below:

Organisation	Executive Director authority	DOF Authority	CEO Authority
Hywel Dda	100k	500k	500k
CTM	250k	500k	1m
Cardiff & Vale	250k	500k	1m

Proposed Change in PTHB Non-Pay Executive Delegation Levels

The following changes are recommended to Non-Pay expenditure autrorisation levels within PTHB:

Delegation	Current Authority (PTHB)	Proposed New Authority (PTHB)	Change Summary
Chief Executive	£100k	£500k	Increase from £100k to £500k
Director of Finance	£50k	£250k	Increase from £50k to £250k
Executive Director	£50k	£100k	Increase from £50k to £100k
Deputy/Assistant Directors	£25k	£25k	No change
Nominated budget holders for specific cost centres	£10k	£10k	No change

PTHB is the smallest health board in Wales in terms of population and annual turnover but must operate to the same requriements and performance standards as all health boards. The proposed changes would, in summary:

- Ensure appropriate levels of non pay authority to the most senior staff in the organisation – all other controls remain in place as outlined in the SFIs including procurement rules and organisational controls such as the non pay scrutiny group
- The volume of authorisations currently required by the CEO would be reduced in the region of 40-60 authorisations per month supporting appropriate delegations and efficient processing
- The introduction of a specific Director of Finance authorisation level is in line with other health board delegations
- Delegation level changes are only proposed to the CEO and executive team, retaining appropriate levels of senior officer control
- All other controls remain in place, the changes apply to non pay only, not to other delegation areas as outlined in the SFIs.

The finance team have confirmed that changes to the Oracle finance system can be applied efficiently and effectively.

OTHER SFI PROPOSED CHANGES

During the course of recent months, some administrative changes have been identified by either PTHB staff and/or audit colleagues as follows:

- Executive team job titles need to be updated throughout the document

- The Head of Financial Services job title needs to be updated to Assistant Director of Finance (Accounting and Services) throughout the document
- Other job titles require update in line with current organisational structure (for example head of Pharmacy is now Assistant Director Medicines Management)
- Board Committee names require updating (for example Performance and Resources Committee needs to be Finance and Performance Committee)
- Minor administrative changes such as the updating the name of the Joint Commissioning Committee.

NEXT STEPS:

If proposals are supported, a full revised set of the SFIs will be presented to the Board in November 2025 with proposed changes shown.

The Committee is also asked to NOTE that the Chief Executive will complete a review of the Executive portfolio scheme of delegation in readiness for the November Board.

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

Agenda item: 7.2

Audit, Risk and Assurance Committee	**Date: 07 October 2025**
Subject:	**POWYS TEACHING HEALTH BOARD (PTHB) BOARD MEMBERS DECLARATION OF INTERESTS, GIFTS and HOSPITALITY 2025/2026**
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee – 17 September 2025

PURPOSE:

This paper presents the position as of 09 September 2025 in respect of the Register of Interest for Independent Members, Executive Directors, consultants and those staff with budget oversight and Gifts and Hospitality.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the contents of Register of Interests for PTHB Board Members, consultants and those staff with budget oversight at 09 September 2025, the PTHB Gifts and Hospitality Register; and
- Take **ASSURANCE** that the organisation has appropriate processes to support the collection, management and reporting of Declarations of interest and Gifts and Hospitality in line with the Standards of Behaviour Policy.

Approve/Take Assurance	Discuss	Note
Y	N	**Y**

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour. The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership. In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions.

BACKGROUND

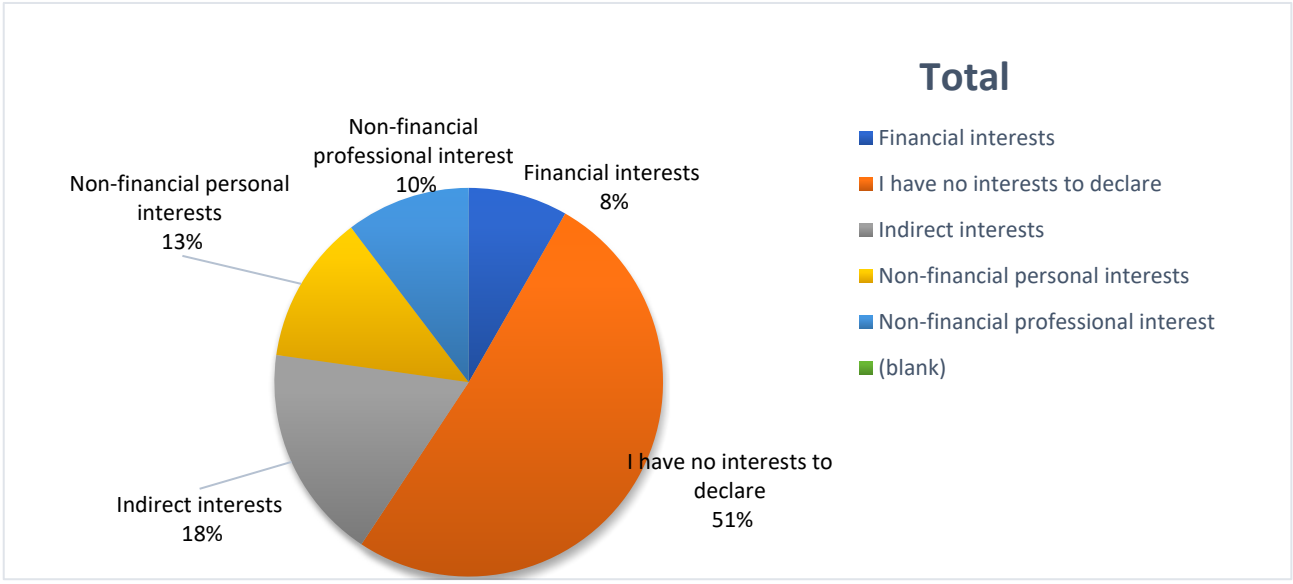
In accordance with the requirements of PTHB's Standing Orders and Standards of Behaviour Policy, a report is required to be received by the Audit, Risk and Assurance Committee (ARAC) which details the Declarations of Interest, Gifts and Hospitality received by Board Members.

In March 2025 the Board approved the revised Standards of Behaviour Policy. The key fundamental change within the revised policy was the addition of recording and maintaining a record of declarations of interests submitted by consultants and those staff with responsibility of budget oversight within the organisation.

Following approval of the revised policy, the Corporate Governance Team has been working with the Board, Executive Directors and Senior Management teams to actively promote and raise awareness of the revised Policy which all employees at PTHB must adhere to, ensuring a clear understanding of all key aspects of behaviours.

The Register of Interests is maintained by the Corporate Governance Department with each declaration reviewed and checked by the Director of Corporate Governance with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests and any gifts and hospitality received or declined. The Corporate Governance team are actively promoting the Declaration of Interests, and recording of Gifts and Hospitality across the organisation via various mechanisms and platforms which include external employees to ensure appropriate information is available.

