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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 11 MARCH 2025 AT 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ronnie Alexander	RA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
Ian Thomas	IT	Independent Member (General)
IN ATTENDANCE		
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive (for Item 3.8)
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Carl Cooper	CC	PTHB Chair (observer)
Mathew Evans	ME	Counter Fraud
Louisa Steel	LS	Lead Local Counter Fraud Specialist
Hywel Pullen	HP	Deputy Director of Finance
Sarah Pritchard	SP	Head of Financial Services
Stella Gwynne	SG	Deputy Board Secretary
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health (Item 4.2)
Hayley Thomas	HT	Chief Executive Officer
Dave Thomas	DT	Audit Wales
Gareth Lucy	GL	Audit Wales
Ali Tariq	AT	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Zoe Ashman	ZA	Interim Assistant Director Women and Children (Item 4.2)
Bethan Powell	BP	Corporate Governance Officer (Committee Support)
APOLOGIES FOR ABSENCE:		
Bethan Hopkins	BH	Audit Wales
Amanda Legge	AL	Post Payment Verification
Sue Tilman	ST	Post Payment Verification
Anne Beegan	AB	Audit Wales

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/24/078)

The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.

1.2 DECLARATIONS OF INTEREST (ARA/24/079)

No declarations of interests were received in addition to those already on the register.

2. CONSENT AGENDA BUSINESS

SE noted a query on item 7.1 Approval to the Annual Accounts, the item was brought forward to the main agenda.

3. ESCALATED ITEMS

There were no items for inclusion in this section.

4. ITEMS FOR ASSURANCE

4.3 EXTERNAL AUDIT PROGRESS REPORT (ARA/24/080)

DT and GL presented the Audit Progress Report which provided an update on the current and planned accounts and performance audit work presented to the Committee in January 2025. It was noted that the planning of the Audit of the 2024-25 Accountability Report and Financial Statement was underway, with a view to providing an opinion by 30 June 2025.

HB highlighted that the Draft Structured Assessment for 2024-25 had been received and was currently under review by colleagues from both the Health Board and Audit Wales to ensure clarity of expectations and actions. The Structured Assessment would be reported to the Committee on 13 May. It was noted that the Board would receive the Structured Assessment in March 2025, however this did not impact on the role of the Committee in relation to the scrutiny of the management responses.

The Committee **RECEIVED** the report.

5.4 EXTERNAL AUDIT ANNUAL PLAN 2025/26 (ARA/24/081)

DT and GL presented an overview of the plan which had been developed following a structured and risk-based planning process. GL highlighted the intention to bring forward the certification of the Health Board's annual accounts to 30 June 2025, from mid-July in 2024/25.

Committee members sought assurance by asked the following questions:

Was there assurance available in relation to the integrity of data shared with third parties via the Oracle Cloud service?

SP confirmed that the data transfer was electronic to electronic as part of the All-Wales Oracle system, the only revision to the process for 2025/26 was the movement of data to cloud-based storage as opposed to a physical data store in Cardiff as utilised in previous years.

Were there any concerns in regard to the impact of the reduced timetable?

SP welcomed the revised timetable and noted that pre-COVID-19 accounts were certified by 30 May each year. HB confirmed the reduced timetable also supported the planning of the Health Boards Annual General Meeting.

GL confirmed that conversations would remain open in future years to ensure the effective timing of the audit of the financial accounts.

Was it anticipated that review of the Wellbeing and Future Generations (WBF) Act would be a standalone audit or integrated across the plan?

DT confirmed that the principles of sustainable development had been factored into the design of Audit Wales reports. There is a five-year cycle in regard to the Welbeing of Future Generations (WBFG) Act with a report due by the Auditor General for Wales in 2025. It was suggested that a watching brief is maintained in regard to WBFG with a standalone audit within the five-year cycle if appropriate on the balance of risk.

The Committee **RECEIVED** the External Audit Plan.

Dave Thomas and Gareth Lucy left the meeting.

4.1 INTERNAL AUDIT PLAN PROGRESS REPORT (ARA/24/082)

IV introduced the progress report and highlighted that the executive summaries of finalised reports since the last Audit Risk and Assurance Committee in January 2025 were included in section 7 of the report. Full copies of the final reports are included at item 4.2 on the agenda.

