

Audit Risk & Assurance Committee

Tue 13 May 2025, 10:00 - 13:00

Agenda

10:00 - 10:00

0 min

1. PRELIMINARY MATTERS

📄 Agenda_ARAC_ 13May25.pdf (3 pages)

1.1. Welcome and Apologies

Verbal Chair

1.2. Declarations of Interest and Board Members Register of Interests

Verbal and Attached All

📄 ARAC_1.2_Board Members Declaration Of Interests summary 2024-25.pdf (4 pages)

10:00 - 10:00

0 min

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

10:00 - 10:00

0 min

3. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

3.1. Minutes of the previous meeting held on the 11 March 2025

Attached Chair

📄 ARAC_3.1_ARAC Minutes 11 March 2025 v1.pdf (12 pages)

3.2. Committee Action Log

Attached Chair

📄 ARAC_3.2_Action Log 2025-26.pdf (1 pages)

3.3. Committee Work Programme 2025/26

Attached Director of Corporate Governance

📄 ARAC_3.3_2025-26_ARAC_Committee work plan.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. PTHB Draft Accountability Report and Financial Accounts

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

Powell Brehan
08/05/2025 16:00

- 📎 ARAC_5.1_Draft Accountability Report 2024-25_Cover Paper.pdf (3 pages)
- 📎 ARAC_5.1a_Draft Accountability Report 2024-2025 28042025.pdf (107 pages)
- 📎 ARAC_5.1b_Draft Annual Accounts 2024-25.pdf (3 pages)
- 📎 ARAC_5.1c_2024-25 Draft Submission 2nd May 2025.pdf (79 pages)

5.2. Internal Audit Progress Report

Attached Head of Internal Audit

- 📎 ARAC_5.2_Internal Audit Progress Report May 25 Cover.pdf (2 pages)
- 📎 ARAC_5.2a_ARAC Internal Audit Progress Report May 25.pdf (24 pages)

5.3. Internal Audit Reports: Primary Care GMS Unified Contract, Pharmacy Stores, Business Continuity Planning, Risk Management, Information Governance, Llandrindod Phase 2, Partnership Governance.

Attached Head of Internal Audit

- 📎 ARAC_5.3a_Primary Care GMS Unified Contract Final Internal Audit Report.pdf (9 pages)
- 📎 ARAC_5.3b_Pharmacy Stores Final Internal Audit Report.pdf (9 pages)
- 📎 ARAC_5.3c_BCP Final Internal Audit Report.pdf (7 pages)
- 📎 ARAC_5.3d_Risk Management Final Internal Audit Report.pdf (9 pages)
- 📎 ARAC_5.3e_Information Governance Follow-up final Internal Audit Report.pdf (8 pages)
- 📎 ARAC_5.3f_Llandrindod Phase 2 Final Internal Audit Report.pdf (12 pages)
- 📎 ARAC_5.3g_Partnership Governance Final Internal Audit Report (Advisory).pdf (13 pages)

5.4. Draft Head of Internal Audit Opinion

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

- 📎 ARAC_5.4_Head Internal Audit Opinion & Annual Report 24-25 Cover.pdf (2 pages)
- 📎 ARAC_5.4a_Head Internal Audit Opinion & Annual Report 24-25.pdf (27 pages)

5.5. External Audit Progress Report and Annual Report

Attached External Audit

- 📎 ARAC_5.5_Audit Wales Update May 2025.pdf (12 pages)
- 📎 ARAC_5.5a_PTHB Annual Audit Report 2024.pdf (20 pages)

5.6. External Audit Reports: Structured Assessment

Attached External Audit

- 📎 ARAC_5.6_PTHB Structured Assessment 2024 Report.pdf (34 pages)

5.7. Counter Fraud Update: Annual Report and Investigations

Attached Counter Fraud

- 📎 ARAC_5.7_Counter Fraud Update Report Cover Paper.pdf (3 pages)
- 📎 ARAC_5.7a_Counter Fraud Update Report.pdf (3 pages)
- 📎 ARAC_5.7b_Appendix 1 - PTHB Counter Fraud Annual Report 2024-25.pdf (20 pages)

5.8. Single Tender Waivers(including extensions to contracts)

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

- 📎 ARAC_5.8_Single Tender Waivers- May 25.pdf (5 pages)

5.9. Losses and Special Payments Annual Report

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

- 📎 ARAC_5.9_Losses and Special Payments Annual Report 2024-25.pdf (8 pages)

5.10. Information Governance Records Management and Annual Report

Powell Bethan
08/05/2025 16:00:41

Attached Director of Corporate Governance

📎 ARAC_5.10_Information Governance Annual Report April 2025.pdf (10 pages)

5.11. Annual Review of Committee Effectiveness

Attached Director of Corporate Governance

📎 ARAC_5.11_Committee effectiveness_2024-25.pdf (26 pages)

5.12. Review of Committee Terms of Reference

Attached Director of Corporate Governance

📎 ARAC_5.12_Audit, Risk and Assurance Committee Terms of Reference Review.pdf (3 pages)

📎 ARAC_5.12a_Appendix A - Audit, Risk and Assurance Committee Terms of Reference (Approved May 2024).pdf (12 pages)

📎 ARAC_5.12b_Appendix B- Audit Risk and Assurance Terms of Reference 2025.pdf (13 pages)

10:00 - 10:00

0 min

6. ITEMS FOR DISCUSSION

There are no items for inclusion within this section

10:00 - 10:00

0 min

7. CONSENT AGENDA

7.1. Post Payment Verification Year End

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

📎 ARAC_7.1_Post Payment Verification End of Year Report 2024-2025.pdf (3 pages)

📎 ARAC_7.1a_PPV Report End of Year 2024-2025.pdf (4 pages)

📎 ARAC_7.1b_PPV SBAR.pdf (2 pages)

7.2. Welsh Health Circular Tracker

Attached Director of Corporate Governance

📎 ARAC_7.2_Welsh Health Circulars and Ministerial Directions Report May 2025 v2.pdf (5 pages)

📎 ARAC_7.2a_App_1_Outstanding WHCs.pdf (35 pages)

📎 ARAC_7.2b_App_2_WHCs Completed since the previous report.pdf (75 pages)

📎 ARAC_7.2c_App3_Outstanding Ministerial Directions.pdf (10 pages)

📎 ARAC_7.2d_App_4_Completed MDs since previous report.pdf (30 pages)

7.3. Committee Annual Report

Attached Director of Corporate Governance

📎 ARAC_7.3_Committee Annual Report_2024-25.pdf (9 pages)

7.4. PTHB Glossary

Attached Director of Corporate Governance

📎 ARAC_7.4_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

Powell, Bethan
08/05/2025 16:00:41

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 the next meeting: 17 June 2025 via Microsoft Teams

AUDIT, RISK AND ASSURANCE COMMITTEE

TUESDAY 13 MAY 2025
10:00-13:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT



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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 11 March 2025	Attached	Chair
	3.2	Committee action log	Attached	Chair
	3.3	Committee Work Programme 2025/26	Attached	Director of Corporate Governance
	4	ESCALATED ITEMS		
There are no items for inclusion within this section				
	5	ITEMS FOR ASSURANCE		
10:10 20min	5.1	PTHB Draft Accountability Report and Financial Accounts	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
10:30 5mins	5.2	Internal Audit Progress Report	Attached	Head of Internal Audit
10:35 35min	5.3	Internal Audit Reports: - Primary Care GMS Unified Contract - Pharmacy Stores - Business Continuity Planning - Risk Management - Information Governance - Llandrindod Phase 2 - Partnership Governance	Attached	Head of Internal Audit
11:10 5min	5.4	Draft Head of Internal Audit Opinion	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services

11:15 5min	5.5	External Audit Progress Report and Annual Report	Attached	External Audit
11:20 10min	COMFORT BREAK (10mins)			
11:30 20min	5.6	External Audit Reports Structured Assessment	Attached	External Audit
11:50 15min	5.7	Counter Fraud Update - Annual Report - Investigations	Attached	Counter Fraud
12:05 5min	5.8	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
12:10 5min	5.9	Losses and Special Payments Annual Report	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
12:15 15	5.10	Information Governance Records Management and Annual Report	Attached	Director of Corporate Governance
12:30 10min	5.11	Annual Review of Committee Effectiveness	Attached	Director of Corporate Governance
12:40 5min	5.12	Review of Committee Terms of Reference	Attached	Director of Corporate Governance
	6	ITEMS FOR DISCUSSION		
		There are no items for inclusion within this section.		
	7	CONSENT AGENDA		
	7.1	Post Payment Verification Year End Purpose: For Assurance.	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
	7.2	Welsh Health Circular Tracker Purpose: For Assurance	Attached	Director of Corporate Governance
	7.3	Committee Annual Report Purpose: For Approval	Attached	Director of Corporate Governance
	7.4	PTHB Glossary Purpose: For Information	Attached	Director of Corporate Governance
	8	OTHER MATTERS		
12:45	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: 17 June 2025 via Microsoft Teams		

Powell, E. J.
08/05/2025 16:00:41

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 – please 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.

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POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25								Updated: February 2025	
Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	Carl Cooper	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/02/2025	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2025	Ongoing	Stepdaughter's partner is a Pharmaceutical Control Analyst employed by Cardiff & Vale Health Board.	Nil		
Vice Chair	Kirsty Williams	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidiory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	Rhobert Lewis	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	Cathie Poynton	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	Ian Phillips	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	Steve Elliot	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	Ronnie Alexander	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	Simon Wright	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University- Various Healthcare Programmes	Salaried Employment		

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		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	08/07/2024	
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	Jennifer Owen Adams	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	Christopher Walsh	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		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		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	Michael Giannai	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	Ian Thomas	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	Hayley Thomas	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	Stephen Powell	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital	Pete Hopgood	Personal	NIL	NIL	NIL	NIL	NIL		

and Support Services		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2024	
Executive Director of Allied Health Professions, Health Science and Digital	Claire Madsen	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	Claire Roche	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	Kate Wright	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	Debra Wood Lawson	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	Mererid Bowley	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	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	NIL		
Interim Executive Director of Operations	Joy Garfitt	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance / Board Secretary	Helen Bushell	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	Wayne Tannahill	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic	Lucie Cornish								

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Improvement and Transformation		Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	Nicola Johnson From 07/10/24	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	
Executive Director of Primary, Community Care and Mental Health	Elaine Lorton From 30/09/2024	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Nov-19	Current	Chair – West Wales Care & Repair	Nil	17/10/2024	
				Apr-24	Current	Independent Member – ateb	£2,960 Per Annum		



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Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE

UNCONFIRMED 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 (WBFG) 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 are 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

Powell, Bethan
08/05/2025 16:00:41

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 (NONE)								

ACTIONS RECOMMENDED FOR CLOSURE (13 MAY 2025)								
11-Mar-25	ARA/24/084	Director of Corporate Governance	Audit Recommendations Tracker	To confirm if any Audit Recommendations reported as having no progress, made high priority	09.04.2025 Update - There were none.			Completed
11-Mar-25	ARA/24/085	Director of Corporate Governance	Financial Controls	An annual review of Financial Controls to be included in the Committee's work programme. It was highlighted that the inclusion of benchmarked data in future would be welcome.	15.04.2025 Update - Added as an annual report from March 2026	Mar-26		Completed
11-Mar-25	ARA/24/088	Director of Corporate Governance	Information Governance	To schedule a deep dive on Information Governance at a future Board Briefing meeting. (October or Jan)	09.04.2025 update- scheduled for October 2025	14/10/2025		Completed

