AUDIT, RISK AND ASSURANCE COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 07 OCTOBER 2025 AT 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ian Thomas	IT	Independent Member (General)
Ronnie Alexander	RA	Independent Member (General)
Rhobert Lewis	RL	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
Hywel Pullen	HP	Deputy Director of Finance
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Stacey Jones	SJ	Finance Business Partner (Observing)
Anne Beegan	AT	Audit Wales
Sarah Pritchard	SP	Head of Financial Services
Stella Gwynne	SG	Deputy Board Secretary
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Louisa Steele	LS	Counter Fraud
Ian Virgil	IV	Head of Internal Audit
Matthew Evans	ME	Counter Fraud
Carl Cooper	CC	PTHB Chair
APOLOGIES FOR ABSENCE:		
Hayley Thomas	HT	Chief Executive
Bethan Hopkins	BH	Audit Wales
Mick Giannasi	MG	Independent Member
Kirsten Jones	KJ	Llais

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/044)

The Chair welcomed everyone to the meeting, in particular those members who were in attendance observing the meeting. Apologies for absence were received as recorded above.

1.2 DECLARATIONS OF INTEREST (ARA/25/045)

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/25/046)

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 08 JULY 2025 (ARA/25/047)

The minutes of the meeting held on 08 July 2025 were **CONFIRMED** as an accurate record.

Members asked whether the Co-pilot platform had been utilised to support with minute taking across Committees and whether the platform had been beneficial to staff.
It was noted that Co-pilot was being tested across the Corporate Governance directorate, however due to a limited number of licenses purchased not all Committee minutes were being produced with AI at the time of the meeting. Shared experiences of using the platform would be fed back to Board members after an appropriate pilot period.

Members raised the utilisation of hot desks by other organisations and whether there were cost implications. This would be checked and confirmed to members.

3.2 COMMITTEE ACTION LOG (ARA/25/048)

The Committee **RECEIVED** the action log, and the following updates were provided:
ARA/25/032 - Work was underway and remains on track for completion by January 2026.

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/25/049)

A summary of the Internal Audit Progress report for 2025/2026 was provided and attention was drawn to a table which provided an update on several audits that had been planned for delivery and reporting to the committee. These audits had not been finalised in time to be presented at the meeting. This was due to a combination of slow progress, challenges in obtaining necessary information, and limited engagement from the Health Board. An overview of the progress with the delivery of the audit plan was provided as follows:

- One audit had been finalised,
- Two were in draft,
- Five were in progress,
- Eight were at the planning stage, with scopes agreed and work scheduled to commence over the coming months.

Two changes were considered to the audit plan for formal agreement by the Committee. The audits relating to the Roadmap to Sustainability and Strategic Commissioning were removed from the plan, following agreement with the Lead Executive and Director of Corporate Governance. This was to avoid duplication, as the scope of these audits was being covered by external support commissioned by the Health Board.

It was noted that the outcome of the external support would be reviewed to assess any developments or changes in the areas previously covered by the removed audits. The review would inform the wider thinking for the 2025/26 internal audit opinion. Should new processes be introduced as a result of the external support, internal audit work could be considered in future years to provide assurance on their implementation and compliance within the Health Board.

The Committee was informed of a request to defer the timing of the follow-up audit on Deprivation of Liberty Safeguards. This followed a previous limited assurance audit, as delays in recruiting to key posts had impacted progress on the associated actions. It was agreed that deferring the audit to later in the year would be more appropriate.

The Committee raised concern of the importance of transparency to ensure the Committee were informed of any change in timescales of Internal Audits and its programme. Should there be a fundamental change to the timescales of completion, the Committee would be made aware.

Could assurance be provided that for those planned audits in 2025/2026, financial implications were considered and the impact upon patients?
The audit programme had been reduced for 2025/2026. It was noted that the two audits which will be deferred from the 2025/26 plan would provide a reduction in the overall costs given the number of audits undertaken.

What was the reasons for the request to delay the Deprivation of Liberty Safeguards (DoLs) audit?
Workforce and spend controls had been restricted and a general delay was seen in recruitment. The rationale and process timing was discussed at a recent Executive Committee which was documented within the Audit Tracker at agenda item 5.7.

Members recognised the importance of the fundamentals of delivery and the recruitment challenges which may impact patients. Reinforcement of the business case investment in DoLs was to provide additional resource. Feedback would be provided to the Director of Nursing for awareness. It was noted that as internal audits were finalised, they would be made available to Independent Members for review to avoid delay.