Current position with progress of the 2024/25 plan:

- Twelve audits finalised to date (three since the last meeting),
- Eight audits are currently work in progress with planned delivery through the remainder of the year,
- Four audits are at the planning stage,
- The audit of Site Co-ordination was proposed for deferral to the 2025/26 plan due to the recent change in director responsibility for this area and on-going recruitment to the Head of Facilities post. The deferment had been agreed by the Executive Director of Finance, Capital & Support Services,
- The planned detailed follow-up of the previous Limited Assurance Estates Condition audit was proposed for removal from the 2024/25 plan, due to the funding constraints in addressing the underlying issues. Assurance on progress with implementation of the agreed actions will be provided through the year-end action tracking work. The removal has been agreed by the Executive Director of Finance, Capital & Support Services.

Committee members sought assurance by asked the following questions:

Given the high volume of audit reports expected in Q1 of 2025/26, are there plans in place to better distribute the timing of final audit reports for the coming year?

HB noted that arrangements had been agreed with the Committee Chair to share finalised audit reports with members as they are received over the coming months to reduce the amount of data shared with Committee Members within the Committee papers. IV highlighted that the timely reporting of final reports throughout the year was a Key Performance Indicator (KPI) for Internal Audit, so this would continue to be an area of focus for improvement in future years.

The Committee **NOTED** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports and **APPROVED** the proposed adjustment to the 2024/25 plan.

4.2 INTERNAL AUDIT REPORTS (ARA/24/083)

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

- a) Community Cardiology Service (Reasonable Assurance)
- b) Additional Learning Needs Legislation (Reasonable Assurance)
- c) Patient Flow and Discharge Management (Reasonable Assurance)

a) Community Cardiology Service (Reasonable Assurance)

IV noted that the purpose of the audit was to review structure and delivery of the Community Cardiology Service implemented in North Powys, to inform further roll-out across Powys. Reasonable assurance had been ascribed to the area; however, it was noted that a Limited Assurance rating had been provided for objective 1 in relation to appropriate structured and resource to allow for the effective delivery of its objectives, and clearly documented and communicated procedures in place for the operation of the Service.

EL noted that actions had been taken to address the two high priority recommendations in relation to structure and resources. It was confirmed that a business case was due to the Investment and Benefits Group imminently.

Committee members sought assurance by asked the following questions:

The relevant governance group was reported as not having met between February and June, what was the reason for this?

EL confirmed that this had been reviewed, and it had been confirmed that this was due to the transfer of the service from a project setting to business as usual, lessons learned had been taken from the transfer which would be applied to any future projects.

What was the current status of the services Standard Operating Procedure (SOP)?

EL confirmed that the SOP had been updated, approved and published.

Was there an intention to extend this availability of this service to the Mid and South of Powys?

EL reported that the purpose of the business case was to strengthen the service within the North, following implementation of this there were plans to consider roll out to the mid and south of the County.

b) Additional Learning Needs (ALN) Legislation (Reasonable Assurance)

IV noted that the purpose of the audit was to review compliance with the ALN legislative Framework. Reasonable assurance had been ascribed to the area; however, it was noted that a Limited Assurance rating had been provided for objectives 2 and 3 in relation to sufficient training and engagement for staff and arrangements for multi-agency working.

Committee members sought assurance by asked the following questions:

Were the plans in place for practically strengthening multi-agency working in regard to ALN?

ZA noted that collaborative governance was a key workstream managed in partnership with the corresponding colleagues within the Local Authority, it was suggested that this was growing at pace and would report into the PTHB and Powys

County Council Joint Leadership Team every 6 months going forward. Work was also underway alongside the Third Sector with a key coproduction approach on the integration of Neurodevelopment into ALN.

c) Patient Flow and Discharge Management (Reasonable Assurance)

IV noted that the purpose of the audit was to review the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Reasonable assurance had been ascribed to the area; however, it was noted that a Limited assurance rating had been provided for objectives 3 in relation to processes and resources in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.

EL highlighted for further assurance that the Community Hospital Discharge Policy and Procedures had been updated and been approved via the appropriate governance route and were due to be published on the intranet imminently. It was also noted that focused work was underway to refresh the process in relation to DigiFLO Whiteboards.

Committee members sought assurance by asked the following questions:

What were the perceived barriers to discharge into the community?

EL noted a number of potential barriers, including process and training but confirmed that having the appropriate resource available in a timely way, is a critical limiting factor.

The Committee **RECEIVED** the findings and conclusions from the finalised audit reports.

Elaine Lorton and Zoe Ashman left the meeting.