Powell, Bethan
08/05/2025 16:00:41

Audit, Risk and Assurance Committees 2025-26								
Theme	Item Title	Exec Lead	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
Governance	Minutes of previous meeting	DCG	✓		✓	✓	✓	✓
Governance	Declaration of Interests	DCG	✓		✓	✓	✓	✓
Governance	Action Log	DCG	✓		✓	✓	✓	✓
Governance	Annual Work Programme	DCG	✓		✓			
Governance	Work Programme (updated through year)	DCG			✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	DCG	✓					✓
Governance	Committee Governance Action Plan	DCG			✓			✓
Governance	Committee Annual Report	DCG	✓					
Governance	Audit Recommendation Tracker	DCG				✓		✓
Governance	WHC Tracker	DCG	✓			✓		✓
Governance	Register of Interests	DCG				✓		✓
Governance	Board Members Register of Interests and Register of Gifts and Hospitality	DCG				✓		✓
Governance	Board Assurance Framework	DCG				✓		
Governance	Review of Terms of Reference	DCG	✓					✓
Governance	Review of Standing Orders and Standing Financial Instructions	DCG						✓
Governance	Confirmation Clinical Audit Programme in place	EMD			✓			
Annual Accounts	Approach to the Annual Accounts	ED FC&SS/DCG						✓
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	ED FC&SS	✓					
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	ED FC&SS		✓				
Internal Audit	Head of Internal Audit Opinion Draft	DCG	✓					
Internal Audit	Head of Internal Audit Opinion Final	DCG		✓				✓
Internal Audit	Internal Audit Annual Plan	DCG						✓
Internal Audit	Internal Audit Progress Report 24/25	DCG	✓		✓	✓	✓	
Internal Audit	Internal Audit Reports (as required)	DCG	✓		✓	✓	✓	✓
Internal Audit	Internal Audit Trend Report	DCG					✓	
External Audit	Enquiries of Management and Those Charged with Governance	ED FC&SS/DCG		✓				
External Audit	External Audit Annual Plan	ED FC&SS/DCG						✓
External Audit	External Audit Progress Report	DCG	✓		✓	✓	✓	
External Audit	External Audit Reports (as required)	Lead	✓		✓		✓	✓
External Audit	Structured Assessment	DCG	✓				✓	
Counter Fraud	Counter Fraud Annual Plan	ED FC&SS						✓
Counter Fraud	Counter Fraud Update	ED FC&SS	✓		✓	✓	✓	
Counter Fraud	Counter Fraud Reports (as required)	ED FC&SS	✓		✓		✓	✓
Finance and Procurement	Single Tender Waivers Annual Report	ED FC&SS	✓					
Finance and Procurement	Single Tender Waivers (including extensions to contracts)	ED FC&SS	✓		✓	✓	✓	✓
Finance and Procurement	Losses and Special Payments Annual Report	ED FC&SS	✓					
Finance and Procurement	Losses and Special Payments	ED FC&SS	✓			✓		✓
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Jan	ED FC&SS	✓				✓	
Finance and Procurement	Financial Controls	ED FC&SS				✓		✓
Risk	Review of Risk Management Framework	DCG				✓		
Risk	Assurance of Risk Management arrangements inc. revised Risk Management Toolkit	DCG			✓			
Governance	Annual Corporate Governance Development Plan	DCG			✓		✓	
Hosted Bodies	Hosted Body annual report (HCRW)	DWOD	✓		✓			
Information Governance	IG Annual Report	DCG	✓					
Information Governance	IG Performance Report	DCG				✓		✓
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)	DCG			✓			
Information Governance	Information Governance & Records Management report	DCG	✓				✓	
Key								
Item to be confirmed								
Item deferred								
Item brought forward								
Going to Board								
Due to Committee								
Find Exec Cttee date								
Added to draft agenda								



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.1

AUDIT RISK AND ASSURANCE COMMITTEE		Date of meeting: 13 MAY 2025
Subject:	Draft Accountability Report Section of the Annual Report 2024/25	
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary	
Prepared by:	Head of Corporate Governance	
Other Committees and meetings considered at:	Executive Committee – 30 April 2025	
PURPOSE:		
The purpose of this paper is to present the Draft Annual Accountability Report for 2024/25 to the Audit, Risk and Assurance Committee to provide an opportunity for feedback.		
This report constitutes one component of the larger document that makes up the statutory Annual Report, comprising the Performance Report, Accountability Report and Financial Statements. (The Draft Performance Report is being considered via a separate process, outlined in more detail below).		
RECOMMENDATION(S):		
The Audit, Risk and Assurance Committee is asked to:		
• CONSIDER the draft Annual Accountability Report 2024/25 and provide any significant feedback to inform the development of the final draft (noting the draft is subject to CEO review and a final proof read will be undertaken for accuracy and consistency)		
Approve/Take Assurance	Discuss	Note
N	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	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 Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include: Part 1 The Performance Report, Part 2 The Accountability Report (A Corporate Governance Report, A Remuneration and Staff Report, A Parliamentary Accountability and Audit Report), and, Part 3 The Financial Statements.

This report forms the Accountability Report element (Part 2) of the Annual Report and Accounts. The purpose of this element of the Annual Report and Accounts is to meet key accountability requirements set by Parliament.

The Draft iteration will be submitted to Welsh Government and Audit Wales on Friday 09 May 2024.

Any feedback provided will be incorporated into the development of the draft, which will be presented to the PTHB Board for formal approval on 25 June 2025; in readiness for the Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by 30 June 2025.

DETAILED BACKGROUND AND ASSESSMENT:

Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)¹ and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them. NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include:

Part 1 The Performance Report, which must include:

- An Overview

Part 2 The Accountability Report, which must include:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report

Part 3 The Financial Statements, which must include:

- The Audited Annual Accounts 2024/25

The 2024/25 Chapter 3 Guidance provides the following reporting timescales:

- Draft Accounts to be submitted to HSSG Finance and Audit Wales Friday 02 May 2025;
- Draft Performance Report Overview, Accountability Report (including the Governance Statement), and Draft Remuneration Report to be submitted to HSSG Finance and Audit Wales by noon on Friday 09 May 2025;
- Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by noon Monday 30 June 2025, as a single unified PDF document.

The following internal mechanisms have been implemented for the development, approval, and publication of 2024/25 Annual Report and Accounts:

- The Draft Accountability Report presented to the Executive Committee on 30 April 2025 for review and feedback prior to the draft submission and has been reviewed and cleared by the Director of Corporate Governance;
- The Draft Performance Report will be reviewed by the Executive Director of Planning, Performance and Commissioning and Chief Executive and then Members of the Delivery and Performance Committee via email for assurance and any significant feedback to inform the development of the final report;
- The Draft Financial Accounts will be presented to the Audit, Risk and Assurance Committee on 13 May 2025 for comments and feedback;
- All three sections will then be combined into a single document, the 'Annual Report and Accounts 2024/25' which will be reviewed by the Audit, Risk and Assurance Committee on 17 June 2025 and presented to the PTHB Board for formal approval on 25 June 2025;
- Subject to approval by the Board the 'Annual Report and Accounts 2024/25' will then be published and presented at the Health Board's Annual General Meeting, date to be confirmed.

NEXT STEPS:

Any significant feedback on the Draft Accountability Report is welcomed as this will inform the final version of the Accountability Report section of the Annual Report.

The Annual Report and Accounts 2024/25 will continue to be developed to enable submission in line with reporting timescales provided within the 2024/25 Chapter 3 Guidance.

Annual Report

2024/2025

THE HEALTH AND CARE STRATEGY FOR POWYS 'AT A GLANCE'



WE ARE DEVELOPING
A VISION OF THE
FUTURE OF HEALTH
AND CARE IN POWYS...



To
2027
AND
BEYOND...



WE AIM TO DELIVER
THIS VISION THROUGH-OUT
THE LIVES OF THE PEOPLE
OF POWYS...



WE WILL SUPPORT
PEOPLE TO IMPROVE
THEIR HEALTH AND
WELLBEING THROUGH...



OUR PRIORITIES AND
ACTION WILL BE
DRIVEN BY CLEAR
PRINCIPLES...



THE FUTURE OF
HEALTH AND CARE
WILL IMPROVE
THROUGH...



WORKFORCE FUTURES

INNOVATIVE ENVIRONMENTS

DIGITAL FIRST

TRANSFORMING IN PARTNERSHIP

2024-2025 16:00:41

Foreword – Statement of Chief Executive and Chair

To be added.



Hayley Thomas
Chief Executive
Powys Teaching Health Board



Dr Carl Cooper
Chair
Powys Teaching Health Board

Powell Bethan
08/05/2025 16:00:41

CONTENTS

To be added

Powell, Bethan
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PLACEHOLDER – ITEM 1- THE PERFORMANCE REPORT

Powell, Bethan
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SECTION TWO: THE ACCOUNTABILITY REPORT

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NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

THE ACCOUNTABILITY REPORT 2024/2025



SIGNED BY:

DATE: XX.XX.2025

**HAYLEY THOMAS
[CHIEF EXECUTIVE]**

Powell, Bethan
08/05/2025 16:00:41

INTRODUCTION TO THE ACCOUNTABILITY REPORT

Powys Teaching Health Board is required, as are all Welsh NHS bodies, to publish an Annual Report and Accounts. Copies of previous years reports are accessible from the Health Board's [website](#).

A key part of the Annual Report is the Accountability Report. The requirements of the Accountability Report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The requirements of the Companies Act 2006 have been adapted for the public sector context and only need to be followed by entities which are not companies, to the extent that they are incorporated into the Treasury's Government Financial Reporting Manual (FReM) and set out in the 2024/2025 Manual for Accounts for NHS Wales, issued by the Welsh Government.

The Accountability Report is required to have three sections:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report.

An overview of the content of each of these three sections is provided below:

The Corporate Governance Report

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2024/2025. It also explains how these governance arrangements supported the achievement of the Health Board's objectives.

The Director of Corporate Governance / Board Secretary has compiled the report, the main document being the Annual Governance Statement. This section of the report has been informed by a review of the work taken forward by the Board and its Committees over the last 12 months and has had input from the Chief Executive, as Accountable Officer, Board Members and the Audit, Risk and Assurance Committee.

In line with requirements set out in the Companies Act 2006, the Corporate Governance report includes:

- The Directors' Report;
- A Statement of Accountable Officer Responsibilities;

Powys Teaching Health Board
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- The Annual Governance Statement.

Remuneration and Staff Report

This report contains information about the remuneration of senior management, fair pay ratios and sickness absence rates and has been compiled by the Executive Director of People and Culture, the Executive Director of Finance, Capital and Support Services and the Director of Corporate Governance / Board Secretary.

Senedd Cymru/Welsh Parliamentary Accountability and Audit Report

This report contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, and the audit certificate and Auditor General for Wales Report.

Powell Bethan
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PART A: CORPORATE GOVERNANCE REPORT

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2024/2025. It includes:

- A Director's Report
- A Statement of Accountable Officer Responsibilities
- A Statement of Executive Directors' Responsibilities in Respect of the Accounts
- The Annual Governance Statement

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1. THE DIRECTOR'S REPORT 2024/2025

Powell, Bethan
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THE COMPOSITION OF THE BOARD AND MEMBERSHIP

Part 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 sets out the required membership of the Boards of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Powys Teaching Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as “the Board” or “Board members”; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights. In addition, the Director of Corporate Governance / Board Secretary position is a non-voting Board level post.

Additionally, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in Schedule 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, and continue to fulfil the relevant requirements throughout the time that they hold office.