The Committee **NOTED** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports and **APPROVED** the proposed adjustments to the 2025/2026 plan.

5.2 INTERNAL AUDIT REPORTS (ARA/25/050)

IV gave an overall view of the assurance obtained from the Duty of Candour audit which confirmed a rating of Reasonable Assurance. One high priority and four medium priority findings had been found. Management had agreed to all five recommendations which would be implemented imminently.

Was the Duty of Candour part of mandatory training, and were the audit findings specific to Powys or known in other Health Boards?
It was not mandatory at the time due to ongoing pressure around training, especially given the volume and scope of existing mandatory training. There was a focus on key staff who were responsible for duty-related process to complete the training.
Audits had been undertaken across other Health Boards, however the outcome was unknown. It was anticipated that the same challenges would be present across NHS Wales Trusts. This would be confirmed at the next meeting in January.

The Committee recognised that where rapid reviews were only completed for incidents involving a death, the management action was unclear. The issues related to Mental Health would be addressed to ensure consistency across the organisation in how reviews were conducted. It was agreed that feedback would be provided to the team to update the wording of the management action.
Action: Director of Corporate Governance.

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

5.3 EXTERNAL AUDIT PROGRESS REPORT (ARA/25/051)

The Planned Care report, originally scheduled for July, was presented and resulted a time gap. Members were advised that some developments had occurred since the report was prepared. The paper indicated that several reports were due to be reported to the next meeting in January, a discussion would take place with the Corporate Governance team to manage scheduling and workload.

It was agreed that audit reports would be shared with committee members ahead of the meeting to allow sufficient time for review. A discussion would be held outside of the meeting regarding the Structured Assessment and whether there was an opportunity to present it directly to the Board, to help manage the demands of the January committee.

It was noted that the Cancer Services review had already been referenced within the update. Following discussions with the Health Board regarding the relevance and scope, particularly its focus on service provision, it was agreed that the scope was not applicable. An alternative approach to focus on commissioning arrangements was considered but overlapped with existing internal audit work. As a result, it was agreed to refund that element of the audit.

The Committee suggested that the checklist of cost savings to be shared with members of the Finance and Performance Committee given its remit. It was noted that a Board Development session was being arranged to review the checklist.
Action: Director of Corporate Governance

A briefing was presented at a recent meeting of the All-Wales Audit Committee on the National Fraud Initiative (NFI). A national summary was being prepared to consolidate findings and outline upcoming work on local governance arrangements for NFI within individual bodies, including a stocktake of match volumes. The briefing would be issued to all committee members outside the meeting.
Action: Director of Corporate Governance

The Committee **RECEIVED** and **NOTED** the External Audit Progress Report

5.4 EXTERNAL AUDIT REPORTS (ARA/25/052)

Planned Care Recovery – Thematic Review

A summary was provided which outlined the findings of the national thematic review of planned care recovery, undertaken across all Welsh Health Boards. The review assessed the Health Board's progress in addressing planned care challenges and reducing the backlog of waiting lists. Four recommendations were made:

1. Strengthen long-term service planning, focusing on demand and capacity.
2. Improve efficiency and productivity, including reducing short-notice surgical cancellations.
3. Develop and implement a plan to improve theatre utilisation and manage clinical risks associated with long waits.
4. Establish a consistent methodology for assessing and reporting patient harm due to long waits to the Quality and Safety Committee.

The Health Board accepted all recommendations. Thanks were extended to Health Board colleagues for their support during the review.

Members acknowledged the change since the report had been undertaken in relation to the arrangements with NHS England averages to conform to the Welsh average and the inequity across Wales.

What evidence could be provided to support the existence of the Health Board appropriately managing and holding its commissioned bodies to account?
The review included the commissioning assurance framework, routine contract quality, and performance review meetings. Despite the complexity of the system, including in-reach, outsourcing, and varied service level agreements, the Health Board was seen to be managing issues proactively and effectively.

Was it known where some of the increase in demand was emanating from the population's demographic changes?
It was acknowledged that while the review did not specifically examine the Health Board's population demographics, a recommendation was made to shift focus from short-term to longer-term planning. The Health Board had developed a demand and capacity modelling approach, but it had not yet been implemented at the time of the review. There was emphasis on the need to explore alternative service provision,

particularly in primary care, to help reduce outpatient referrals and manage demand more effectively.