4.5 AUDIT RECOMMENDATIONS TRACKER (ARA/24/084)

HB gave an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit and Audit Wales. It was noted that development of the system for managing, analysing and reporting of audit recommendations remained ongoing, and it was highlighted that greater clarity in relation to audit with revised deadlines and detail in relation to the ownership of overdue recommendations by directorate had been included in this iteration of the report.

HB confirmed that work would continue in relation to this, with further development and digitisation opportunities due to be implemented over the coming months.

Committee members sought assurance by asked the following questions:

Would it be possible to have Executive Leads in attendance to discuss long overdue recommendations for future meetings?

HT confirmed that a discussion had been held in relation to long overdue recommendation in the last Executive Committee, as well as with individual

Executive Directors. It was confirmed that if any long overdue recommendation remained the Executive Lead would be asked to attend the next meeting.

Had the use of Artificial Intelligence (AI) been considered to support the analysis of the data?

HB confirmed that shared learning from the other Health Boards had been considered, and that work was underway as part of the All-Wales Peer Groups to develop audit tracking. It was the intention to move to a more automated system at this stage, recognising the scope for further development as the work progresses.

Were any of the recommendations reported as having had no progress made high priority?

HB agreed that this would be checked and confirmed following the meeting.

Action: Director of Corporate Governance

IV noted the positive progress made in this area and welcomed the 20 closed recommendations since the last report. It was noted that as part of the Internal Audit plan for 2024/25 a sample of complete recommendations would be tested by Internal Audit to ensure there is sufficient evidence to support their closure.

The Committee **CONSIDERED** the current position of outstanding Audit Recommendations and took **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.

4.6 FINANCIAL CONTROLS 2024/25 (ARA/24/085)

HP presented the report which provided an overview of the financial controls in operation during 2024/25 including additional scrutiny and processes introduced in-year to ensure tighter control of the expenditure the Health Board commits.

Committee members sought assurance by asked the following questions:

Does the committee review the financial controls in operation on an annual basis?

PH noted that the paper was an additional paper brought forward to provide assurance that appropriate controls are in place. It was agreed that an annual review would be beneficial and would be included in the Committee's work programme. It was highlighted that the inclusion of benchmarked data in future would be welcome.

Action: Director of Corporate Governance

The Committee **RECEIVED** the paper and took **ASSURANCE** that appropriate controls are in place across the Health Board.

4.7 COUNTER FRAUD UPDATE (ARA/24/086)

ME presented the item which provided an updated on key areas of work undertaken by the Local Counter Fraud Specialists during 2024/25 including:

- Inform and Involve
- Prevent and Deter
- Hold to Account

Committee members sought assurance by asked the following questions:

Was it anticipated that an increase in third party information would place additional pressure on local resources?

ME confirmed that an amount of flexibility was built into the plan's scope over a 2-3-year cycle, though an increased shift to proactive activity was anticipated for future years given the effective outcomes and lesser resource requirements.

How do we ensure staff are aware of which AI tools are appropriate and safe?

ME noted that nationally, there was an increasing level of integration in relation to AI tools, notably Project Athena in England which is run by a specialist team in regard to procurement programmes. Locally, it was confirmed that the team are mindful of AI usage, only utilising tools which can be where data can be manually verified. It was also noted that the Counter Fraud Authority had recently shared information drawing on AI associated scams involving deep fakes and recruitment.

When there is an awareness of wrongdoing by our staff, are we aware of the perceived barriers to reporting?

ME noted a number of initiatives in place to encourage reporting, including the Crimestoppers telephone line, PTHB Online Reporting Tool and the availability of appropriately training frontline staff. It was however recognised that staff are often anxious about formal processes and any potential retribution, however work was ongoing within the Health Board to ensure that support is available to staff throughout the reporting process.

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

4.8 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/24/087)

SP presented the item and noted that there was one Single Tender Waiver (STW) request made between 1 January 2025 and 28 February 2025.

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective
2425-038-STA-POW	TENDER	DEKOMED LTD	Value for Money and Consistency to previously purchased equipment for programme	Continuation of work linked to previous undertaking	15/01/2025	£34,120	N/A	Prospective

It was reported that the rationale for the use of a STW was to ensure that the equipment acquired was standardised with those already in use within the Health Board.

SP confirmed that this was only the second use of a STW in 2024/25, with the Annual Report on the use of Single Tender Waivers due to be presented to the next meeting of the Committee on 13 May 2025.

The Committee **NOTED** that there has been one Single Tender Waiver request in the reporting period and took **ASSURANCE** that the organisation has appropriate monitoring in place for single tender waivers.