The Regulations can be accessed via the Government’s legislation website: <http://www.legislation.gov.uk/wsi/2009/779/contents/made>

VOTING MEMBERS OF THE BOARD DURING 2024-25

During 2024-25, the following individuals were voting members of the Board of Powys Teaching Health Board:

Independent Members (IM)		
Carl Cooper	Chair	Full Year
Ronnie Alexander	IM (General)	Full Year
Steve Elliot	IM (Finance)	From 17/04/24
Robert Lewis	IM (General)	Full Year
Jennifer Owen Adams	IM (Third Sector)	Full Year

Ian Phillips	IM (ICT)	To 22/08/2024
Cathie Poynton	IM (Trade Union)	Full Year
Ian Thomas	IM (General)	From 06/01/25
Chris Walsh	IM (Local Authority)	Full Year
Kirsty Williams	Vice-Chair	Full Year
Simon Wright	IM (University)	Full Year
Direct Appointment		
Mick Giannasi	IM (to support vacant Capital & Estates role)	Full Year
Executive Directors		
Hayley Thomas	Chief Executive	Full Year
Pete Hopgood	Interim Deputy Chief Executive, Executive Director of Finance, Information and IT Services, and Interim Executive Director of Primary Care	To 16/05/2024
Pete Hopgood	Deputy Chief Executive, Executive Director of Finance, Capital and Support Services and Interim Executive Director of Primary Care	From 17/05/2024 to 29/09/2024
Pete Hopgood	Deputy Chief Executive and Executive Director of Finance, Capital and Support Services	From 30/09/2024
Mererid Bowley	Executive Director of Public Health	Full Year
David Farnsworth	Interim Executive Director of Operations,	To 02/06/24 ²

Powell/Bethan
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	Community Care and Mental Health	
Joy Garfitt	Interim Executive Director of Operations, Community Care and Mental Health	From 01/04/24 – 30/09/24 ^{1 and 2}
Elaine Lorton	Executive Director of Primary, Community Care and Mental Health	From 30/09/24
Nicola Johnson	Executive Director of Planning, Performance and Commissioning	From 07/10/24
Claire Madsen	Executive Director of Therapies and Health Sciences	To 30/04/2024
Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	From 01/05/2024
Stephen Powell ³	Interim Executive Director of Planning, Performance and Commissioning	To 06/10/2024
Claire Roche	Executive Director of Nursing and Midwifery	To 30/04/2024
Claire Roche	Executive Director of Nursing, Quality, Women and Family Health	From 01/05/2024
Debra Wood-Lawson	Executive Director of Workforce and OD	To 30/04/2024
Debra Wood-Lawson	Executive Director of People and Culture	From 01/05/2024
Kate Wright	Executive Medical Director	Full Year

Powell, Nathan
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Footnotes:

- 1 – JG was on sickness absence from 01/04/2024 to 05/05/2024 with the Portfolio covered on an interim basis by DF. JG was again on sickness absence from 08/07/2024 to 30/09/2024, during which time the Portfolio was covered by other Executive colleagues
- 2 – there was a period of handover between DF and JG between 06/05/2024 and 02/06/2024
- 3 - SP remained with the Health Board from 07/10/2024 - 20/10/2024 for a handover period to the newly appointed NJ.

During 2024/25, vacancies in the Board consisted of:

Independent Members	Executive Director
- Independent Member (Finance) from 01/04/24 to 16/04/2024 - Independent Member (Capital and Estates) from 01/04/2024 to 31/03/2025	Executive Director for Strategy, Primary Care and Partnerships from 01/04/2025 to 01/05/2025 (covered by a continuation of interim arrangements put in place in 2023/2024)

Additional support for the Finance IM role prior to the formal appointment of the IM Finance was provided by Steve Elliot – a non-executive Special Advisor (Finance) to Delivery and Performance Committee and Audit, Risk and Assurance Committee 01/04/24 to 16/04/2024

Additional support in the absence of the Capital and Estates IM was provided by the Direct Appointment, by the Cabinet Secretary, of Mick Giannasi for the full year.

Whilst a small number of roles on the Board were vacant for short periods, responsibilities were covered by other Board members to ensure continuity of business and effective governance arrangements. Independent Members attended Board Committee meetings where necessary to ensure meetings remained quorate and the Board’s duties could be discharged.

NON-VOTING MEMBERS OF THE BOARD DURING 2024/2025

Helen Bushell is the Director of Corporate Governance / Board Secretary (a member of the Executive team and non-voting attendee at Board meetings).

Nina Davies, Director of Social Services, Powys County Council was appointed, by the Minister for Health and Social Services, to the role of Associate Member (non-voting member of the Board).

Further details in relation to role and composition of the Board can be found within the Annual Governance Statement. The Annual Governance Statement also contains further information in respect of the Board and Committee activity.

AUDIT, RISK AND ASSURANCE COMMITTEE

During 2024/25, the following individuals were members of the Audit, Risk and Assurance Committee:

Independent Members (IM)		
Steve Elliot	IM (Finance)	From 17/04/2024 to 08/10/2024
	Committee Chair – IM Finance	From 09/10/2024
Rhobert Lewis	Committee Chair – IM (General)	To 08/10/2024
Ronnie Alexander	IM (General)	Full Year
Chris Walsh	IM (Local Authority)	Full Year
Executive Team Officers by Attendance Only		
Hayley Thomas	Chief Executive	Full Year
Pete Hopgood	Executive Director of Finance and IT	Full Year
Helen Bushell	Director of Corporate Governance / Board Secretary	Full Year

To provide additional support whilst an Independent Member (Finance) was being appointed, Steve Elliot, a non-Executive Special Advisor Finance was appointed from 01/04/2024 – 16/04/2024.

DECLARATION OF INTERESTS

Details of company Directorships and other significant interests held by members and attendees of the Board which may conflict with their responsibilities are maintained and updated on a regular basis. A register of Interests is available on the Health Board’s [website](#), or a hard copy can be obtained from the Director of Corporate Governance / Board Secretary.

PERSONAL DATA RELATED INCIDENTS

Information on personal data related incidents formally reported to the Information Commissioner's office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed within the Annual Governance Statement on **page XX**.

ENVIRONMENTAL, SOCIAL AND COMMUNITY ISSUES

Environmental, social and community issues are integrated into planning of and day-to-day running of the Health Board. Major capital investment has continued to respond to the climate emergency and limit the impact of the Health Board's operations on the environment and help the public sector in Wales be net zero by 2030. Substantial energy conservation measures are underway to replace all lighting to LEDs, roof-mounted solar PV arrays, building heating efficiencies, and insulation augmentation within roof spaces and pipework.

Development of strong community ties are essential for delivering effective healthcare with community-delivered projects and partnerships key to realising the benefits of green prescribing and fully integrating our green spaces for therapeutic gains. In support, the Health Board has created a new welfare hub within Bronllys Hospital as a base and ablution provision for community teams working on outdoor space improvements and teaching opportunities with local community groups. Furthermore, community enhancements include expansion of public-facing electric vehicle charging infrastructure at Bronllys and Ystradgynlais hospitals with more planned across the estate.

Social inequalities are continuously being addressed by the Health Board, with equal access to healthcare and support at time of need key. Outcomes including expanded mental health services to provide better access and support for those in need, with the introduction of support services such as Powys 111#2 mental health access helpline, CAMHS Sanctuary and modern community mental health hub within Llandrindod.

PTHB is committed to promoting a sustainable, fair and healthy community and will continue to expand these initiatives to meet the changing needs of our population while reducing our environmental impact.

STATEMENT OF PUBLIC SECTOR INFORMATION HOLDERS

As the Accountable Officer of Powys Teaching Health Board and in line with the disclosure requirements set out by the Welsh Government and HM Treasury, I confirm that the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the year.

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SIGNED BY:

DATE: XX XXXX 2025

HAYLEY THOMAS
[CHIEF EXECUTIVE]

Powell, Bethan
08/05/2025 16:00:41

2. STATEMENT OF ACCOUNTABLE OFFICER RESPONSIBILITIES: 2024/2025

Powell, Bethan
08/05/2025 16:00:41

STATEMENT OF MY CHIEF EXECUTIVE RESPONSIBILITIES AS ACCOUNTABLE OFFICER OF POWYS TEACHING HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive, should be the Accountable Officer to the Powys Teaching Health Board.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as the Accountable Officer.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which Powys Teaching Health Board's auditors are unaware. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Powys Teaching Health Board's auditors are aware of that information;
- Powys Teaching Health Board's Annual Report and Accounts as a whole is fair, balanced, and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable;
- I am responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

SIGNED BY:

DATE: **XX.XX.2025**

**HAYLEY THOMAS
[CHIEF EXECUTIVE]**

Powell Bethan
08/05/2025 16:00:41

3. STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2024/2025

Powell, Bethan
08/05/2025 16:00:41

STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2024/2025

The Executive Directors of Powys Teaching Health Board are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts the Executive Directors are required to:

- apply accounting principles on a consistent basis, that are laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates that are responsible and prudent; and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

On behalf of the Executive Directors of Powys Teaching Health Board we confirm:

- that we have complied with the above requirements in preparing the 2024/2025 accounts: and
- that we are clear of our responsibilities in relation to keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the authority, and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction by the Welsh Ministers.

By order of the Board

SIGNED BY:

DATE:

CARL COOPER [CHAIR]

SIGNED BY:

DATE:

HAYLEY THOMAS [CHIEF EXECUTIVE]

SIGNED BY

DATE:

**PETE HOPGOOD [DEPUTY CHIEF EXECUTIVE / EXECUTIVE
DIRECTOR OF FINANCE, CAPITAL AND SUPPORT SERVICES]**

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4. ANNUAL GOVERNANCE STATEMENT

Powell, Bethan
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SCOPE OF RESPONSIBILITY

The Board is accountable for Governance, Risk Management, and Internal Control. As Chief Executive of the Health Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided. Additional information is provided in the Governance Statement where necessary. However, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

I am held to account for my performance by the Chair of the Board and the Chief Executive of NHS Wales / Director General of Welsh Government, acting as the Accountable Officer for the NHS in Wales. I have formal performance meetings with both the Chair and the Chief Executive of NHS Wales. Further, the Executive Team of the Health Board meet with the senior leaders of the Department of Health and Social Services on a regular basis.

During 2024/2025, the Health Board and the NHS in Wales continued to face substantial pressure in planning, recovering from the impacts of the Covid-19 pandemic, significant economic and financial challenges and responding to industrial action amongst other political challenges. Financial challenges were particularly difficult both locally and across the wider public sector in Wales and the UK. 2024/2025 continued the post-pandemic business as usual arrangements returned to in 2023/2024. The Executive Committee oversaw internal 'local' escalation arrangements for mental health and learning disability services (March 2024 – October 2024) and children's neurodiversity services (October 2024 - ongoing).

Outside formal meetings, Board Members remained fully informed receiving briefings at Board Development and Board briefing sessions. Further detail on maintaining good governance during 2024/25 is provided within this Annual Governance Statement.

Powell, R
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ESCALATION STATUS

In common with all Health Boards across Wales, the Health Board has faced extreme financial challenges. Although the Health Board had a Board approved Plan, it has not been possible to comply with requirements to balance the budget and the Health Board has worked closely with Welsh Government to identify an appropriate way forward matching fiscal prudence against meeting Ministerial priorities. Welsh Government moved the Health Board from Enhanced Monitoring (Level 3) in which it had been placed in September 2023 to Level 4 (previously known as Targeted Intervention) for finance, strategy and planning in November 2024. The NHS Wales Escalation and Intervention Arrangements can be seen in more detail here - [NHS Wales escalation and intervention arrangements | GOV.WALES](https://gov.wales/nhs-wales-escalation-and-intervention-arrangements)

The Health Board remains at Level 1 for all other domains of the NHS Wales Escalation and Intervention Framework.

FUNCTIONS HOSTED BY POWYS TEACHING HEALTH BOARD

In compliance with requests made by the Welsh Ministers, the Health Board hosts the following function:

- **Health and Care Research Wales (HCRW):** HCRW is a national, multi-faceted, virtual organisation funded and overseen by the Welsh Government's Division for Social Care and Health Research. It provides an infrastructure to support and increase capacity in research and development, runs a number of funding schemes, and manages the NHS research and development funding allocation in Wales. Its aim is to generate and support excellent research to improve the health and care of people in Wales across a range of conditions and settings.

The Board of PTHB is not responsible for the delivery of the objectives of HCRW, or their day-to-day management. However, it is responsible for ensuring that the functions are staffed using appropriate recruitment mechanisms, and that PTHB's Standing Orders, Standing Financial Instructions and Workforce and Organisational Development policies are complied with.

The Health Board has nominated its Executive Director of People and Culture as the Lead Executive Director for these functions. Key officers from Finance, IT, Governance and Workforce teams have been identified to provide support to the function, as appropriate.