The chart below provides a summary position of the Declarations of Interest submissions received for 2025/26.



The full register for Declaration of Interests 2025/26 at 09 September 2025 is attached at **Appendix A,** as of 09 September 2025 there are no items on the Gifts and Hospitality Register for reporting to the Committee. The Register of Board Members Declarations of Interest is also published on the Health Board's website and used for reporting to the Board's Committees in support of the declaration of interests in meetings. The broader register which includes consultants and budget holders, as well as Board Members, is held internally and made publicly available via reporting to this Committee as per Appendix A.

All employees and Independent Members of the Board must ensure that they are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the Health Board. Declarations must be made to the Health Board for recording in the Register of Interests any relevant interests at the commencement of employment, whenever a new interest arises or if asked to do so at periodic intervals by the organisation. The onus regarding declaration will reside with the individual employee or Independent Member.

An escalation process has been implemented by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted. Progress has been made in this area and the Corporate Governance Team is now pursuing best practice and encouraging all staff to declare interests where applicable.

To actively promote the Standards of Behaviour Policy and Declarations of Interests across the organisation, the Corporate Governance Team is reviewing current processes of how declarations are made and recorded. In addition, work

is underway to develop a communications plan, and to streamline the process of which declarations are made and recorded.

The Standards of Behaviour Framework summary is set out here: Standards-of-behaviour-framework and (available on request). The Director of Corporate Governance has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on PTHB's website and is also added to all Board and Committee agendas to ensure openness and transparency.

NEXT STEPS:

The Register of Declaration of Interests (Board Members only) and Gifts and Hospitality Register for 2025/2026 will be published on the PTHB website and will be maintained by the Corporate Governance team.

Employee Name	Employee Number	Position Title	Consent Flag	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Independant Monitoring Authority - Non-executive Director. Remuneration £7250.00 per Annum		18/03/2021	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	01/10/2018	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Member of Finance, Risk and Audit Committee - Hafod-Hendre Housing Association.	Hafod does not undertake functions in Powys Small annual payment only - £2500.00 per anum.	31/12/2017	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Shareholdings and other ownership interests	Director of RA and CJ Consulting Ltd	Dividend payment only	31/08/2012	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Shareholdings and other ownership interests	Partner - Director of RA and CJ Consulting Ltd	Dividend payment only	06/08/2017	14/04/2025
Ashman, Mrs. Zoe Kate	30321709	Assistant Director of Quality & Safety	Y	N	I have no interests to declare				05/06/2025	
Barnes, Mrs. Sarah	31363315	Head of Service: Public Health Programmes and Projects	Y	N	I have no interests to declare				30/06/2025	
Beavan, Mr. Paul	10601945	Digital Technology Lead	Y	N	I have no interests to declare				05/06/2025	
Beavan, Mr. Paul	10601945	Bank Digital Technology Lead	Y	N	I have no interests to declare				05/06/2025	
Bennett, Mrs. Jacqueline Helen	10602133	Senior Area Dental Nurse	Y	N	I have no interests to declare				10/06/2025	
Bertie, Mrs. Hannah Mae	29169740	Senior Communication and Engagement Manager	Y	N	I have no interests to declare				13/06/2025	
Bocking, Mrs. Karen Jean	20458005	Facilities Co-ordinator	Y	N	I have no interests to declare				26/08/2025	
Bowley, Mrs. Shan Mererid (Mezz)	30743956	Director of Public Health	Y	Y	Financial interests	Shareholdings and other ownership interests	Husband employed by Mitie Engineering as estimating manager, who holds contracts / work iwth some NHS Bodies/Organisations. Shares held by husband & myself in Mitie. Jointly hold share certificates Royal Mail.	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	14/05/2025	
Bowley, Mrs. Shan Mererid (Mezz)	30743956	Director of Public Health	Y	Y	Non-financial professional interest	Loyalty interests	Fellowship membership of the Facutly of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date). Unclear which situation option to select as this is professional membership.	14/05/2025	
Brown, Mrs. Amanda Jane	10604787	Admin & Patient Services Manager	Y	N	I have no interests to declare				04/06/2025	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Indirect interests	Outside employment	My partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Last worked for the organisation in October 2024.	01/06/2024	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Indirect interests	Outside employment	My partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Chair since June 2023, Board member since August 2016. Newydd/Cadarn Housing Group	01/08/2016	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Non-financial personal interests	Outside employment	Governor - Llangynwyd primary School (Bridgend)	Current term runs to November 2027	01/11/2023	
Cooper, Dr Carl	31039601	Board Chair	Y	Y	Indirect interests	Loyalty interests	Family Member Employment	Pharmaceutical Control Analyst. Cardiff & Vale UHB.	02/02/2025	
Cooper, Dr Carl	31039601	Board Chair	Y	Y	Indirect interests	Loyalty interests	Spouse's Employment	Sole Trader - Mandy Williams Consulting	02/04/2025	
Cooper, Mrs. Vicki Andrea	28462424	Chief Digital Data Officer	Y	N	I have no interests to declare		No further comment	no further comment	30/04/2025	
Crawley, Mr. Duncan Neil	31968897	Professional Lead for Catering and Environmental Cleanliness	Y	N	I have no interests to declare				11/06/2025	
Davies, Mr. Geraint William	28434855	Head of Estates	Y	N	I have no interests to declare		I have no declarations to declare	I have no declarations to declare	26/08/2025	
Davies, Mrs. Catrin Ann	30675100	Lead Advanced Nurse Practitioner for Children	Y	Y	Financial interests	Outside employment	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies. Spouse / Partner or other Relative. – Yes Director of Owen Davies Consulting Ltd and Gwagle Space Ltd	Ongoing for both companies owned by spouse.	01/08/2013	
Day, Mrs. Wendy Jane	31520037	Assistant Head of Childrens Public Health Nursing	Y	N	I have no interests to declare				07/05/2025	
Deacon, Mrs. Tracey Elizabeth	31598575	Head of Service: Public Health Programmes and Projects	Y	N	I have no interests to declare				05/06/2025	
Deakins, Mrs. Victoria Louise	10604327	Lead Therapist North Locality	Y	N	I have no interests to declare				06/05/2025	
Edwards, Mrs. Amandalane	25429509	Assistant Director of Improvement and Innovation	Y	N	I have no interests to declare				10/06/2025	
Elliot, Mr. Stephen Richard	32535276	Board Non Officer	Y	Y	Non-financial professional interest	Outside employment	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity		17/04/2024	