4.9 INFORMATION GOVERNANCE REPORT (ARA/24/088)

HB presented the report which provided 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. It was highlighted that a number of positive metrics were reported within the paper, including achievement of uptake above target for matters such as Information Governance Training and response to Freedom of Information Requests. It was however noted that the team was committed to some areas of improvement such as uptake of training for new starters and delays in reporting.

Committee members sought assurance by asked the following questions:

Was it known whether the breach under UK GDPR of 117 days exposed the Health Board to the risk of reporting to the Information Commissioners Office (ICO)?

HB confirmed that the team were committed to rectifying long standing cases and would provide feedback in relation to the specific case outside of the meeting.

The Committee welcomed the report and agreed to consider adding a deep dive on Information Governance to a future meeting.

Action: Director of Corporate Governance

The Committee:

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

5. ITEMS FOR APPROVAL/DECISION/RATIFICATION

5.1 MINUTES OF THE PREVIOUS MEETING HELD ON 14 JANUARY 2025 (ARA/24/089)

The minutes of the meeting held on 14 January were **CONFIRMED** as an accurate record.

5.2 COMMITTEE ACTION LOG (ARA/24/090)

HB noted that four actions were recommended for closure.

The Committee **RECEIVED** and **NOTED** the Action Log.

5.3 INTERNAL AUDIT PLAN 2025/26 (ARA/24/091)

IV presented the plan and summarised that following details:

- Development of the plan
- Planned internal audit coverage
- Resource needs for delivery

It was highlighted that under the approach adopted for several years, the top slice provided to Internal Audit to undertake the programme is supplemented by an additional charge for work over and above the top slice. To this end the health board would need to pay an additional £95,131 over and above the 'top slice' recharge agreed as part of NHS Wales Shared Services Partnership's (NWSSP) overall funding

for 2025/26. This was a reduction of £11k from the previous year (£106,680 in 2024/25). IV reassured the Committee that despite the reduction in number of audits there remained sufficient coverage to provide assurance to the Health Board and provide a Head of Internal Audit Opinion for 2025/26.

HB welcomed the report and expressed thanks to the Internal Audit team for the thorough and collaborative approach. It was highlighted that half of the audits had been planned for Q1 and Q2, with the other half planned for Q3 and Q4.

The Committee welcomed the plan and:

- **APPROVED** the Internal Audit Plan for 2025/26;
- **APPROVED** the Internal Audit Mandate and Charter; and
- **NOTED** the associated Internal Audit resource requirements and Key Performance Indicators.

5.5 REVIEW OF STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS (ARA/24/092)

HB presented the report which provided an outline of the amendments to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards following the making of the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024.

The Health Board is required to review its Standing Orders annually and it was noted that the Standing Orders were last reviewed in May 2024 but had also been subject to minor change in relation to the Joint Commissioning Committee in January 2025.

The Committee **REVIEWED** the paper, **RECOMMEND** the identified changes to the Board for approval and **NOTED** recommended changes to the Standing Financial Instructions and Executive Scheme of Delegation were likely to be recommended in 2025.

5.6 AUDIT HANDBOOK (ARA/24/093)

SG provided an overview of the Audit Process and Reporting Handbook which had been developed to provide colleagues with useful information should they be involved in an audit and to support them through audit process, including defining roles and responsibilities of those involved, senior management and the Board's Committees, a glossary of key terms and information regarding the audit tracking process. Thanks were expressed to audit colleagues for their support in the development of the document.

It was raised that an error had been recognised within the handbook, within section 6.6 the monitoring of management actions to address recommendations / identified issues should be allocated to the Audit, Risk and Assurance Committee's, not 'other committees'. This would be rectified prior to publication.

It was recognised that the communication, awareness and training in support of the document's release would be key to ensuring successful use within the organisation. It was noted that an engagement plan was under development by the Corporate Governance Team.

Committee members sought assurance by asked the following questions:

Was there a specific reason for the exclusion of clinical and quality audits?

HB clarified that clinical audit is managed by the Director of Nursing, Quality, Women and Family Health, whereas other audits are within the remit of Corporate Governance. It was suggested that the organisation may wish to consider greater integration as a point of potential development in future.

HT recognised the separation of responsibility regarding audits and suggested that a review of any potential greater integration and resilience would be welcomed.

It was noted that there was slightly different audience and requirements around clinical audit however shared learning from the implementation of the Audit Process and Reporting Handbook was welcomed.