Powys Bro Morgannwg
08/05/2025 16:00:41

OUR GOVERNANCE AND ASSURANCE FRAMEWORKS

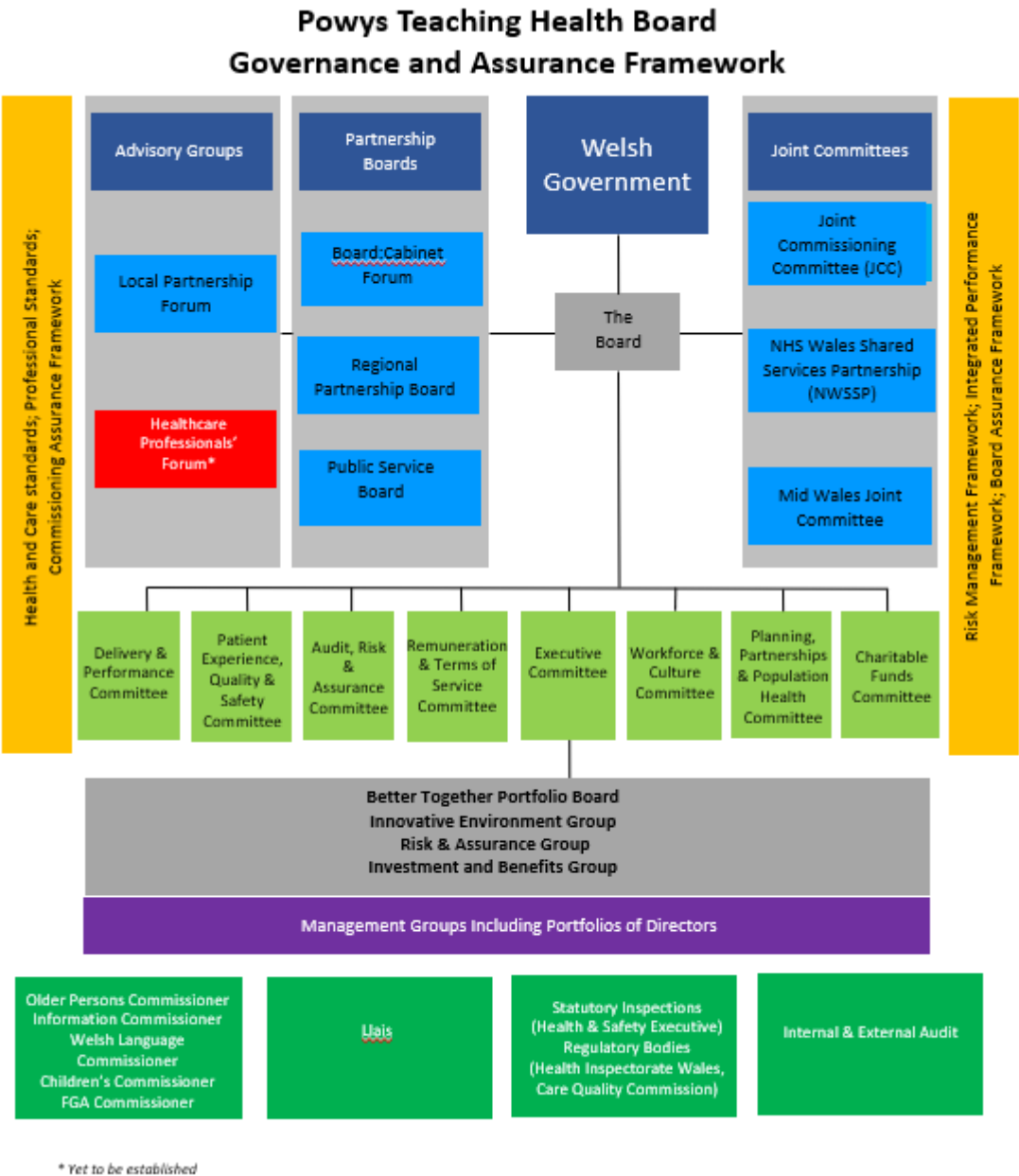
Powys Teaching Health Board has a clear purpose from which its strategic aims and objectives have been developed. Our vision is to enable a 'Healthy Caring Powys'. The Board is accountable for setting the organisation's strategic direction, ensuring that effective governance and risk management arrangements are in place and holding Executive Directors to account for the effective delivery of its Integrated Plan and Annual Delivery Plan. The Integrated Plan was approved by Board on 20 March 2024. A copy of our Integrated Plan for 2024 - 2029 can be found on the Health Board [website](#).

The Board keeps its governance and assurance frameworks under review. Current arrangements have been in place since July 2021 with the exception of the following changes:

- In May 2024 the Board confirmed a decision not to operate a Stakeholder Reference Group, on the basis the Health Board has several other mechanisms for stakeholder engagement
- The Joint Partnership Board (JPB) was disbanded in December 2023 and has been replaced by the Board Cabinet Forum.

Powell Bethan
08/05/2025 16:00:41

Figure 1 – Governance Assurance Framework



THE BOARD

The Board has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board. Details of those who sit on the Board are published on the Health Board [website](#). Further information is also provided within the Directors' Report.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide

strategic direction and control. The Board is accountable for governance and internal control in the organisation, and I, as the Chief Executive and Accountable Officer, am responsible for maintaining appropriate governance structures and procedures. In summary, the Board:

- sets the tone and culture of the organisation;
- sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- establishes and maintains high standards of Corporate Governance;
- sets the risk appetite for the organisation and provides oversight of strategic risks;
- ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- monitors progress against the delivery of strategic and annual objectives; and
- ensures effective financial stewardship by effective administration and economic use of resources.

STANDARDS OF BEHAVIOUR

The Welsh Government's *Citizen-Centred Governance Principles* apply to all the public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public and behaviour including openness, customer service standards, diversity and engaged leadership. The Board has in place a Standards of Behaviour Policy, which sets out the Board's expectations and provides guidance so that individuals are supported in delivering that requirement.

The Standards of Behaviour Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles, and responsibilities of those employed by the Health Board, and the arrangements for ensuring that declarations of interests, gifts, hospitality, and sponsorship can be made. The policy also aims to capture public acceptability of behaviours of those working in the public sector in order that the Health Board can be seen to have exemplary practice in this regard.

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Details of the Board's Standards of Behaviour Policy incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship, is available on the Health Board's [website](#).

STANDING ORDERS AND SCHEME OF RESERVATION AND DELEGATION

The Health Board's governance and assurance arrangements have been aligned to the requirements set out in the Welsh Government's Governance e-manual and the Citizen Centred Governance Principles. Care has been taken to ensure that governance arrangements also reflect the requirements set out in HM Treasury's 'Corporate Governance in Central Government Departments: Code of Good Practice 2017'.

The Board has approved Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved for the Board, a detailed scheme of delegation to officers and Standing Financial conduct of the Health Board and define "its ways of working". The Standing Orders in place during 2024/2025 were adopted by the Board on 27 November 2019, with minor amendments adopted at Board on 28 July 2021, 25 May 2022, 24 May 2023 and 27 September 2023, and were fully updated on 22 May 2024. Further minor amendments were made on 20 March 2025. The Standing Orders are available on the Health Board's [website](#).

The Board, subject to any directions that may be made by the Welsh Ministers, is required to make appropriate arrangements for certain functions to be carried out on its behalf. This enables the day-to-day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Committee structure is outlined in the following section and the Terms of Reference are available on the Health Board's [website](#).

COMMITTEES OF THE BOARD

Section 3 of Powys Teaching Health Board's Standing Orders provides that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions."*

In line with these requirements the Board has established a standing Committee structure, which it has determined best meets the needs of the Health Board, while taking account of any regulatory or Welsh Government

Powys Teaching Health Board
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requirements. Each Committee is chaired by an Independent Member of the Board, with the exception of the Executive Committee which is chaired by the Chief Executive as Accountable Officer and is constituted to comply with Welsh Government's Good Practice Guide – Effective Board Committees. All Committees regularly review their Terms of Reference and Work Plans to support the Board's business. Committees also work together on behalf of the Board to ensure that work is planned cohesively and focusses on matters of greatest risk that would prevent the Health Board from meeting its vision, aims and objectives.

As part of the regular review of Board arrangements changes to the Committee structure were agreed at Board on 28 July 2021 and Terms of Reference for each Committee were agreed at Board on 29 September 2021. Since then, minor changes have been made to the Committees Terms of Reference which are available on the Health Board's [website](#).

The following Committee structure is in place:

- Audit, Risk and Assurance Committee;
- Charitable Funds Committee;
- Delivery and Performance Committee;
- Executive Committee;
- Patient Experience, Quality and Safety Committee;
- Planning, Partnerships and Population Health Committee;
- Remuneration and Terms of Service Committee; and
- Workforce and Culture Committee.

Agendas for each of the Committees (excepting Executive Committee and the Remuneration and Terms of Service Committee) can be found on the Health Board's [website](#). The agenda and papers for those items to be considered in open session are included in the agenda packs.

The Chair of each Committee reports the business of each meeting to the Board on the committee's activities and any matters of concern or escalation to be brought to the attention of the Board, through a Chair's report. This contributes to the Board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. Annual reports will be prepared for individual committees after year-end.

Board and Committee Effectiveness reviews were undertaken in individual committee meetings. The reviews were undertaken by way of a survey of Members, Lead Officers, regular attendees and external stakeholders of each committee which will be reported either to last meeting of 2024/25 or to the first meeting in 2025/2026. This information will be collated and analysed and reported to Board in July 2025.

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Decision logs for Board and committees are maintained and used to inform the summary of Board and committee business. Decisions are recorded within minutes which are reported at the following Board or committee meeting.

ACCESS TO BOARD AND COMMITTEE MEETINGS

With the limitations on public gatherings introduced early in the pandemic the Health Board moved to holding Board and Committee meetings virtually, via electronic means. This is not in accordance with the intended spirit of the Public Bodies (Admissions to Meetings) Act 1960 whereby the organisation is required to hold its meetings in public. In-public Board meetings have continued to be held online and livestreamed, giving the public access to view the meeting in real time. Members of the public can also view Board Committee meetings by contacting the Director of Corporate Governance / Board Secretary to request arrangements be made for an opportunity to observe Committee meetings which are not livestreamed.

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

Members of the public are also invited to submit any questions to the Board to each of the scheduled in-public Board meetings, for which there are generally six in the year.

The following notice is included in each Board agenda:

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. At present Board meetings are held virtually and livestreamed. Members of the public are able to view the livestream or view the uploaded copy of the meeting on demand.

The following notice is included in each Committee agenda:

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.

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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 – please 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.

During the year Board was held with in-person attendance of Board Members twice (September 2024 and March 2025) where the meeting was recorded and uploaded to the website after the meeting.

The opportunity for public questions in advance was exercised on three occasions at Board. No public questions were received for meetings of the Board's committees.

The arrangements have continued in relation to Health Board committee meetings throughout the year. It is acknowledged that Standing Orders have not been fully complied with in terms of access to Board Committee meetings. However, the arrangements outlined above have been put in place to mitigate for this and are, in the Health Boards view, in the public interest.

During 2024/2025 the Health Board have met twice to hold in person Board meetings. The first of these meetings was recorded and uploaded to the website after the event, the second meeting was livestreamed and uploaded to the website after the event. All other Board meetings have been livestreamed, and the recording is also available to view after the event.

Figures 2 below provide an overview of the role and responsibilities of the Board's Committees, as set out within respective Terms of Reference.

Figure 3 below provides an overview of Board and Committee meetings held during 2024/25.

Details of attendance at Board meetings can be found at Appendix 1 (page XXX).

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FIGURE 2: ROLES AND RESPONSIBILITIES OF COMMITTEES OF THE BOARD FROM APRIL 2024 – MARCH 2025



FIGURE 3: BOARD AND COMMITTEE MEETINGS HELD DURING 2024/2025

Board/ Committee	Dates											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Board	11	22		11 24		24	10	27		10 29		26
Board In-Committee	11	22 30		24	07 21	24		27		29		06 26
Audit, Risk and Assurance (ARAC)		14		09			08			14		11
Charitable Funds (CFC)			10			09			02	20		17
Delivery and Performance (D&P)		07	27		29		22		05		06	
Patient Experience Quality and Safety (PEQS)	16			30		05		07			11	
Planning, Partnerships and Population Health (PPPH)		16			13			14			04	
Remuneration and Terms of Service	18			11		19						20
Workforce and Culture (W&C)			04				03		10			13
Joint D&P Committee and PPPH Committee												17

ITEMS CONSIDERED BY THE BOARD IN 2024/2025

During 2024/2025 the Board formally held:

- ten public meetings, seven of which were livestreamed, and nine of which had recording uploaded after the meeting (the recording of the tenth meeting is not available due to a technical error);
- eleven In-Committee (private) meetings (seven following a public Board meeting, four standalone meetings);
- an Annual General Meeting;
- one Chair's Action;
- five Board Briefings; and
- eleven Board development sessions.