Evans, Mrs. Caroline	27784514	Research, Innovation & Improvement Manager	Y	N	I have no interests to declare				19/08/2025	
Falvey, Mr. Aled Joseph	27086017	Professional Head of Physiotherapy	Y	N	I have no interests to declare				18/08/2025	
Falvey, Ms. Katelyn Emma	21187975	Head of Workforce Transformation, Planning & Resourcing	Y	N	I have no interests to declare				18/08/2025	
Falvey, Ms. Katelyn Emma	21187975	Assistant Director or Workforce and OD	Y	N	I have no interests to declare				18/08/2025	
Farnsworth, Mr. David Mark	30692747	Assistant Director of Community Services	Y	Y	Non-financial personal interests	Loyalty interests	My spouse works as a clinical practitioner in dementia for St Michael's Hospice, Hereford.	I have no direct involvement in the commissioning of any services with this provider.	09/05/2025	
Giannasi, Mr. Michael Anthony (Mick)	32493172	Board Non Officer	Y	Y	Indirect interests	Outside employment	I am currently the Chair of Social Care Wales which is a Welsh Government Sponsored Body.	The Health Board has no direct contractual or financial relationship with Social Care Wales. However, as the regulator for the social care workforce in Wales, it is part of the wider health and care system and as such, matters may arise in the course off the Board's business which could be perceived by others to amount to a conflict.	01/08/2019	31/07/2027
Gwynne, Mrs. Stella Elizabeth	27926256	Assist. Dir. Corporate Governance/Deputy Board Secretary	Y	N	I have no interests to declare				22/04/2025	
Gwyther, Mrs. Tracey Louise	32884839	Head of Commissioning	Y	N	I have no interests to declare				14/05/2025	
Harris, Mrs. Susan Dorothy	25348800	Facilities Co-ordinator	Y	N	I have no interests to declare				05/06/2025	
Hartwright, Dr Christopher Gerald (Chris	28862934	Head of Psychology	Y	N	I have no interests to declare				05/06/2025	
Hills, Mrs. Alex Jayne	23105814	National Head of Researcher Development	Y	N	I have no interests to declare				13/06/2025	
Hobbs, Ms. Rhiannon Catrin	32797600	Principal Public Health Practitioner	Y	N	I have no interests to declare				10/06/2025	
Hopgood, Mr. Peter Lewis (Pete)	27376161	Deputy CEO & Director of Finance	Y	Y	Non-financial personal interests	Loyalty interests	Wife/Partner is a Finance Manager in Swansea Bay UHB.	Wife/Partner is currently employed as a Finance Manager in Swansea Bay UHB.	18/06/2018	
Hughes, Mr. Owen	10604720	Head of Pain & Fatigue Management	Y	Y	Financial interests	Clinical private practice	I am a director of a limited company called psych45 ltd. I use this company to run training events, clinical private practice and expert witness work		05/04/2010	
Hymers, Mrs. Louise	28527252	Macmillan Lead Nurse for Cancer and Palliative Care	Y	Y	Indirect interests	Loyalty interests	My husband is employed by RNIB as one of the Eye Care Liaison Officers covering PTHB - this is a commissioned service via an SLA between PTHB and RNIB - I have no interaction with the commissioning process of his role, or his role within the health board.		20/06/2025	
Ingram-Jones, Mrs. Jayne Elizabeth	30965037	Business Support Manager	Y	N	I have no interests to declare				29/07/2025	
Jamieson, Mrs. Judith Rosemary	10601981	Senior Nurse Mgr - Outpatients	Y	N	I have no interests to declare			I have no conflicts of interest to declare	01/06/2011	01/06/2029
Jamieson, Mrs. Judith Rosemary	10601981	Senior Nurse Mgr - Outpatients	Y	N	I have no interests to declare				05/06/2025	
Johnson, Mrs. Nicola	32833200	Director of Planning	Y	N	I have no interests to declare				30/04/2025	
Jones, Mrs. Donna Leela	32147098	Integrated Clinical Team Manager	Y	N	I have no interests to declare				05/06/2025	05/06/2026
Kelly, Miss Nicola Jane	26623607	Head of Planned Care	Y	N	I have no interests to declare				18/08/2025	
Kelly, Ms. Vivien Maria	25599815	Senior Clinical/Counselling Psychologist - Older Adult	Y	Y	Non-financial professional interest	Clinical private practice	I have a private practice providing clinical supervision	I have in the past also provided consultancy and training to third sector organisations, local authorities, educational institutions and the NHS (under the name 'People Skills Wales'). I have also had a private practice as a therapist. At the moment I only offer a limited supervision provision	11/06/2025	
Kirkham, Mrs. Michelle	24909224	Professional Head of Radiography	Y	N	I have no interests to declare				13/06/2025	
Lawrence, Mrs. Jayne Louise	10604680	Assistant Director of Primary Care Services	Y	N	I have no interests to declare				16/07/2025	
Lewis, Dr Rhobert	27442212	Board Non Officer	Y	Y	Indirect interests	Outside employment	External member Cross-party STEMM Group Welsh Government	Unsure of exact date. No payment involved. Continuing.	01/01/2020	15/04/2025
Lewis, Dr Rhobert	27442212	Board Non Officer	Y	Y	Non-financial professional interest	Outside employment	Chair NPTC Group of Colleges	And continuing No payment involved	17/11/2021	15/04/2025
Lines, Mrs. Clare Peace	10603301	Assistant Director Partnership Development	Y	Y	Indirect interests	Outside employment	My husband is; *A trustee of the Wales Council for Voluntary Action * The Chair of the Gateway Dental Practice * The Chair of Social Investment Cymru Committee (WCVA) * Member of Carers Trust Wales Advisory Board	Update May 2025 - positions have been held for longer	07/05/2025	07/05/2027
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Financial interests	Outside employment	Independent Member - ateb housing associate		01/04/2024	
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Indirect interests	Outside employment	Daughter works for Aneurin Bevan University Health Board		01/08/2023	

Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Indirect interests	Outside employment	Husband works for Hywel Dda University Health Board		02/06/2025	
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Non-financial professional interest	Outside employment	Chair of West Wales Care & Repair Board	Voluntary Board Member	01/11/2019	
Madsen, Mrs. Claire Louise	28421856	Director of Therapies and Health Sciences	Y	Y	Financial interests	Outside employment		I sometimes do visiting lecturer work ad hoc for the University of the West of England	30/04/2025	20/04/2027
Madsen, Mrs. Claire Louise	28421856	Director of Therapies and Health Sciences	Y	Y	Non-financial professional interest	Loyalty interests		Member of the Chartered Society of Physiotherapy	02/06/2025	01/06/2027
McGowan, Mrs. Emma Jayne	20904349	Clinical Informatics Lead Nursing	Y	N	I have no interests to declare				05/06/2025	
McGowan, Mrs. Emma Jayne	20904349	N&M Bank Staff Qualified AFC	Y	N	I have no interests to declare				05/06/2025	
McIntyre, Mr. Mark Edward	26581555	Deputy Director of People & Culture	Y	N	I have no interests to declare				18/08/2025	
Morris, Miss Louise Marie	26846132	Head of Capital	Y	N	I have no interests to declare				14/04/2025	
Moss, Mr. Christopher	32035998	Assistant Director of Performance & Commissioning	Y	N	I have no interests to declare				05/06/2025	
Osborne, Mr. Adrian	26873573	Deputy Director of Communication, Engagement & Corporate Gov	Y	Y	Non-financial personal interests	Outside employment	I am a volunteer Trustee of Powys Citizens Advice which is in receipt of grant funding from the health board and other partner bodies.		01/04/2025	
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Brother is Senior Manager Freedom Leisure South Powys & Swansea		01/01/2020	31/12/2030
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Chair PSB Scrutinmy Committee		01/04/2024	01/04/2027
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Coopted member PAVO		01/09/2024	01/06/2028
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Member (not a NED) Glas Cymru		01/06/2016	10/06/2027
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Vice Chair PAVO		07/02/2025	09/02/2028
Owen, Mr. David Michael	31289889	Assistant Director of Digital Technology and Data Operations	Y	N	I have no interests to declare				04/06/2025	
Parry, Miss Jane	10604865	Library Services Manager	Y	N	I have no interests to declare				25/06/2025	
Pearce, Dr Adam Hugh	30005784	Service Improvement Manager Welsh Language & Equalities	Y	Y	Financial interests	Outside employment	I run a small independent publisher called Melin Bapur books (www.melinbapur.cymru) as an additional (self) employment. I have also previously delivered Equality training, including to NHS Wales orgnaisations, on a freelance basis; I have and will not solicit any such work through my NHS Wales role.	I have previously received a payment from Public Health Wales in my capacity as Melin Bapur CEO for delivering a speaking engagement. This engagement was not solicited by myself and was totally coincidental to my employment by NHS Wales, and was carried out on my own time.	01/03/2023	
Phillips, Ms. Justine	10604523	Specialist Continence Service Lead	Y	N	I have no interests to declare				05/06/2025	
Powell, Mrs. Sarah	27544342	Assistant Director of People & Culture, OD & Wellbeing	Y	N	I have no interests to declare				09/06/2025	
Poynton, Ms. Catherine	10606185	UNISON Branch Secretary	Y	N	I have no interests to declare				11/04/2025	
Price, Dr Fiona Catherine Mary	31511062	Head of Clinical Education	Y	N	I have no interests to declare				05/06/2025	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Outside employment	Husband Interests Husband – Pharmacist consultant providing support to Pharmacy departments in NHS England and Wales. Husband – working as a pharmacy and medicines consultant providing advisory and expert services to: Bain & Co.		03/04/2023	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Shareholdings and other	Brother in law owns building in Welshpool currently rented by Rowlands Pharmacy. I have no interest or gain in this.		03/06/2018	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Shareholdings and other	Second cousin is senior GP partner for Newtown Medical Practice		01/06/2017	
Pritchard, Mrs. Sarah Elizabeth	10601943	Assistant Director of Finance	Y	Y	Indirect interests	Loyalty interests	My son is a planning officer with Bannau Brycheiniog National Parks to which the HB will submit planning applications for contruction works on its land and buildings,	I will not be making any planning applications directly but may be required to facilitate payment for such applications but based on budget holder approval.	23/07/2025	
Pritchard, Mrs. Sarah Elizabeth	10601943	Assistant Director of Finance	Y	Y	Indirect interests	Shareholdings and other	My brother owns a petrol station in Sennybridge where THB fleet fuel cards may be used.	I have no personal/owner interest in this business but declaring family relationship as this business may have possible transactions with the THB via third party vendor for fuel cards	23/06/2025	
Pullen, Mr. Hywel Richard	31291840	Deputy Director of Finance	Y	N	I have no interests to declare				01/02/2023	
Quarrell, Miss Catherine Linda	10602220	Corporate Services Manager	Y	N	I have no interests to declare				05/06/2025	
Quarrell, Mr. Andrew Phillip	27519808	Non Emergency Patient Transport	Y	N	I have no interests to declare				11/06/2025	11/06/2026
Randell, Mrs. Rebecca Claire	10604591	AHPs Head of Paeds Physiotherapy	Y	N	I have no interests to declare				04/08/2000	

Roche, Mrs. Claire Louise	30400027	Director of Nursing	Y	N	I have no interests to declare				29/05/2025	
Ruthven-Hill, Miss Samantha (Sam)	27190725	Assistant Director of Planning	Y	N	I have no interests to declare				05/06/2025	
Shone, Mrs. Linzi Ann	21597775	Prof Head of Nursing	Y	N	I have no interests to declare				06/05/2025	
Shooter, Dr Ben Michael	26229116	Consultant in Adult Mental Health	Y	N	I have no interests to declare				03/05/2022	
Shooter, Dr Ben Michael	26229116	Consultant in Adult Mental Health	Y	N	I have no interests to declare				06/05/2025	
Sinclair, Mrs. Heidi Marie	31366346	Head of Quality and Safety	Y	N	I have no interests to declare				29/04/2025	
Smart, Mrs. Amanda Louise	10601949	Head of Information Governance, Records & Data Protection	Y	N	I have no interests to declare				30/07/2025	
Summerfield, Mrs. Tanya Maria	10604108	Business Manager Online CBT	Y	N	I have no interests to declare				05/06/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal interests	Clinical private practice	Director of BEST KEPT SECRET AESTHETICS WALES LTD.	Joint Director of this Ltd company undertaking private clinical practice in aesthetics. No direct or relationship with NHS activity.	22/08/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal interests	Outside employment	Director of LLAMORS LTD.	Joint director with my husband, working in the construction of new residential dwellings. No direct or related interest in public service.	22/08/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal	Shareholdings and other	Registered Landlord - rental of residential dwellings	I am joint owner of a portfolio of residential dwellings with my husband. I am the RentSmart Wales registered landlord undertaking activities in line with legislative obligations. No affiliation with NHS activity, property located outside the county of Powys.	22/08/2025	
Tannahill, Mr. Wayne Robert (Wayne)	25129663	Associate Director of Capital, Estates & Property	Y	N	I have no interests to declare				02/07/2025	
Taylor, Mr. Peter Martin Henry	28858271	AHPs Head of Podiatry	Y	N	I have no interests to declare				06/07/2020	
Taylor, Mr. Peter Martin Henry	28858271	AHPs Head of Podiatry	Y	N	I have no interests to declare				18/08/2025	
Thomas, Mr. Christian Delfryn	10604706	Assistant Director of Finance	Y	N	I have no interests to declare		No Intereest to Declare		05/06/2025	
Thomas, Mr. Ian	33136771	Board Non Officer	Y	Y	Non-financial personal interests	Outside employment	I have worked with a team of consultants as an independent associate in the past	I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	09/04/2025	
Thomas, Mrs. Christina Marie	24460992	Senior Manager - Unscheduled Care	Y	N	I have no interests to declare				01/09/2025	
Thomas, Mrs. Hayley	23581771	CEO Chief Executive	Y	N	I have no interests to declare				09/05/2025	
Thomas, Mrs. Tanya Marie	28323968	Transformation Manager - Mental Health Renewal	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Transformation Manager - Mental Health Renewal	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Mental Health Team Bank	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Mental Health Team Bank	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	CAMHS Primary Mental Health Worker	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	CAMHS Primary Mental Health Worker	Y	N	I have no interests to declare				05/06/2025	
Tolley, Dr Warren	10604274	Associate Dental Director	Y	N	I have no interests to declare		I have no interests to declare	I have no interests to declare	18/08/2025	
Toy, Mrs. Julia Anne	10602270	Strategic Workforce Lead for Health, Care and Partnership	Y	N	I have no interests to declare				05/06/2025	
Vitolo, Miss Lydia	23757448	National Lead Commercial Research Delivery Wales	Y	N	I have no interests to declare		I have no declarations to declare and am happy for this to be published	I have no declarations to declare and am happy for this to be published	27/08/2025	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Associate Member of the Association of Genealogists and Registered Archivists		08/05/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Elected Member Powys County Council		05/05/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Sole Trader/Owner of Celebratory Gifts Heraldic Names		01/06/2003	

Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Sole Trader/Owner:CTW Genealogy Research		01/06/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Indirect interests	Loyalty interests	Trustee/Chair: Brecon University Scholarship Fund		01/07/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Indirect interests	Outside employment	Brecon Town Council Elected Member		10/08/1995	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Governor of Priory Church in Wales School		22/05/2017	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Labour Party Member		01/12/1988	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel		25/09/2017	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member of Community Speed Watch Group		01/06/2010	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member of Society Genealogists		01/01/2019	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Shareholdings and other ownership interests	Owner of Property in the County of Powys		01/06/1988	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Member of Royal College of Nursing		01/01/1986	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Registered Member of Nursing and Midwifery Council		31/03/1988	
Walters, Mrs. Amanda Jayne	29825659	Head of Primary Care	Y	N	I have no interests to declare				18/08/2025	
Waters, Mrs. Felicity Jayne	28227441	Communication and Engagement Manager	Y	N	I have no interests to declare				16/06/2025	16/06/2026
Wheeler Sexton, Mrs. Jayne	28484260	Assistant Director of Nursing	Y	N	I have no interests to declare				08/04/2025	
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Outside employment	Magistrate	Gwent Bench	01/03/2016	
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Outside employment	Private work as a sole trader - delivering coaching, training and marking services. Associate at TPC Leadership and TPC Health Other clients include Macmillan UK, NHSE/I, Personalised Care Institute (England), Welsh Government, HDUHB Changed to Ltd company in Feb 2022	Previously submitted declarations by email to Med Dirs office/HR	04/01/2016	03/02/2027
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Shareholdings and other ownership interests	Founder/Director of Williams Creative Consultancy Ltd -T/A Mynd Leadership. Registration number 13938853		22/02/2022	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Indirect interests	Outside employment	Chair of the GCRE Community Liason Committee		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Indirect interests	Outside employment	Commissioner South Wales Fire and Rescue Service		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Co Director Powys Samaritans		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Director of ILEP Ltd a subsiduary of Cardiff University		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Vice Chair Brecknock YFC Board of Managment		22/04/2025	
Wood-Lawson, Ms. Debra	31521670	Director of Workforce and Organisational Development	Y	Y	Indirect interests	Outside employment	Non Executive Director of Cadarn Housing Association	I am a non Executive Director of a Housing Association and a member of their Group Board and Governance Committee The 'group' is a zonal partner with Powys for the provision of housing stock	01/11/2024	01/11/2027
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Financial interests	Outside employment	I am employed as Academic Registrar at Cardiff University which delivers a number of health care programmes		03/03/2015	18/06/2025
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Financial interests	Outside employment	My wife is employed as a District Nurse for Cardiff and Vale Health Board		18/06/2025	
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Indirect interests	Loyalty interests	My sister is a Senior Operations Manager, Milestone Trust Bristol		18/06/2025	

Agenda item: 7.2

Audit Risk and Assurance Committee	07 October 2025
Subject:	LOSSES AND SPECIAL PAYMENTS INTERIM REPORT 2025/26
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To receive the Interim Report of Losses and Special Payments for the period 1st April 2025 to 31st August 2025.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

- **RECEIVE** this Interim Report on Losses and Special payments covering the period 1st April 2025 to 31st August 2025.
- Take **ASSURANCE** appropriate reporting mechanisms are in place.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

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

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

HEADING:

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

This paper provides an interim report for the period 1st April 2025 to 31st August 2025.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Redress, Compensation Claims & Inquest Case Co-Ordinator, manages the claims on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support are provided by Legal & Risk Services on the processes and on the management of individual cases. Addressing learning following settlement of individual cases, learning and evidence is shared with Welsh Risk Pool (WRP) with the LFER process for reimbursement.

Systems and processes have been established and databases documenting all claims activity alongside the individual claims files exist. Decision making on payments are approved in a number of ways:

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery. All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety Committee. The last report was provided to the July 2025 Committee.

- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2025 to 31 August 2025, the THB made payments in respect of 5 cases totalling £463,286.39 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year to date the THB has not received reimbursement in respect of cases that exceeded the £25,000 THB liability.

Details of the payments are included in Appendix Ai.

	No. of payments	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	13	5	£ £463,286.39
Total	**13**	**5**	**£463,286.39**

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 17 cases which are which are inclusive of clinical negligence (12),and personal injury (5) claims with NWSSP Legal and Risk Services instructed to act on behalf of the health board.

There has been no reimbursement to date from Welsh Risk Pool during 2025/26 but a couple of claims have concluded and been recently submitted to Welsh Risk Pool for reimbursement.

Redress (Putting Things Right)

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

Details of the payments made during 1st April 2025 to 31st August 2025 are included in Appendix Aii.

	No. of payments/receipts	No. of cases	£
Redress Payments	2	2	£4,845.00
Total	**2**	**2**	**£4,845.00**
Redress Receipts	0	0	£0
Total	**0**	**0**	**£0**

There are currently 8 open redress cases at variable stages

General Medical Practice Indemnity (GMPI)

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2025 to 31st August 2025 are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
GMPI Payments	9	4	£11,634
Total	**9**	**4**	**£11,634**
GMPI Receipts	0	0	£0
Total	**0**	**0**	**£0**

There are currently 7 open GMPI cases at variable stages of review/progression.

There has been no reimbursement to date from Welsh Risk Pool during 2025/26 but one claim has been withdrawn and associated costs to date have been recently submitted to Welsh Risk Pool for reimbursement.