How does the DNA (Did not attend) rate of 3.8% in Powys compare to other Health boards?
The chart of DNA rates would be shared with members outside of the meeting. The audit was undertaken to scope *opportunities for potential efficiencies and minimise DNA rates and associated costs.*

Members raised concern around Theatre utilisation being at a low percentage, given the investment and its unimproved position. It was noted that a theatre transformation programme was under development.

It was agreed that confirmation of the data for cancelled operations and the reporting pathway would be fedback to the committee.
Action: Medical Director

The investment in terms of improvement to reduce waiting lists had plateaued. A piece of work was being undertaken by Grant Thornton, and it was anticipated that a report would be received in the coming weeks and would be shared with committee members.
Action: Director of Corporate Governance

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

5.5 LEARNING FROM ANNUAL EXTERNAL AUDIT OF ACCOUNTS AND ANNUAL REPORT 2024/25 (ARA/25/053)

A summary was provided of the review of Continuing Health Care (CHC) processes following completion of the Annual Accounts. An overview of the issues identified were provided and actions taken to address the findings from the Audit of Accounts in 2024/2025.

It was noted that the lessons learnt from the Audit of Accounts and Annual report had been shared with Audit Wales who recognised the significant work undertaken by the Health Board to address the issues raised. Follow up meetings had been taken place between the Finance and Audit Wales team to discuss the mitigating actions taken. Following completion of the feedback report, this would be shared with members of the committee.

Had consideration been given to other areas across the Health Board which may post a similar risk to the CHC accruals?
Following completion of the audit, no other areas had been identified of concern. The team were undertaking a review of potential risk areas to ensure a similar approach would be taken.

The Committee proposed that the specific actions taken in relation to the lessons learned from the Annual Aduit and accounts to be inclusive within the Approach for

2025/26 Annual Accounts. The Committee AGREED to the proposal and would be included within the report in March 2026.

The Committee **RECEIVED** the report and took **ASSURNACE** that the issues and learning identified as part of the 2024/2025 audit were being addressed.

5.6 COUNTER FRAUD UPDATE AND REPORTS (ARA/25/054)

An overview of the key areas of work undertaken by the Health Board's Local Counter Fraud Specialist were provided. It was noted that the Health Boards service level agreement with Swansea Bay University Health Board (SBUHB) for the delivery of counter fraud services was due for renewal. Discussion with the Director of Finance, Estates and Support Services was underway.

An agreement had been reached with Corporate Governance to use National Fraud Initiative (NFI) data to assess compliance with the Declaration of Interest policy. The exercise would help evaluate its effectiveness. Members discussed and noted the benefits received against the Service Level Agreement (SLA) agreement review to enable services to react and take action as required.

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

5.7 AUDIT RECOMMENDATION TRACKER (ARA/25/055)

An overview of the Audit Recommendations Tracker was presented to Committee and it was noted that the report was provided in a revised format. Since the last report, significant improvements had been implemented based on Committee feedback and wider learning/review. A data quality and validation exercise had been completed, along with a review of the tracker to improve formatting and readability. The report focused on the following key elements:

- Overdue findings
- Revised deadlines
- High-priority items
- Issues linked to limited assurance reports

The Committee welcomed the revised report and acknowledged the work undertaken to provide a focus on overdue, revised deadlines and high priority audit findings. It was noted that future development of the report would consider the accessibility and visibility of the cover paper.

Was there a process in place for those overdue recommendations to be reviewed and updated by Executive leads?
The audit handbook allows the committee to invite Executive Directors to explain why recommendations have remained overdue for more than six months. The report was also reviewed by the Executive Committee, where directors assess overdue findings. Updates from these reviews would be shared with the Committee to support oversight and progress tracking.

An update was provided on the Mattresses Internal Audit findings which had received a Limited Assurance. It was acknowledged that initial expectations for resolving the issue was overly ambitious. Despite delays, progress was on track, and assurance was given that the issue should be resolved within the next month.

The Committee **RECEIVED** the position of Audit Findings and took **ASSURNACE** that the organisation has appropriate systems in place to tracking and responding to audit recommendations.