All meetings of the Board held in 2024/2025 were appropriately constituted with the required quorum.

Board Activity:

During the year, the Board considered a number of key issues and took action where appropriate, these are summarised below:

Standing Items:

- Experience Stories (patient and staff)
- Report of Chair
- Report of Vice-Chair
- Report of CEO
- Report of the Director of Corporate Governance
- Minutes from previous meetings and action log
- Performance Reports on:
 - the Integrated Plan
 - the Delivery Plan; and
 - Financial Performance
- Corporate Risk Register
- Assurance Reports from Board Committees, Joint Committees, Partnerships and Advisory Groups
- Report of the Regional Director of Llais

The Board Approved the following items:

- Annual Delivery Plan 2024/25
- Charitable Funds Annual Accounts and Report 2022/23
- Board Assurance Framework
- Director of Corporate Governance / Board Secretary Reports
 - Application of the Common Seal

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- Changes to Standing Orders
- Revised Scheme of Delegation and Committee Terms of Reference
- Chair's Action regarding Module 8 (UK Covid-19 Public Inquiry)
- Committee Membership 2024/25
- Register of Interests
- Annual Report and Accounts 2023/24
- Major Incident and Emergency Response Plan and the Health Board's Corporate Business Continuity Plan
- Civil Contingencies Annual Report 2023/24
- Annual Duty of Quality Report 2023/24
- Safeguarding Annual Report 2023/24
- Joint Commissioning Committee Governance arrangements
- Temporary Service Changes (to Minor Injury Units and Ready to Go Home Units)
- Compassionate Leadership Charter
- Charitable Funds Annual Accounts and Report 2023/24
- Annual Delivery Plan 2024/25 urgent mitigating actions
- Annual Delivery Plan 2024/25 next steps
- Anti Racism Plan
- Annual Plan 2025/26
- Capital Programme 2025/26
- Standards of Behaviour Policy
- Risk Management Framework

The Board received the following items for assurance:

- Update on Integrated Plan 2024/29 and Temporary Service Change
- Vaccination Programmes
- Winter Planning/Resilience
- Approach to Integrated Plan 2025/26
- Updates to Temporary Service change
- Digital Strategic Framework Annual Update
- Nurse Staffing Levels (Wales) Act 2023/24

The Board considered the following items:

- Emergency Medical Retrieval and Transfer Service

The Board within In-Committee meetings approved the following items:

- Core Participant Status Covid-19 Public Inquiry Module 7 and Module 9
- General Medical Services Out of Hours Contract Procurement

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- Electronic Prescribing and Medicines Management Business Case
- Judicial Review – Emergency Medical Retrieval and Transfer Service
- Emergency Response and Planning Self Assessment
- Committee Annual Report – Remuneration and Terms of Service Committee
- North Powys Wellbeing Programme
- Integrated Plan 2024/29 response to Welsh Government
- Financial Performance – Year End Forecast, further options
- Future Provision of General Medical Services at Rhayader Medical Practice
- GP Out of Hours contract extension
- North Powys Wellbeing Programme

The Board within In-Committee meetings considered the following items:

- Continuing Health Care historic cases update
- North Powys Wellbeing Programme update
- 2024-29 Integrated Plan Response to Welsh Government Feedback May 2024
- Transformation Service Change update
- Integrated Plan 2025-28 update

Chair's Action was taken on the following item:

- To not apply for Core Participant Status Covid-19 Public Inquiry Module 8

The Chair's Action was taken in the interest of timely decision making and was reported into a public Board meeting.

ITEMS CONSIDERED BY COMMITTEES OF THE BOARD

During 2024/25, Board Committees considered and scrutinised a range of reports and issues relevant to the matters delegated to them by the Board. Reports considered by the Committees included a range of internal audit reports, external audit reports and reports from other review and regulatory bodies, such as Healthcare Inspectorate Wales and the Health and Safety Executive.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in my assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms.

The Committees also considered and advised on areas of local and national strategic developments and new policy areas. Board Members are also involved in a range of other activities on behalf of the Board, such as Board

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Development sessions, attending partnership meetings, shadowing, and a range of other internal and external meetings.

Figure 4: Key Areas of Focus of Committees of the Board (in summary) 2024-25

Audit, Risk and Assurance Committee	▪ ratified approval of Single Tender Waivers and Annual Report; ▪ received the Internal Audit Annual Report and Opinion; ▪ reviewed Standing Orders, Financial Instructions and Board Assurance Framework; ▪ approved the Annual Internal Audit Plan; ▪ received Internal and External Progress reports; ▪ received Internal and External Audit Reports and tracked implementation of audit recommendations; ▪ received Counter Fraud updates and reports; ▪ received Hosted Body Annual report; ▪ tracked implementation of Welsh Health Circulars; ▪ kept under review the Health Board's arrangements for risk management and assurance; ▪ reviewed and sought assurance on the accuracy of the Annual accounts and Annual accountability statement; ▪ reviewed and sought assurance on the accuracy of annual reports; ▪ sought assurance on the Standards of Behaviour mechanisms; ▪ reviewed Post Payment verification; ▪ sought assurance on Records Management Improvement plans; ▪ approved the Audit Handbook; ▪ supported the Risk Management Framework for Board approval; ▪ received Annual Register of Interests; ▪ reviewed and sought assurance on the Annual Governance Programme; and ▪ reviewed and sought assurance on losses and special payments.
Executive Committee	▪ provided advice to the Board in relation to the development of the Integrated Plan for 2025-2026 and Maturity Matrix; ▪ reviewed and sought assurance on the 2025/2026 Financial allocation for the 6 goals for Urgent and Emergency Care;

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	▪ reviewed and provided advice to the Board in relation to the identification and management of corporate risks; ▪ reviewed and monitored Neurodevelopmental services and took forward an improvement plan to the Board, ▪ reviewed and sought assurance in relation to limited and no assurance internal and external audit reports; ▪ received various service-based business cases, service, and improvement plans, making decisions relevant to operational delivery of the Boards strategy and in-year plan; ▪ took forward actions arising from the Integrated Performance Report and performance managing the delivery of those action plans; ▪ kept the operational effectiveness of policies and procedures under review; ▪ reviewed and sought assurance on staff sickness absence across the Organisation; ▪ scrutinised key reports and strategies prior to their submission to other Committees of the Board and/or the Board to ensure their accuracy and quality; ▪ provided a strategic view of issues of concern ensuring co-ordination between Executive Directorates; ▪ provided advice to the Committees of the Board and/or the Board on matters related to quality, safety, planning, commissioning, service level agreements and change management initiatives; ▪ ensured staff are kept up to date on Health Board wide issues; and ▪ acted as the forum in which Executive Directors and senior managers can formally raise concerns and issues for discussion, making decisions on these issues.
Charitable Funds Committee	▪ scrutinised applications for charitable funds; ▪ kept an overview of charitable funds income and expenditure; ▪ updated Charity Terms of Reference and documents, ▪ received project evaluations, ▪ reviewed the Committees Effectiveness and; ▪ reviewed and recommended to the Board the Charity's Annual report and Annual accounts.
Delivery and Performance Committee	▪ sought assurance on performance on the Integrated Quality Performance Report and Annual Delivery Plan; ▪ reviewed the Performance section of the Annual Report;

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	▪ scrutinised the Organisational Status (NHS Wales Escalation Framework) Enhanced Monitoring; ▪ sought assurance on financial performance, closely scrutinising areas of cost pressure and savings plans; ▪ sought assurance on the Emergency Ambulance services; ▪ sought assurance on In-Reach Fragility; ▪ scrutinised primary care performance (General Medical Services, General Dental Services, Community Pharmacy and Out of Hours); ▪ reviewed Digital First Updates including Cyber Security; ▪ sought assurance on Food Safety compliance; ▪ reviewed the Capital and Estates Programme delivery overview including Decarbonisation action plan and progress report; ▪ reviewed Innovative Environments updates, including seeking assurance on Health and Safety matters; ▪ sought assurance on the Information Governance and Records Management Improvement plans; ▪ reviewed the Powys Public Service Board Climate Working Group update; ▪ sought assurance on Endoscopy Services (including JAG accreditation) ▪ reviewed Strategic Renewal Portfolio priorities including Value Based Healthcare, Children and Young People, Urgent and Emergency Care and Community Model; and ▪ sought assurance on the Committee based Corporate Risk Register.
Patient Experience, Quality and Safety Committee	▪ scrutinised the Integrated Quality Report including: ○ implementation of the Quality and Engagement Act ○ monitor Incidents and Concerns ○ monitor the Inspections and External Bodies Report and Action Tracking ○ sought assurance on patient experience ○ sought assurance on Infection, Prevention and Control including nosocomial updates ○ received Public Services Ombudsman Wales Annual Report, and ○ implementation of the Duties of Quality and Candour. ▪ Received and sought assurance on Maternity Services; ▪ Received and sought assurance on Mental Health Services;

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	- received the Annual Reports of the Accountable Officer Controlled Drugs; - sought assurance on the Clinical Audit progress; - sought assurance on the Joint Inspection of Child Protection arrangements and Child Practice review; - monitored the Infection Prevention and Control Plan; - monitored compliance with Mental Health legislation; - scrutinised and received the Duty of Quality Annual Report 2023/2024; - sought assurance on the Transition of Care Annual Report 2023/2024 - received and sought assurance on the Annual Safeguarding Report 2023/24; - received and sought assurance on the Medicines Management Annual report; - reviewed and sought assurance on the Medical Devices and Point of Care Testing report; - received Internal Audit Reports,(Continuing Health Care, End of Life Care services, Deprivation of Liberty Safeguards and Patient Experience); - monitored and sought assurance on the development of an improvement plan regarding the Mental Health Deep Dive of local escalation; - sought assurance on the Mental Health Power of Discharge Annual Report, - approved the Clinical Audit progress and Plan 2024/2025; - reviewed and scrutinised Neurodiversity Services; - sought assurance on the Care Inspectorate Wales-Cottage View Knighton and Health Inspectorate ales (HIW) review; - sought assurance on Health and Safety metrics; - sought assurance on the Committee based Corporate Risk Register.
Planning, Partnerships and Population Health Committee	- sought assurance on the Strategic Change Programmes; - scrutinised the Integrated Plan 2025/26 development and draft Maturity Matrix; - sought assurance on Childhood Immunisations; - reviewed the ALN and sought assurance regarding activity and plans; - sought assurance on a Whole System Approach of prevention of obesity (including weight management pathways, Healthy Child Wales Programme and Diabetes)

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	▪ reviewed the Winter Respiratory Vaccination plans and Winter plan; ▪ reviewed and sought assurance on the Transformation-Better Together development programme; ▪ reviewed the Regional Partnership Board approach to the Delivery Plan 2025/26; ▪ scrutinised Primary Care Cluster plans ▪ sought assurance on the Population Screening Programme Uptake and Health protection; ▪ sought assurance on Oral Health – Design to Smile programme; ▪ sought assurance on Local and National Civil Contingency arrangements; ▪ sought assurance on North Powys Wellbeing Programme; ▪ sought assurance on Tobacco Control and Smoking cessation; ▪ sought assurance on Endoscopy services; ▪ sought assurance on the Committee based Corporate Risk Register.
Workforce and Culture Committee	▪ scrutinised the Workforce Performance Reports; ▪ reviewed the Director of People and Culture reports, ▪ received the NHS Wales Staff Survey; ▪ reviewed and sought assurance on the Workforce Futures: ○ Transformation and Sustainability ○ Staff Bank Service ○ Staff Health and Wellbeing ○ Great Place to Work ○ Welsh Language, Equality, Diversity and Inclusion ▪ sought assurance and on the Communications and Engagement report; ▪ reviewed the implementation of agile working and new ways of working; ▪ approval and publication on the Health Board’s website of the Welsh Language 2024/25 and Equalities Annual Reports; ▪ sought assurance on Temporary Service Changes; ▪ received Audit Wales report: Audit Wales Workforce Planning; ▪ reviewed and recommended the Staff Retention and Implementation plan; ▪ sought assurance on Health and Safety updates;

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	▪ reviewed the Committees Effectiveness and; ▪ sought assurance on the Committee based Corporate Risk Register.