Other Special Payments

There have been no Ex Gratia payments made during April to August 2025

Conclusion

The Audit Committee is asked to note the above interim report for 2025/26 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

The Audit Risk and Assurance Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

Losses And Special Payments for 2025-26 Financial Year (Interim) 1st April 2025 to 31st August 2025				Appendix Ai		
Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Pa	Payments	Amount by case	Additional Information
Clinical Negligence	Defence Fees	SSPLR143880	Jun-25	£14,216.70	£14,216.70	
Personal Injury	Defence Fees	SSPLR149755	Jun-25	£310.77	£310.77	
Clinical Negligence	Defence Fees	SSPLR153510	May-25	£1,152.00	£1,152.00	
Clinical Negligence	Damages	SSPLR154114	Apr-25	£362,500.00		
Clinical Negligence	Defence Fees	SSPLR154114	Jun-25	£673.75		
Clinical Negligence	Defence Fees	SSPLR154114	Jun-25	£18.00		
Clinical Negligence	Defence Fees	SSPLR154114	Jun-25	£1,299.67		
Clinical Negligence	Defence Fees	SSPLR154114	Jul-25	£480.00		
Clinical Negligence	Final Claimant Costs	SSPLR154114	Jul-25	£12,500.00		
Clinical Negligence	Interim Payment of Claim	SSPLR154114	Jul-25	£67,500.00		
Clinical Negligence	Defence Fees	SSPLR154114	Aug-25	£367.50	£445,338.92	Claim concluded submission to WRP to reclaim
Clinical Negligence	Defence Fees	SSPLR154920	Jul-25	£1,260.00		
Clinical Negligence	Defence Fees	SSPLR154920	Aug-25	£1,008.00	£2,268.00	
		TOTAL		£463,286.39	£463,286.39	
Reimbursements from Welsh Risk Pool						
Receipt Date	WRP Reference	Laspar Reference		Amount		
Nil receipts to date						
		Total		£0.00		

Appendix Aii

Redress Losses And Special Payments for 2025-26 Financial Year (Interim) 1st April 2025 to 31st August 2025			Appendix Aii		
Payment Date	Redress Reference	WRP Reference	Nature of Payment	Amount	Amount by case
Apr-25	3954/WEB36031	RED-7A7-0010-CT	Defence Costs	£2,125.00	£2,125.00
Aug-25	RED 72	RED-7A7-0055-JO	Claimants Costs	£1,920.00	£1,920.00
			Total	£4,045.00	£4,045.00
Reimbursements from Welsh Risk Pool					
Receipt Date	WRP Reference	Redress Reference		Amount	Amount by case
Nil receipts to date					
			Total	£0.00	£0.00

Appendix Aiii

GP Indemnity Losses And Special Payments for 2025-26 Financial Year (Interim)

Appendix Aiii

1st April 2025 to 31st August 2025

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount by case
Jul-25	SSPLR148695	Defence costs	£1,000.00	
Jul-25	SSPLR148695	Defence costs	£1,200.00	
Jul-25	SSPLR148695	Defence costs	£2,375.00	£4,575.00
Jul-25	SSPLR149098	Defence costs	£2,880.00	
Aug-25	SSPLR149098	Defence costs	£525.00	£3,405.00
Aug-25	SSPLR154808	Defence costs	£594.00	
Aug-25	SSPLR154808	Defence costs	£384.00	£978.00
Aug-25	SSPLR155471	Defence costs	£2,376.00	
Aug-25	SSPLR155471	Defence costs	£300.00	£2,676.00
		Total	**£11,634.00**	**£11,634.00**

Reimbursements from Welsh Risk Pool

Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Nil receipts to date			
		Total	**£0.00**

Appendix Aiv

Other Losses And Special Payments for 2025-26 Financial Year (Interim)

1st April 2025 to 31st August 2025

Appendix Aiv

Payment Date	Losses Reference	Nature of Reimbursement	Amount
Nil payments to date			
		Total	**£0.00**

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both
Safe				
Timely				
Effective				
Efficient				
Equitable				
Person Centred				
Workforce				
Leadership				
Culture				
Information				
Learn, Improve, Research				
Whole Systems Approach				

EQUALITY:

	No impact	Negative	Positive	Both
Age				
Disability				
Gender reassignment				
Marriage / civil partnership				
Pregnancy / maternity				
Race				
Religion or Belief				
Gender				
Sexual Orientation				
Welsh Language				
Socio-economic status				
Social exclusion				
Carers				

RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical				
Financial				
Corporate				
Operational				
Reputational				

Agenda item: 7.3

Audit Risk and Assurance Committee	07 October 2025
Subject:	Single Tender Waivers
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To inform the Audit Risk and Assurance Committee that there has been no Single Tender Waiver requests made between 1 July 2025 and 30 September 2025.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there has been No Single Tender Waiver requests made between 1 July 2025 and 30 September 2025.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:
In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements
HEADING:
The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its July 2025 meeting which covered the period from 1 May 2025 and 30 June 2025. It is confirmed there has been no Single Tender Waiver requests made between 1 July 2025 and 30 September 2025.

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

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both
Safe				
Timely				
Effective				
Efficient				
Equitable				
Person Centred				
Workforce				
Leadership				
Culture				
Information				
Learn, Improve, Research				
Whole Systems Approach				

EQUALITY:

	No impact	Negative	Positive	Both
Age				
Disability				
Gender reassignment				
Marriage / civil partnership				
Pregnancy / maternity				
Race				
Religion or Belief				
Gender				
Sexual Orientation				
Welsh Language				
Socio-economic status				
Social exclusion				
Carers				

RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical				
Financial				
Corporate				
Operational				
Reputational				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.5

AUDIT, RISK AND ASSURANCE COMMITTEE	**07 OCTOBER 2025**
Subject:	Information Governance Toolkit Out-Turn Report 2024-2025 and Improvement Plan 2025/26
Approved and presented by:	Kate Wright, Medical Director and Caldicott Guardian
Prepared by:	Head of Information Governance, Records and Data Protection Officer and Information Governance Manager
Other Committees and meetings considered at:	Executive Committee - 06 August 2025 who approved the paper.

PURPOSE:

The purpose of this paper is to inform the Committee of the Health Board's performance against the NHS Wales Information Governance Toolkit for Health Boards and Trusts 2024-2025 submission for assurance purposes. Note: Figures provided include Health and Care Research Wales as a hosted organisation.

An Improvement Plan has been developed highlighting areas of work required to improve the current compliance in support of the 2025-2026 submission.