5.8 FINANCIAL CONTROLS (ARA/25/056)

The Committee received an overview of current financial governance arrangements, which included:

- Standard Financial Instructions and Scheme of Delegation
- Procurement Thresholds and the role of the Non-Pay Scrutiny Group
- Policies relating to Training, Travel, and Expenses
- Overview of Long-Term Agreements and Service Level Agreements
- Continuing Healthcare (CHC) processes, with noted overlap from earlier agenda discussions
- Primary Care and Pay Expenditure, with further actions to be progressed as discussed at Board level
- Vacancy Control Processes and reference to the Investment Benefits Group
- General approach to Budgetary Control and Savings
- Arrangements for Income Management and Internal Audit, including relevant financial system audits
- CHC-related actions following the End-of-Year Audit
- Update on Level 4 Escalation work, including input from External Consultants who have undertaken a "Grip and Control" checklist. Feedback and recommendations for improvement were expected.

What was the impact of financial changes use of Health Care Support Workers (HCSW) and had recruitment improved?
Patient safety and the provision of appropriate care remain the highest priority. All financial controls and governance approaches are implemented with this principle at the forefront. Decisions were made under these arrangements, including the development of protocols for on-call use and the approach to agency staffing, are guided by this priority. These considerations underpin all relevant processes.

The Committee **RECEIVED** the contents of the paper and took **ASSURANCE** from the financial controls in place.

5.9 RISK AND ASSURANCE UPDATE (ARA/25/057)

The Committee received a summary of the Risk and Assurance programme. Work continued to mature the Board Assurance Framework through the development of detailed assurance analysis for each strategic risk.

The rollout of the Datix System had been delayed due to long-term staff absence in the risk post and data input errors identified during the pilot phase. These issues

required corrective action to ensure reliable reporting. A workaround was identified to address the data input issue.

Was there any feedback following the development of the Operational Leadership Group (OLG)?

It was noted that the establishment of Operational Learning Group (OLG) was in its early stages of development, with the intention to formally bring together Deputy and Assistant Directors. The purpose of the meeting was to review a range of cross-organisational matters, including but not limited to risk management.

The Committee took **ASSURANCE** from the update on progress provided against the implementation of the Risk Management Framework (RMF) and took **ASSURANCE** from the update on progress provided against the implementation of the Board Assurance Framework (BAF).

5.10 INFORMATION GOVERNANCE PERFORMANCE REPORT (ARA/25/058)

Members were provided with a summary of the Information Governance (IG) performance, where the following themes were highlighted:

- **Freedom of Information (FOI):** A consistent 92% compliance rate was maintained
- **Personal Information Requests:** 171 requests were received, with a 99% compliance rate
- **DATIX Incident Reporting:** 63 IG-related incidents reported. Of these, 17 were not reported within the required 72-hour timeframe, and 2 were deemed reportable to the Information Commissioners Office (ICO).
- **Information Asset Register:** 146 new assets recorded to date. Promotion of this was in development.
- Records management remained a challenge, primarily due to the volume of paper records and the geographical spread across Powys. This remained a key focus within the development of the IG and Records Management Strategy.

What was the rationale for the low percentage in training compliance for Bank staff?
A meeting was due to take place with the Temporary Staffing Unit to explore ways to target bank staff in a more effective way. An update on progress would be reported Tempo staffing unit leads explore ways to target bank staff. Challenges around ensure compliant for training.

What were the reasons for the low training compliance across the Medical Directorate in comparison to other directorates?
An exercise was due to be undertaken to target new staff and improve training compliance which would take place in Q3. Progress would be included within the next report. There was ongoing work with key services to address the burden of repeated FOI requests. A pilot was underway with the Finance and People and Culture directorates to explore opportunities for routine publication of information via the organisation's Publication Scheme. If successful, the approach would be extended to other services.

Was the organisation exempt from providing information under the enactment where the cost of assimilating that information was deemed disproportionate?
The legislation stated that there was a requirement to respond at a high level during certain circumstances.

The Committee were informed that a series of targeted exercises had been undertaken with specific services experiencing a high number of incidents. Changes implemented over the previous four months had a positive impact in reducing future occurrences with historical trend analysis inclusive within the IG Annual report. The Committee acknowledged the proactive approach taken to address these challenges.

Given the increase of information assets, what action was being taken to address the directorates who are yet to complete this work?
Work was planned in Q3 to work with services to support and encourage staff complete entries. Six-monthly and annual reviews were conducted and at the annual review stage, a range of data to support the Directorate's overall assessment was provided. The input was designed to be both supportive and helpful in drawing out key themes and issues.