BOARD DEVELOPMENT

During the year, the Board took part in a number of development and briefing sessions which covered the following topics:

Developing the (Board) team:

- Powys Balance Programme experiential session
- Board & Committee Effectiveness
- Board Member perspectives
- Compassionate Leadership

Developing the Organisation:

- Transformation and Change including
 - Developing the route map to sustainability
 - Planned Engagement for route map to sustainability
 - Temporary Service Change
 - Better Together Transformation
- Strategy and Planning including
 - Annual Plan 2024/25
 - Integrated Plan 2024/25 finance and escalation update
 - Integrated Plan 2025/28 base line assessment
 - Delivering the 2024/25 plan – in year mitigations
 - Planning approach 2025/26
- Research and innovation
- Board Level Risk Appetite
- Primary Care
- Balancing performance, value and quality
- Safeguarding Children, Adults and Vulnerable People
- Level 4 escalation

Engaging with and learning from the organisation

- Corporate Governance – Covid 19 Public Inquiry
- CAHMS in reach team
- Cottage View, Knighton
- Facilities and Support Services
- Planned Care
- Therapies Service
- Digiflow (in patient monitoring software)
- NHS Staff Survey

Engaging with and learning from external partners

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- Emergency Medical Retrieval and Transport Service briefing
- Joint Commissioning Committee
- Welsh Government - Escalation and Intervention arrangements

ADVISORY GROUPS

Whilst Model Standing Orders required the Board to have three advisory groups, PTHB's Standing Orders require the Board to have two advisory groups in place (a Board decision was taken to not hold a Stakeholder Reference Group). When active, these allow the Board to seek advice from and consult with staff and key stakeholders. They are:

- a Local Partnership Forum; and
- a Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board [website](#).

The Local Partnership Forum (LPF) is well established. Work has continued during 2024/2025 to strengthen the Forum's operating arrangements and maximise its role in providing advice to the Board. The Forum has considered the Integrated Plan, reviewed the Terms of Reference, received regular updates on the financial position, workforce analysis and a regular summary report from the Director of People and Culture. Other areas considered include NHS Staff survey results, Business efficiencies and improvement, the Admin review, updates on the Agile Working Policy, implementation of the non-pay parts of the 2022-24 collective agreement, temporary service change, the route map to sustainability, Bands 2 and 3 Nursing workforce and Speaking up Safely. All reports have a staff side focus.

The Standing Orders require the Health Board to constitute a Healthcare Professionals Forum. System pressures have meant that progress was not made to constitute the Healthcare Professionals Forum during 2024/2025. The Health Board therefore declares a non-compliance with our Standing Orders in so far as this forum is concerned.

In the absence of the Healthcare Professionals Forum, the Board engages clinical professionals through its clinical Executive Directors (Medical, Nursing and Midwifery, Therapies and Health Sciences and Public Health), and existing management groups such as the Heads of Nursing and Midwifery Group and the Heads of Therapies. The Health Board also engages with GPs through its cluster arrangements, other primary care contractors through established forums and with many representative and

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regulatory bodies. Progress will be made in 2025/2026 to establish the Healthcare Professionals Forum.

The Health Board has determined that it considers it has more effective mechanisms to engage with partners and stakeholders through robust local partnership arrangements which make best use of the coterminous relationship between the Health Board, Local Authority and third sector umbrella body, PAVO. This includes the Powys Public Service Board, Board to Cabinet Forum and Powys Regional Partnership Board.

The Regional Partnership Board (RPB) has well established engagement mechanisms to inform an integrated health and care agenda, with user voice and stakeholder engagement networks in place. The RPB's Engagement and Insight Network also brings together engagement officers from across partner organisations to ensure a co-ordinated and collaborative approach to community engagement. This puts the citizen at its heart, as evidence through a joined-up engagement approach to inform the develop of well-being and population assessments, and the area plan and well-being plan. Constructive relationships have also been in place during the year with Llais.

Given the complex geography of Powys and our dependence on care pathways to multiple acute and tertiary providers outside our borders, we also need to take a bespoke and localised approach to service engagement that works closely with the most relevant stakeholders. For example, focused activity across North Powys as part of our North Powys Wellbeing partnership programme, localised activity in south Powys in relation to temporary changes to stroke services at Prince Charles Hospital, and initial planning in readiness for a formal consultation by Hywel Dda University Health Board on the next steps on their clinical services plan which may impact on some pathways for residents of northwest Powys.

JOINT COMMITTEES

Regular reports on the work of the Joint Committees are provided by the Chief Executive to the Board at each meeting and further information regarding the Joint Committees can be viewed on the Health Board's [website](#).

JOINT COMMISSIONING COMMITTEE (JCC)

The Joint Commissioning Committee (JCC) was constituted as of 01 April 2024. Update and assurance reports from the JCC are reported to Board and of the JCC's Quality and Patient Safety Committee are reported to the Patient Experience, Quality and Safety Committee. The JCC's newly

constituted Planning, Performance and Finance Sub-Committee will be reported to the Delivery and Performance Committee and Planning, Partnerships and Population Health Committee. Further detail about the NHS Joint Commissioning Committee can be found here - [Home - NHS Wales Joint Commissioning Committee](#)

PARTNERSHIP AND COLLECTIVE WORKING

Regular reports on the work of the Partnership Boards are provided by the Chief Executive to the Board at each meeting and can be viewed on the Board and Committee pages of the Health Board [website](#). The Planning, Partnerships and Population Health Committee also has a key role in ensuring that the Health Board is working effectively with partners.

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE (NWSSPC)

An NHS Wales Shared Services Partnership Committee (NWSSPC) was established in 2010 and is hosted by Velindre NHS Trust. NWSSP is responsible for exercising shared services functions including the management and provision of Shared Services to the NHS in Wales.

More information on the governance and hosting arrangement of these committees can be found in the Health Board's Standing Orders on the Health Board [website](#).

POWYS COUNTY COUNCIL

Powys Teaching Health Board and Powys County Council have a series of overarching Section 33 agreements through which the organisations manage joint arrangements for Care Homes, the Community Equipment Service, Glan Irfon, Reablement Services and Substance Misuse. In addition to Section 33 agreements, a Memorandum of Understanding is in place regarding services for Carers and there are a number of key areas where there is integrated working. These include Mental Health services, services for people with learning disabilities, older people, and children. Oversight arrangements of Section 33 agreements are provided by the Joint Leadership Team between the Health Board and County Council.

BOARD TO CABINET FORUM AND JOINT LEADERSHIP TEAM

Powys was made a region in its own right under Part 9 of the Social Services Wellbeing (Wales) Act 2014. In light of this and combined with the requirements of the Well-being of Future Generations Act (Wales) 2015 and the Social Services Wellbeing (Wales) Act 2014, together with the collective drive towards increased integration between the two organisations, in

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February 2016, PTHB and Powys County Council established a Joint Partnership Board (JPB). When reviewing the terms of reference for the JPB it was agreed to replace and extending the functions of the JPB with a Board to Cabinet Forum and Joint Leadership Team arrangement. The new arrangements were implemented in January 2024 and agreed their terms of reference at their first meetings in March 2024.

The Joint Leadership Team meets monthly to consider matters of common operational concern and engender closer working arrangements between the Health Board and the County Council.

The senior membership of the Board to Cabinet Forum met in November 2024 noting the wider membership of the group was too large to be an effective fora and requested that the Terms of Reference be reviewed to facilitate occasional meetings of the whole Board to Cabinet Forum and more frequent meetings of the senior membership of the Forum. The group considered common matters including future sustainability and patient flow.

POWYS PUBLIC SERVICE BOARD

The Public Service Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Powys to meet the needs of Powys citizens present and future. The aim of the group is to improve the economic, social, environmental, and cultural well-being of Powys. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan. The Well-being Plan which has been developed through extensive engagement sets out four local objectives for the Powys we want by 2040.

The Health Board contributes to achieving these objectives through the delivery of 'A Healthy Caring Powys' and the Integrated Medium-Term Plan. The PSB has set out its Well-being Plan 12 well-being steps that we will concentrate on to contribute achieving the four local objectives. These steps are those where the biggest difference can be made by developing solutions together.

The PSB reports annually outlining progress and next steps. The PSB annual reports can be found here: [Powys Public Service Board – Our Annual Progress Report – Powys County Council](#) and agendas and papers can be accessed [here](#).

POWYS REGIONAL PARTNERSHIP BOARD

The Powys Regional Partnership Board (RPB) was established under the Social Services and Well-being (SSWB) (Wales) Act 2014 in April 2016.

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The RPB brings together a range of public service representatives including Powys County Council, the Health Board, third sector, citizens, and other key partners, to promote effective working together better to improve health and wellbeing in Powys.

The RPB identifies key areas of improvement for care and support services in Powys. The RPB has also been legally tasked with identifying integration opportunities between social care and health. This has been achieved through building on years of joint working and through the development of 'A Healthy Caring Powys' which has identified key priorities. The key opportunities for integrated working identified, and the actions to be taken in support of them are outlined in the Area Plan and focuses on 'Delivering the Vision'. Priorities have been identified as a Focus on Well-being, Tackling the Big 4 (Cancer, Cardio-vascular diseases, respiratory diseases, and mental health), Early Help and Support and Joined up Care. The Regional Partnership Board is currently overseeing a major integrated project in North Powys providing a new model of care jointly for health and social care and extending to include supported accommodation and primary education.

Putting people and what matters to them at the centre of health and care services is core to the RPB. The RPB oversees the delivery of this in Powys, which is done through its programmes: Start Well, Live Well, Age Well as well as some other work which cuts across all of these.

The Board's priorities are set out in the Powys Area Plan – 'A Healthy Caring Powys'. Some of the Board's responsibilities include making sure resources are available, that people remain independent for as long as possible, and that health and care services are fully joined up.

To help make this happen, the RPB also has responsibility for allocating funds from Welsh Government's Regional Integration Fund (RIF), which it uses to support key priorities.

Further information regarding the RPB can be accessed at: [Health And Wellbeing | Powys Regional Partnership Board | Wales \(powysrpb.org\)](https://powysrpb.org)

MID WALES JOINT COMMITTEE FOR HEALTH AND CARE

Following the Welsh Government's formal recognition of mid Wales as a designated planning area, the Mid Wales Healthcare Collaborative transitioned to the Mid Wales Joint Committee for Health and Care in March 2018. The Welsh Government's long-term plan for the future of health and social care in Wales, 'A Healthier Wales: Our Plan for Health and Social Care', sets out the long-term future vision of a 'whole system approach to

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a health and social care' which focuses on health, wellbeing, and prevention of illness.

The Mid Wales Joint Committee supports this direction of travel, and its Strategic Intent sets out what we will do to ensure there is a joined-up approach to the planning and delivery of regional solutions across organisational boundaries.

The Board receives reports from the Mid Wales Joint Committee as part of the partnership assurance arrangements.

Further detail on the Mid Wales Joint Committee can be found [here](#).

THE CORPORATE GOVERNANCE CODE

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017).

The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies.

The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include self-assessment, internal and external Audit, and independent reviews.

The Board complies with the relevant principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

As reported in previous Annual Governance Statements, the system of internal control operating across the Health Board is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of policies, aims and objectives of the Health Board, to evaluate the likelihood of those risks being realised and to manage them efficiently, effectively, and economically. I can confirm the system of internal control has been in place at the Health Board for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

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The Board is accountable for maintaining a sound system of internal control which supports the achievement of the organisation's objectives. The system of internal control is based on a framework of regular management information, administrative procedures including the segregation of duties and a system of delegation and accountability. It has been supported in this role by the work of the committees, each of which provides regular reports to the Board, underpinned by a sub-committee structure, as shown in Figure 1 of this statement (page X).

CONTROL FRAMEWORK

The Board collectively has responsibility and accountability for the setting of the organisation's objectives, defining strategies to achieve those objectives, and establishing governance structures and processes to best manage the risks in accomplishing those objectives.