RECOMMENDATION(S):

The Audit and Risk Assurance Committee is asked to:

1. **NOTE** the changes to reporting of compliance score for this report and future reporting
2. **NOTE** concerns have been raised with National Team, DHCW around some question sets
3. **NOTE** the Executive Committee reviewed the content of this report and supported the management actions identified in the Improvement Plan to enable the continued assurance that that the health board is meeting data protection obligations.
4. **NOTE** that the Executive Committee approved the publication of the Toolkit compliance standard for each area for assurance purposes.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	N	IG Toolkit ensures that the health board handles information safely, legally, and efficiently building trust among partners, stakeholders, and the public. Also supports regulatory compliance and supports digital transformation and collaborative service redesign.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Committee are asked to note that compliance is shown within this report as individual scores for each of the categories; Accountability, Freedom of Information, Business Continuity and Information Security. Due to the change in platform an overall compliance score can no longer be provided.

There are two sets of requirements within the Toolkit "Minimum Expectations" containing 176 questions and "Expectations Exceeded" containing 58 questions.

"Minimum Expectations" sets out the minimum requirements which form the backbone of the organisation's IG compliance and includes questions which are either legal requirements or are set out within the Information Commissioner's Office (ICO) Accountability Framework.

"Expectations Exceeded" demonstrate that we are working above the minimum requirements in that topic area, however **the** question set only becomes available once the minimum expectations have been fully achieved (100% completion). Section will automatically revert to 0% even if some questions have been answered

The committee are asked to NOTE that concerns have been raised nationally that there are some requirements within the categories that will not be met by many of the Health Boards and Trusts. For example, the requirement to have a system to monitor that staff have read and understood policies and procedures. Without additional investment to pay for a system, we are unable to meet this requirement.

Table below highlights the performance trends in comparison with the 2023-24 submission:

Key:

- Maintained
- Reduced
- Improved

Category	Minimum Expectations % compliance	Exceeded expectations % compliance	Performance against previous submission (2023-24)

Accountability: Leadership and Oversight	100% (26/26)	100% (4/4)	
Accountability: Policies and Procedures	88% (15/17)	0% (0/6)	
Accountability: Training and Awareness	100% (24/24)	80% (8/10)	
Accountability: Individuals Rights	100% (17/17)	100% (7/7)	
Accountability: Records of Processing and Lawful Basis	100% (6/6)	0% (0/1)	
Accountability: Contracts and Information Sharing	100% (18/18)	100% (7/7)	
Accountability: Risks and Data Protection Impact Assessments	100% (16/16)	75% (6/8)	
Accountability: Breach Response and Monitoring	100% (4/4)	100% (4/4)	
Freedom of Information and Environmental Information	100% (7/7)	100% (5/5)	
Business Continuity	81% (9/11)	0% (0/4)	
Information Security	100% (29/30)	0% (0/2)	

Reduction in scores from last year: reflect changes in the question set on the Toolkit and not a decline in performance. Some questions previously included under "Exceeded Expectations" have been moved to the "Minimum Expectations" question set due to updated Information Commissioner's Office (ICO) guidance. We had already met the requirement, but the scoring can now only contribute to "Minimum Expectations" rather than "Expectations Exceeded".

There have also been additional requirements added for 2024-2025 such as under the "Training and Awareness" section where organisations now need to meet 95% compliance for mandatory IG training before they can achieve "Expectations Exceeded". A collective response from health boards in Wales has previously advised that they are unlikely to meet this higher benchmark unless the compliance score does not include those who may be away from work for a long period e.g. parental leave and long-term sickness. There has not yet been a decision made from the Information Governance Management Advisory Group (IGMAG) on whether to pursue this additional work to meet that compliance.

Improvements since last submission (2023-2024):

Accountability: Records of Processing and Lawful Basis – the finalisation of the health board's Information Asset Register (IAR) which also acts as the Health Board's Record of Processing Activities (ROPA), was implemented Q3 2023/24 and thus available for this year's submission improving compliance in this area. A ROPA is a legal requirement under Article 30 of the UK GDPR which PTHB is now compliant against. The IAR/ROPA enables the health board to provide assurance that it can identify where information is securely stored, how and why it is processed, the legal basis for processing and how we manage the life cycle of information. This will ensure that we only hold what we require for our purposes (meeting requirements under the data minimisation principle) and reduces the risk to the organisation should there be a severe data breach or cyber-attack. It supports business continuity and importantly assures patients and staff that we can manage personal information about them securely.

Accountability: Contracts and Information Sharing - Enhanced collaboration with services and additional IG team resources have improved oversight and monitoring of contracts and agreements.The team have been able to invest time identifying agreements and contracts due for review to ensure they are up to date in terms of purpose, scope and legal requirements. This improved monitoring has increased liaison with other services who are now more likely to approach IG for support in other IG areas which is positive, alongside the improvement in compliance.

Information Security - The Digital Data and Technology Cyber specialists have undertaken the Cyber Assurance Framework (CAF) which is a requirement by NHS Wales Cyber Resilience Unit (CRU) within the last 18 months. This improvement has enabled the health board to now reach "Minimum Expectations" for this category.

Future Developments by DHCW: The next iteration of the toolkit will be available in Autumn 2025. There will be changes to some of the question sets in line with regulator guidance and updates to legislation, including a **new category covering Video Surveillance.**

DETAILED BACKGROUND AND ASSESSMENT:

The Welsh Information Governance Toolkit is a self-assessment tool enabling NHS Wales organisations to measure their level of compliance against national Information Governance standards and legislation.

The aim of the assessment is to demonstrate that the Health Board can be trusted to maintain the confidentiality and security of both personal and business information and final scores along with the improvement plan are published to show open and transparency to the wider public.

While the toolkit demonstrates IG and records management compliance, some aspects are also assessed under the biannual Welsh Cyber Assurance Process

(WCAP). The assessment assists in identifying areas which require improvement, and these inform the IG Toolkit Improvement Plan.

Measuring Compliance: Compliance is measured by positively answering assessment questions within each of the categories. Supporting evidence is uploaded or text descriptors inserted to detail the Organisation's position.

Measures: Each category in the toolkit has a varying number of questions depending on the requirement. To complete a section, all questions for that category must be sufficiently answered. Following completion and submission of the toolkit, results are reviewed by each organisation and DHCW and an improvement plan is generated for local development and approval. The IG Improvement Plan 2025-2026 has been included with this paper with any areas requiring action for improvement to increase compliance.

Assurance: Where the Health Board can demonstrate full compliance (100%), work should and always will continue to ensure that the high level of assurance is maintained to demonstrate compliance with data protection and records management obligations, provide assurance to key stakeholders such as provider organisations, our service users and the Information Commissioner's Office (ICO).

NEXT STEPS:
1) Engage with Responsible Managers to progress outstanding actions, agree timelines to improve compliance for next year's submission 2) Work will commence on completion of the 2025/26 submission by 31 March 2026**.** 3) On-going updates and progress reports will be submitted to the Executive Committee and Audit, Risk and Assurance Committee quarterly. 4) 2024/25 scores will be published.