The Audit, Risk and Assurance Committee **RECEIVED** the report, took **ASSURANCE** on areas of good compliance, acknowledged efforts and successes and **NOTED** areas of poor or non-compliance and took **ASSURANCE** a programme of work was in place to improve compliance.

5.11 DIGITAL FIRST ANNUAL PLAN (ARA/25/059)

The Committee received the report and asked the following questions:

What was the current position on the NHS Welsh App cross border?

There had been a renewed push from Digital Health and Care Wales (DHCW) to implement functionality as expected by Welsh Government. It was anticipated that initial results would be seen in the coming months, with referral information beginning to surface on the NHS Wales App as the first phase of delivery. Work had continued on the Cross-Border Project, it was acknowledged that information gaps remained in terms of data presented on the NHS Wales App. The gaps were expected to be minimised as the project progressed toward key milestones, with closure anticipated in the coming months.

Was Digital inflation seen to increase the Service Level Agreement (SLA) costs with Digital Health Care Wales (DCHW)?

Some cost pressures were unavoidable. The organisation had been actively engaged in national negotiations with Microsoft regarding the Enterprise Agreement, which represented one of the largest digital costs faced by the Health Board. Positive developments in the negotiation had been reported, and further details would be considered once fully reviewed.

What was the rationale for the 10% of user experience and satisfaction results?

The general theme related to expectations around response timelines. Although Service Level Agreements (SLAs) had been documented and targets clearly defined, there remained varying opinions on the urgency of issues, with some individuals expecting responses within an hour.

The team had been actively driving increased usage of remote consultations, successfully onboarding multiple new services. The issue of late funding notifications was discussed. While some delays were acknowledged as unavoidable, they posed challenges to delivering national initiatives effectively.
A reporting structure of the various groups and how they interface on digital would be clarified and reported to a future committee for members awareness.

The Committee took **ASSURANCE** that the Health Board was 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, **NOTED** the key achievements and **NOTED** the key challenges.

5.12 SFI EXECUTIVE FINANCIAL DELEGATION LIMITS (ARA/25/060)

The Committee **RECEIVED** the report and **DISCUSSED** the proposed changes to the Standing Financial Instructions, which included:

- Executive authorisation levels increased to £500k for the Chief Executive;
- £250k for the Director of Finance and up to £100k for Executive team;
- A series of administrative updates would be applied to the SFIs which included Executive and other job title changes, Board Committee titles and external agency name changes where appropriate.
- The Committee **NOTED** that the Chief Executive would complete a review of the Executive portfolio scheme of delegation in readiness for the Board in November.

The Committee **SUPPORTED** the recommendations to go onward to the Board.

6. ITEMS FOR DISCUSSION

There were no items for inclusion in this section.

7. CONSENT AGENDA

7.1 ORGANISATIONAL REGISTER OF INTERESTS (INCLUDING BUDGET OVERSIGHT), GIFTS AND HOSPITALITY (ARA/25/061)

The Committee **RECEIVED** the Register of Interests for Board Members, Consultants, those staff with budget oversight and the Gifts and Hospitality Register.

7.2 LOSSES AND SPECIAL PAYMENTS (ARA/25/062)

The Committee **RECEIVED** the report on Losses and Special payments covering the period 1st April 2025 to 31st August 2025.

7.3 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/25/063)

The Committee **RECEIVED** the Single Tender Waiver report.

7.4 INFORMATION GOVERNANCE TOOLKIT (NATIONAL AUDIT REPLACES CALDICOTT PRINCIPLES) (ARA/25/064)

The Committee **RECEIVED** the Information Governance Toolkit.
7.5 COMMITTEE WORK PROGRAMME 2025/2026 (ARA/25/065)
Members **RECEIVED** the Committee Work Programme for 2025/2026.
7.6 PTHB GLOSSARY(ARA/25/066)
The Committee **RECEIVED** the PTHB Glossary.
8.OTHER MATTERS
8.1 ANY OTHER URGENT BUSINESS (ARA/25/067)
There was no other urgent business.
8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/25/068)
There were none.
8.3 COMMITTEE REFLECTIONS (ARA/25/069)
The following feedback was noted: • Timely and well managed chairing • Welcome early sight of Internal Audit reports prior to the next meeting in January 2026.
8.4 DATE OF NEXT MEETING
The date of the next meeting is scheduled on 13 January 2026 at 10:00 via Microsoft Teams.

Meeting closed at 12:33