As Accountable Officer, I have overall responsibility for risk management and report to the Board on the effectiveness of risk management across the Health Board. My advice to the Board has been informed by executive officers and feedback received from the Board's Committees, in particular the Audit, Risk and Assurance Committee and Patient Experience, Quality and Safety Committee.

The Executive Committee (Committee of the Board, as per page X) meetings present an opportunity for executive directors to consider, evaluate and address risk, and actively report to the Board and its committees on the organisation's risk profile.

The Health Board's lead for risk is the Director of Corporate Governance / Board Secretary, who is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Risks are assigned to Directors to lead the organisational response.

Emergency plans and business continuity arrangements have been in place for the duration of 2024/2025, in accordance with the Health Board's statutory duties under the Civil Contingencies Act 2004 and Emergency Planning Guidance as issued by Welsh Government. The organisation continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response to system pressures including our enhanced status of monitoring and escalation. It has been necessary to ensure that this is underpinned by robust risk management arrangements and the ability to identify, assess, and mitigate risks which may impact on the ability of the organisation to achieve its strategic objectives.

THE RISK MANAGEMENT FRAMEWORK

The Health Board's Risk Management Framework forms a key part of the governance framework and aims to ensure the Health Board is able to identify, evaluate and effectively manage its risks in order to increase the probability of success and reduce the likelihood of failure.

Our risk management framework clearly sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in the organisation. It clarifies roles and responsibilities, communication, escalation of risks and reporting lines.

It has been developed to create a robust risk management culture across the Health Board by setting out the approach and mechanisms by which the Health Board will:

- ensure that the principles, processes, and procedures for best practice risk management are consistent across the Health Board and are fit-for-purpose;
- ensure that risks are identified and managed through a robust organisational Assurance Framework and accompanying infrastructure of risk registers;
- embed risk management and established local risk reporting procedures to ensure an effective integrated management process across the Health Board's activities;
- ensure that strategic and operational decisions are informed by an understanding of the organisation's risks and their likely impact;
- ensure that risks to delivery of the Health Board's strategic objectives are proactively managed;
- manage the clinical and non-clinical risks facing the Health Board in a co-ordinated way; and
- keep the Board and its Committees suitably informed of significant risks facing the Health Board and associated plans to treat risks.

The Risk Management Framework sets out a multi-layered reporting process. It has been developed to help build and sustain a culture that uses risk to inform decision making, encourages appropriate risk taking, and encourages organisational learning in order to continuously improve the quality of the services provided and commissioned and provide greater assurance to our stakeholders.

In year the Health Board has further strengthened its oversight and assurance of its risk management arrangements. In March 2025 Board approved a revised Risk Management Framework, the main update was to the structure deployed by the Health Board to manage risk. This included the closure of current Corporate Risk Register from May 2025, 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 and reported to the Board for awareness. This creation of an additional risk register focused on

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significant operational risk is intended to 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.

The Risk Management Framework also sets out the ways in which risks will be identified, assessed, treated, monitored and reporting in alignment with the Orange Book 2023. The Risk Management Toolkit was developed to assist risk owners in the day-to-day identification, assessment, and management of risk. This is supported with training, support and advice from the Health Board's Corporate Governance Team who endeavor to facilitate a risk aware culture by effectively engaging with services to embed the risk management framework and process. Generic Risk Management Training is available to all staff via the Electronic Staff Record (ESR). Tailored Health Board specific training is provided to the Risk and Assurance Group on an annual basis and to directorates/services upon request.

In 2025/2026 work will continue to be undertaken by the Corporate Governance Team to develop comprehensive risk management training materials in support of the newly approved Risk Management Framework and introduction of the Datix Cloud Risk Management Module as the organisation's platform for managing risk. Engagement will also continue to Executive Directors and other senior leaders to identify directorates or services who would benefit from tailored risk management training and support in order to develop a risk management training plan.

The Risk Management Framework is available on the Health Board's website [here](#).

MANAGEMENT OF RISKS DURING 2024/2025

Strategic Risks

Strategic risks are those risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence.

Strategic risks are recorded in the Board's Corporate Risk Register (CRR), which provides an organisational-wide summary of significant risks facing the Board. Throughout 2024-25 the criteria for a risk to be included in the Corporate Risk register was:

- the risk must represent an issue that has the potential to hinder achievement of one or more of the Health Board's strategic objectives;
 - the risk cannot be addressed at directorate level; and/or
 - further control measures are needed to reduce or eliminate the risk;
- A considerable input of resource is needed to treat the risk (finance,

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people, time, etc.).

A fundamental review of the CRR was undertaken in 2024/2025 following the Boards approval of the 2024/25 Integrated Plan, in order to ensure that the register reflected consistently the risks to delivering the Health Board's strategic objectives. The Corporate Risk Register was reviewed on a continuous basis throughout 2024/25 with updates reported to each meeting of the Board via the Executive Committee and Risk and Assurance Group. Key themes of the Corporate Risk Register are as follows:

- financial sustainability and use of resources
- sustainability of services throughout the health and care system
- the ongoing need to monitor quality, defined as safety, effectiveness and experience and the potential for harm to patients
- the risk represented by ongoing challenges in recruiting and retaining staff
- the potential for care to be compromised due to the Health Board's estate not being fit for purpose
- the ever-present risk of a cyber-attack;
- the risk of a national power outage;
- risk in relation to alignment with National Digital Programmes; and
- the risk presented by a significant public health event/emergency.

EMBEDDING EFFECTIVE RISK MANAGEMENT

Embedding effective risk management remains a key priority for the Board as it is integral to enabling the delivery of our objectives, both strategic and operational, and most importantly to the delivery of safe, high-quality services.

Since March 2021 Internal Audit has provided reasonable assurance each year in relation to the Health Board's arrangements for Risk Management and the Board Assurance Framework. The draft report for 2024/25 continues to provide reasonable assurance, with either reasonable or substantial assurance provided across all five audit objectives.

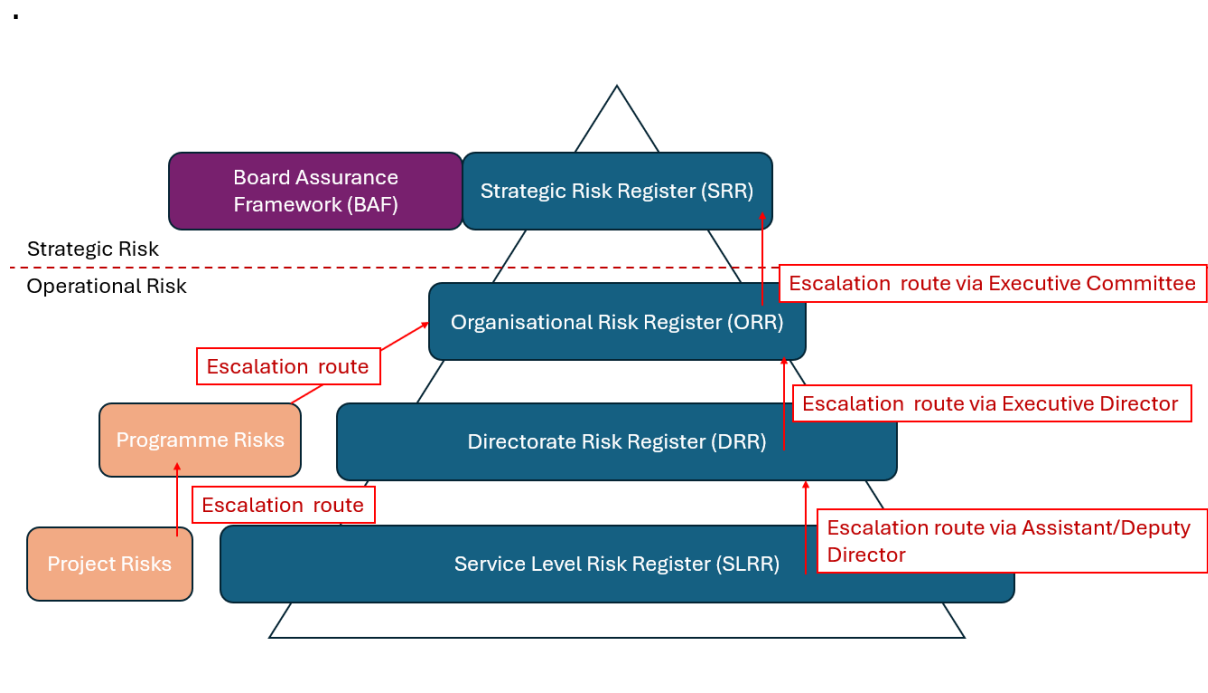
The Risk Management Framework outlines the roles and responsibilities for risk management, the organisational risk management structure, Corporate and Directorate monitoring and reporting lines, the Board's approach to risk appetite and risk management processes including the escalation, consolidation, and aggregation of risks. The Framework (alongside the Risk Appetite Statement) is reviewed on an annual basis by the Board. This was undertaken in Quarter 4 of 2024/2025 and a revised version was approved by the Board in March 2025 to include the following amendments:

- clarify processes in relation to escalation and de-escalation;

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- ensure currency with revised organisational structures, systems and processes; and
- align with established risk management guidance and best practice.
- recognise the transition to the Datix Cloud Risk Management module as the organisational system for recording and reporting on risk in 2025/26
- 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 as per the figure included below.

A revised Risk Toolkit is in development following approval of the updated Risk Management Framework, and is due to be presented to the Audit, Risk and Assurance Committee in July 2025 for approval. The updated Toolkit will then be rolled out to staff across the organisation in conjunction with a training plan in support of the transfer to the Datix Cloud Risk Management System.



As a result of the pandemic the review of the Board Assurance Framework (BAF) was paused in 2020/2021. We recognise the importance of the BAF in the risk environment. In May 2024 the Board approved a revised BAF, work will continue into 2025/26 to develop and embed BAF.

The Risk and Assurance Group met five times in 2024/2025, the work of this group will continue to operate in 2025/26 to enable coordination of the achievement of the Risk Management Framework's objectives through the

organisation's directorates, by embedding risk management and establishing local risk reporting procedures. This will enable the effective integrated management of risk and assurance. The Group will also seek to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the BAF.

Consultation with internal and external stakeholders and partners is an important element of the risk management process. Communication and engagement vary depending upon the nature and severity of the risk. For example, our risk related to accessing planned, secondary, and specialised care requires a partnership approach and is dependent on working closely with key commissioners in both NHS Wales and NHS England. Engagement of stakeholders has also taken place through multi-agency partnership working. The Regional Partnership Board, Joint Partnership Board and Public Services Board is part of the Health Board governance structure that helps to support the management of risk facing the organisation through collective dialogue.

RISK APPETITE

The Board's Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a 'live' document that is regularly revised and modified, so that any changes to the organisation's strategies, objectives, or its capacity to manage risk are properly reflected. The Risk Appetite Statement is composed of two parts: a general written statement, supported by the cumulative risk appetite categories.

In updating and approving its Risk Appetite Statement, the Board considered the Health Board's capacity and capability to manage risk.

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

In 2024/2025 the Board undertook a fundamental review of its Risk Appetite Statement in response to the increasingly complex and significant challenges and opportunities facing the Health Board. In recognising the risks inherent in healthcare services, the risk appetite statement starts at the basis of a low appetite. In 2021/2022 the Risk Appetite Statement was developed to reflect an increased appetite in relation to innovation, strategic change and partnership risks. In 2024/2025 it was agreed that appetite would also be increased in regard to reputation and public confidence, and financial sustainability risks, which may be necessary to support

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achievement of the Board's ten-year strategy 'A Healthy, Caring Powys'.

The whole Board were involved in preparing the statement and the complexities in relation to the establishment of the Board's appetite in respect of quality in the context of current and future system pressures and financial outlook was recognised. Ongoing monitoring of the external environment within which the Health Board operates, and the internal risk environment will continue to be monitored, and the Risk Appetite Statement adjusted as required to provide clarity and granularity to aid effective decision making and the treatment of risk.

The following risk appetite levels, have been included and have been used as the basis in determining the appetite levels set out in the Statement:

Risk Appetite	Description
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 virtually no inherent risk.
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.
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.
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 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.