IMPACT ASSESSMENT
Not required

Information Governance Toolkit Improvement Plan 2025-2026

The table below outlines the **actions required to meet the "Minimum Expectations"** for each category and improve on the current PTHB assurance compliance score from the NHS Wales IG Toolkit for Health Boards and Trusts 2024-2025.

Actions Required to meet "Minimum Expectations"						
Action	**Category**	**Subsection**	**Issue/ Requirement**	**Action Required and Updates**	**Responsible Manager**	**Responsible Director**
1	Accountability	Policies and Procedures	No PTHB Data Quality Policy currently in place	Policy to be developed and implemented Update: Policy being drafted in readiness for wider Health Board consultation process.	Assistant Director of Digital Technology & Data Operations	Executive Director of Allied Health Professions, Health Sciences and Digital
2	Accountability	Contracts and Information Sharing	Cyber Certification is already in place for PTHB ICT System suppliers within the last 5 years. The IG Toolkit references ISO27001 as a standard requirement for ALL suppliers.	IG team to liaise with Cyber Security to discuss feasibility of process for retrospectively reviewing certification of suppliers contracted before the last 5 years, where appropriate resources can be made available to support this.	Assistant Director of Digital Technology & Data Operations	Executive Director of Allied Health Professions, Health Sciences and Digital
3	Business Continuity	Business Continuity	No existing specific testing in place for Cyber Security to support PTHB ICT Business Continuity Plans.	To liaise with Cyber Team on the progress of the development of this plan.	Assistant Director of Digital Technology & Data Operations	Executive Director of Allied Health Professions, Health Sciences and Digital

The table below outlines the **actions required to meet "Expectations Exceeded"** for each category and improve on the current PTHB assurance compliance score from the NHS Wales IG Toolkit for Health Boards and Trusts 2024-2025.

Actions Required to meet "Expectations Exceeded"						
Action	**Category**	**Subsection**	**Issue/ Requirement**	**Action Required and Updates**	**Responsible Manager**	**Responsible Director**
4	Accountability	Policies and Procedures	No system to monitor if staff have read and understood policies	Explore Health Board options to meet this requirement Update: this action cannot be achieved without investment from the Health Board to procure a system to meet this requirement.	Business & Governance Officer	Director of Corporate Governance/Board Secretary
5	Accountability	Records of Processing and Lawful Basis	Review implantation of ROPA (Record of Processing Activities)	Review and assess if any improvements are required	Head of Information Governance, Records & DPO	Director of Corporate Governance/Board Secretary
6	Accountability	Risks and Data Protection Impact Assessments (DPIAs)	System in place to routinely publish information about DPIAs	While we will not be routinely publishing DPIAs due to them being commercially sensitive, we will keep a register of current DPIAs that can be published on the PTHB intranet.	Head of Information Governance, Records & DPO	Director of Corporate Governance/Board Secretary
7	Accountability	Training and Awareness	Meet or exceed 95% training compliance score for mandatory	Continue to liaise with services that are low on compliance and identify	Head of Information Governance,	Director of Corporate Governance/Board Secretary

			Information Governance, Records management and Cyber Security e-learning	ways of improving compliance Concerns have been raised nationally that health boards/Trusts will struggle to meet this compliance rate due to non-compliance of staff on long term sick leave/maternity. Bank staff also present a problem with compliance.	Records & DPO	
8	Information Security	Information Security	Routine information security checks/audits regularly conducted that consider compliance with information security policies and procedures	IG team to liaise with Digital Data and Technology team to determine how feasible this is and how this could be actioned/progressed.	Head of Information Governance, Records & DPO Assistant Director of Digital Technology & Data Operations	Director of Corporate Governance/Board Secretary Executive Director of Allied Health Professions, Health Sciences and Digital

Audit, Risk and Assurance Committees 2025-26

Item Title	May 13/05/2025	June 17/06/2025 (Annual Accounts)	July 08/07/2025	Oct 7/10/24	Jan 13/01/2026	March 10/03/2026
Minutes of previous meeting	✓		✓	✓	✓	✓
Declaration of Interests	✓		✓	✓	✓	✓
Action Log	✓		✓	✓	✓	✓
Annual Work Programme	✓		✓			
Work Programme (updated through year)			✓	✓	✓	✓
Annual Assessment of Committee Effectiveness	✓					✓
Committee Governance Action Plan			✓	✓		✓
Committee Annual Report	✓					
Audit Recommendation Tracker				✓		✓
WHC Tracker	✓			✓		✓
Organisational Register of Interests				✓		✓
Orgsanisational Register of Interests and Register of Gifts and Hospitality				✓		✓
Board Assurance Framework				✓		
Review of Terms of Reference	✓					✓
Review of Standing Orders and Standing Financial Instructions						✓
Confirmation Clinical Audit Programme in place			✓			
Approach to the Annual Accounts						✓
PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	✓					
PTHB Final Accountability Report and Financial Accounts and Letter of Representation		✓				
Head of Internal Audit Opinion Draft	✓					
Head of Internal Audit Opinion Final		✓				✓
Internal Audit Annual Plan						✓
Internal Audit Progress Report 25/26	✓		✓	✓	✓	
Internal Audit Reports (as required)	✓		✓	✓	✓	✓
Internal Audit Trend Report					✓	
Enquiries of Management and Those Charged with Governance		✓				
External Audit Annual Plan						✓
External Audit Progress Report	✓		✓	✓	✓	
External Audit Reports (as required)	✓		✓		✓	✓
Structured Assessment	✓				✓	
Counter Fraud Annual Plan						✓
Counter Fraud Update	✓		✓	✓	✓	
Counter Fraud Reports (as required)	✓		✓		✓	✓
Single Tender Waivers Annual Report	✓					
Single Tender Waivers (including extensions to contracts)	✓		✓	✓	✓	✓
Losses and Special Payments Annual Report	✓					
Losses and Special Payments	✓			✓		✓
Post payment Verification Yr End May, Mid Yr Jan	✓				✓	
Financial Controls				✓		
Review of Risk Management Framework				✓		
Assurance of Risk Management arrangements inc. revised Risk Management Toolkit	✓		✓	✓	✓	
Hosted Body annual report (HCRW)		✓				
IG Annual Report	✓					
IG Performance Report				✓		✓
IG Toolkit (National Audit replaces Caldicott Principles)			✓	✓		
Information Governance & Records Management report	✓				✓	
Digital First: annual deep dive into the Digital Programme					✓	
Digital First Annual Plan				✓		
Digital First Quarterly Monitoring (including cyber security)			✓	✓	✓	✓
SFI executive financial delegation limits				✓		

Key:

Date to be confirmed
Item to be confirmed
Item deferred
Item brought forward
Going to Board
Find Exec Cttee date
Added to draft agenda

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board Glossary (Last updated oktober 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
APB	Area Planning Board
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer

CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team

H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health

MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse

RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date