In the earlier conversation on Audit Tracking the Committee discussed inviting Executive Director's to the Committee in respect of overdue matters arising, was there potential to integrate this into the Audit Tracking section of the Handbook?

HB welcomed the suggestion and agreed that a paragraph confirming this arrangement would be included prior to publication.

The Committee **APPROVED** the Audit Process and Reporting Handbook and took **ASSURANCE** that the organisation has a system in place to equip colleagues with the necessary information should they be involved in an internal or external audit within the Health Board.

5.7 RISK MANAGEMENT FRAMEWORK (ARA/24/094)

SG presented the revised Risk Management Framework which proposed the first material changes to the structure deployed to manage risk since 2019. It was noted that the key change proposed was the closure of the current Corporate Risk Register, to be replaced with a Strategic Risk Register, owned by the Board and an Organisational Risk Register, focused on significant and cross-organisation operational risk, owned by the Executive Committee. Both registers will be co-ordinated by the Corporate Governance Team. The system of Directorate and Service Level Risk Registers will remain unchanged.

The creation of the additional risk register focused on significant operational risk would allow greater focus on the risks to Health Board's strategic objectives at Board level, as well as more dynamic escalation, oversight and management of significant, cross-organisational operational risks by the Executive Team and increased sightedness by the Board.

It was noted that the framework had also been updated to:

- clarify processes in relation to escalation and de-escalation;
- ensure currency with revised organisational structures, systems and processes; and
- align with established risk management guidance and best practice.

The Risk Management Toolkit would also be redeveloped, alongside additional training and guidance materials in support of the updated framework following Board approval.

The Committee welcomed to update and **ENDORSED** the revised Risk Management Framework, for onwards presentation to the Board for approval.

5.8 COUNTER FRAUD WORK PLAN 2025/26 (ARA/24/095)

ME presented the plan which set out key areas of work intended to be undertaken by the Local Counter Fraud Specialists during 2025/26, taking account of the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.

It was noted that the development of the plan had been aligned to areas of risk, and engagement with Internal Audit on the development plan was welcomed.

Committee members sought assurance by asked the following questions:

What was the response rate to Counter Fraud surveys?

ME noted that previous all staff surveys had received pretty poor response rates, however a more targeted approach had been implemented more recently which had garnered higher responses and detailed feedback.

The Committee **RECEIVED** and **APPROVED** the Counter Fraud Work Plan 2025/26.

6. ITEMS FOR DISCUSSION

There were no items for inclusion in this section

7. CONSENT AGENDA

7.1 APPROACH TO ANNUAL ACCOUNTS (ARA/24/096)

As noted under agenda item 2 the following query was raised in regard to the Approach to the Annual Accounts:

Is it anticipated that the intention to bring forward the completion of the audit of the Annual Accounts will materially impact the approach to the annual accounts for 2024/25?

SP confirmed that the Health Board will work to the standard five-week timeline, it was recognised that the work to support the audit of the annual accounts remained significant but there was nothing material to note.

7.2 DECLARATIONS OF INTEREST AND REGISTER OF GIFTS AND HOSPITALITY (ARA/24/097)

The Committee **TOOK ASSURANCE** and **NOTED** the Declarations of Interest and Register of Gifts and Hospitality. There were no amendments or questions.

7.3 COMMITTEE WORK PROGRAMME (ARA/24/098)

The Committee **NOTED** the Committee Work Programme. There were no amendments or questions.

7.4 PTHB GLOSSARY (ARA/24/099)

The Committee **NOTED** the PTHB Glossary. There were no amendments or questions.

8. OTHER MATTERS

8.1 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/24/100)

The following items were agreed to be brought to the Board and other Committees:

- Internal Audit reports to be provided to appropriate Committees for information
- Items endorsed for onwards Board approval were due to be presented to the Board on 26 March 2025.

8.2 ANY OTHER URGENT BUSINESS (ARA/24/101)

There was no other urgent business.

8.3 COMMITTEE FEEDBACK (ARA/24/102)

The following feedback was noted:

- A focussed and purposeful meeting
- The agenda was set out in a sensible, systematic way
- The meeting was well chaired and finished within time
- The additional time added to the meeting was welcomed and it was felt that enables greater scope and depth of discussion
- A high number of finalised regulatory reports were due to be presented in May and June, the sharing on final reports as they become available in between meetings was welcomed to more effectively manage the volume of information shared with Committee Members.

5.5 DATE OF NEXT MEETING

The date of the next meeting is scheduled on 13 May 2025 at 10:00 via Microsoft Teams.

Meeting closed at 12:50