The thresholds provided with the Risk Appetite Statement are provided below:

Risk Category	Description
APPETITE FOR RISK: Averse	
Safety	We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of, incidents of avoidable harm to our patients or staff. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.
APPETITE FOR RISK: Minimal	
Quality	The provision of high-quality services is of the utmost importance for the health board. The Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a low appetite for risks which may compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact on quality could adversely affect outcomes and experiences of our patients, service users and communities.
APPETITE FOR RISK: Cautious	
Regulation & Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.
Performance	We have a low-moderate risk appetite for risks which may

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Risk Category	Description
and Service Sustainability	affect our performance and service sustainability. We are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19, workforce availability and limited resources) which may result in lower performance levels and unsustainable service delivery for a short period of time.
Workforce	The Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work.
APPETITE FOR RISK: Open	
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours Framework, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. In light of the challenging environment related to public sector funding, we have a more open appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory and financial environment.
Financial Sustainability	We recognise we have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to delivery of core patient services supporting innovation and strategic change.

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Risk Category	Description
	We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.
Partnerships	The health board is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a high risk appetite for partnerships which may support and benefit the patients in our care. For example, the health board has a high appetite for risks associated with innovation and partnership with the third sector, industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the health board will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Medium Term Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

THE HEALTH BOARD'S RISK PROFILE

As can be seen from the Heat Map at Figure 7, at the end of March 2025 a number of key risks to the delivery of the Health Board's strategic objectives had been identified. Full details of the controls in place and actions taken to address these risks can be found in the Corporate Risk Register on the Health Board's website [here](#).

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Figure 7: Strategic Risk Heat Map

In-Committee Risks (Private)		<i>CRR 008 A cyber-attack results in significant disruption to services and quality of patient care (Risk Score: L5 x I4 = 20)</i> <i>CRR 011 A national power outage results in significant disruption to services and the quality of patient care (Risk Score: L4 X I5 = 20)</i> <i>CRR 012 - National Digital Programmes do not always meet Powys requirements (Risk Score L4 X I4 = 16)</i>					
Impact	Catastrophic	5				- CRR011 (Power outage) - CRR002 (Financial resources) - CRR007 (Primary Care)	
	Major	4			CRR001 (Financial forecast)	- CRR003 (Resource allocation) - CRR004 (Demand - provider) - CRR006 (Workforce) - CRR009 (Estates) - CRR010 (Public Health Emergency) - CRR012 (National Digital Programmes)	- CRR005 (Demand – commissioner) - CRR008 (Cyber-attack)
	Moderate	3					
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Likelihood				

An overview of the key (catastrophic) risks (i.e., those in the catastrophic section of the Heat Map) and actions taken to manage the risks are provided in Figure 8.

Figure 8: Key Risks and Controls

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CRR 002 – Risk Score 20 - the Health Board fails to manage its financial resources in line with statutory requirements over a three-year period 2024-2027.

CONTROLS IN PLACE & ACTION TAKEN

- Clear Financial Plan included in revised IMTP Submission with recurrent mitigating actions of £9.9m.
- Additional control - Introduced joint CEO and FD finance only focussed meetings with each Exec Director individually.
- Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.
- 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 D&P Committee to track actions to improve.
- Investment Benefits Group to increase its focus on benefits realisation alongside supporting the VBHC approach.
- Regular communication and reporting to Welsh Government and NHS Executive (Financial Planning and Delivery Directorate) regarding the impact of pressures on Financial Plan and underlying position.
- An organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings and financial sustainability (Route Map to Sustainability).

IMPROVEMENT ACTIONS

- Executive Directors are focussed on delivery of £9.9m recurrent mitigating actions targeted for 2024/25.
- Revisit the assessment of cost pressures in the Financial Plan for 2024/25.
- As part of financial planning, an organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings and determine Routemap to Financial sustainability.

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CRR 007 – Risk Score 20 - Demand for primary care services is higher than the capacity available. Related workforce challenges may lead to services becoming unsustainable.

CONTROLS IN PLACE & ACTION TAKEN

- 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.
- National Contract Assurance Framework in place – Desktop reviews and 5 practice visits completed. Practice Improvement plans being developed, for PTHB review mid-March. Identified improvements will carry forward into Q1 25/26
- 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
- New contract with Shropdoc being progressed to be implemented from 01/04/25 to 05/01/26. Assessment of delivery of current OOH service provision will inform future specification to re-tender for an OOH service provision from 05/01/26. The commissioning arrangement will be via an APMS arrangement. Resolve and secure current commissioning arrangements with SBUHB to ensure ongoing provision of OOH cover for Ystradgynlais patients and Ystradgynlais Community Hospital. Quarterly Performance Reviews continue to monitor out of hours services.
- 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

IMPROVEMENT ACTIONS

- To complete GP Practice visits following outcome of Desktop Reviews. These will take place in Q4
- Review and assess completion of General Practice Improvement Plans
- To undertake GDS End of year review visits
- Undertake GDS Mid-Year Review visits
- Review of GMS sustainability matrix
- Implementation of additional HB salaried GDS service in Newtown
- Implementation of mobile dental clinic in Hay on Wye
- Relocated Mobile Dental clinic to Bronllys site.
- Offer new recurrent GDS access opportunities across Powys via a procurement process for 25/26
- Progress new OOH contract Shropdoc from 01/04/25 – 05/01/26
- Assessment of delivery model of current OOH service provision
- Commence Procurement for future provision of OOH services

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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. Next location for mobile will be Brecon from March onwards (currently in Hay on Wye). Recurrent contract adjustments planned for 25/26 which will release funding to potentially secure future access provision via a procurement process, including orthodontic increased provision.

- Ensure future provision of general medical services for patients registered at Rhayader Medical Practice post 30th September 2025

CRR 011 – Risk Score 20 - national power outage results in significant disruption to services and the quality of patient care.

Due to the sensitive nature of this risk, detailed content in relation to controls and improvement actions are not made publicly available.

A full copy of the Corporate Risk register is linked [here](#) - The Board received and reviewed the Corporate Risk register at five meetings of the Board during 2024/2025. As a result of the reviews undertaken by the Executive Committee and the Board, the risk scores for a number of risks changed during the year in the context of the external environment, and other developments such as improvements made to the control process.

As undertaken in 2024/2025, following Board approval of the Integrated Plan for 2025 - 2026 a full review of Strategic Risk will take place to ensure priorities are identified, assessed and mitigating actions established, as well as assurance levels assessed.

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EMERGENCY PREPAREDNESS

The Civil Contingencies Act 2004 and Emergency Planning Guidance issued by Welsh Government, places statutory duties on the Health Board to ensure arrangements are in place to respond to emergencies and major incidents. To meet this duty, the Health Board has a range of emergency response and business continuity plans in place to respond to emergencies and disruption to services. This includes the provision of training and participation in other emergency preparedness events.

Over the last twelve-month period, the Health Board has used the arrangements outlined in our plans to respond to a number of incidents that have impacted on the Health Board's services. The Health Board has also participated in a number of exercises which have taken place to test the arrangements detailed within the Health Board's response plans and procedures.

The Health Board continues to regularly engage and work collaboratively with our multi-agency partners on a wide range of preparedness activities and in response to incidents. This collaboration is achieved through the Dyfed Powys multi-agency Local Resilience Forum, Welsh Government, the NHS Wales Executive and with other NHS Wales organisations through a variety of groups.

To demonstrate compliance with the Civil Contingencies Act, the Health Board is required to submit an assessment on the Health Board's emergency preparedness activities to NHS Wales Executive on an annual basis. The Health Board also produced an Annual Report on Civil Contingencies Planning for the Board.

KEY ASPECTS OF THE CONTROL FRAMEWORK

In addition to the Board and Committee arrangements described earlier in this document, I have worked to further strengthen the Health Board's control framework over the last 12 months. Key elements of this include:

QUALITY GOVERNANCE ARRANGEMENTS, INCLUDING CLINICAL RISKS AND CLINICAL AUDIT PLAN

As an NHS Wales organisation, we have a duty of Quality. Quality Governance arrangements are informed by the expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

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- NHS Wales Quality and Safety Framework

Since the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, we have continued to develop and grow as a quality led organisation. Our Integrated Quality and Performance Framework, including our internal escalation framework has been critical to us developing a more mature culture of learning. This is demonstrated in our Integrated Quality Report and in our Integrated Performance Report, thereby ensuring that quality runs like a golden thread through the Organisation.

Engagement with our citizens and wider communities and working closely with Llais, the Citizen Voice body has been a focused commitment during 2024/25. Our increasing incidences of evoking the duty of candour is evidence of commitment to openness and transparency with people who use our services.

The existing quality governance structure has been maintained. The Patient Experience, Quality and Safety Committee continued to receive reports on assurance and escalated risks linked to patient experience, quality, and safety.

The key aspects of the quality governance arrangements in the Health Board are:

- Commissioning Assurance Framework:
 - Quality
 - Access
 - Cost/Finance
 - Governance & strategic change
- Putting Things Right (Concerns, Incident, Redress and Clinical Negligence)
- Clinical Audit
- Data – CHKS – healthcare intelligence and quality improvement, benchmarking
- External Reviews – e.g. Getting It Right First Time
- Professional practice supervision/regulation
- Staff Surveys
- Organisational Development Framework
- Relationships/Escalations – Care Quality Commission, Healthcare Inspectorate Wales etc

Health and Care Standards and Duty of Quality

The Quality Standards aligned to the [Duty of Quality](#) introduced in April 2023 through the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) set out the expectations for services provided and

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commissioned by Powys Teaching Health Board for local citizens. These standards are an integral pillar of our Integrated Quality and Performance Framework and are fundamental to our quality planning, quality control and quality improvement, ensuring that we operate a Quality Management System across all services in the Health Board, supporting quality governance in all Committees and Board.

Decisions are based on the 12 Health and Care Quality Standards 2023: Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEP) care delivered through: Leadership, Workforce, Culture and Valuing People, Information, Learning, improvement and research, Whole systems approach. The Duty of Quality and Duty of Candour Annual Report will be published after this Annual Report and will be available on the Health Board website.

The diagram below illustrates the standards:



Clinical Audit

For 2024/25 a comprehensive Clinical Audit Plan was developed by the Health Boards service groups and approved by the Patient Experience, Quality and Safety Committee in April 2024.

166 audits covering service improvement, service evaluation, National Audit Programme work and responses to incidents were included in the Clinical Audit Plan.

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Two update and progress reports on the delivery of the Clinical Audit plan were provided in June 2024 and October 2024.

An audit included in the June 2024 report highlighted that the Midwifery service had failed to demonstrate a standard sufficient to qualify for accreditation to the WHO's Baby Friendly Initiative standards. Accreditation is a key objective in this year's annual plan. There will be a repeat audit in 2026-27.

The October 2024 progress report highlighted the work undertaken in identifying children with a significant disability due to Cerebral Palsy who are at risk of respiratory infections. The audit ensured that 12 children with significant gross motor dysfunction had a comprehensive care package in place to reduce the risk of respiratory infection.

In November, the Health Board held its first Audit Hour, a Multi-Disciplinary Team presentation by video link where three members of staff presented their audits including: a systematic review of potential ligature point risks in a Mental Health unit with actions reducing the risk that a client might self-harm, how clinical audit can improve cost management by identifying process weaknesses in Primary Care that result in wasted vaccine doses which led to a nearly 70% reduction in lost doses, and the clinically effective practice around the use of antibiotics. The Audit Hour will continue to be held quarterly over the coming year.

Complaints and Concerns Framework

Compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulation 2011 timeframes have continued to improve throughout 2024/25. Our focus has been on appropriate and proportionate response to concerns, wherever possible responding through the Early Resolution mechanism. The implementation of the Duty of Candour continues to strengthen Health Board processes, influencing our growing maturity as a Learning Organisation.

The Patient Experience, Quality and Safety Committee receives regular reports against the complaints and concerns framework, forming part of the Integrated Quality Report for the organisation. During 2024/25, we have seen our duty of candour incidents rise which signals both an open and transparent culture of learning but also an increased confidence and capability of our staff to enact the duty.

These and further information on Putting Things Right can be found on the Health Board [website](#).

Mortality Reviews

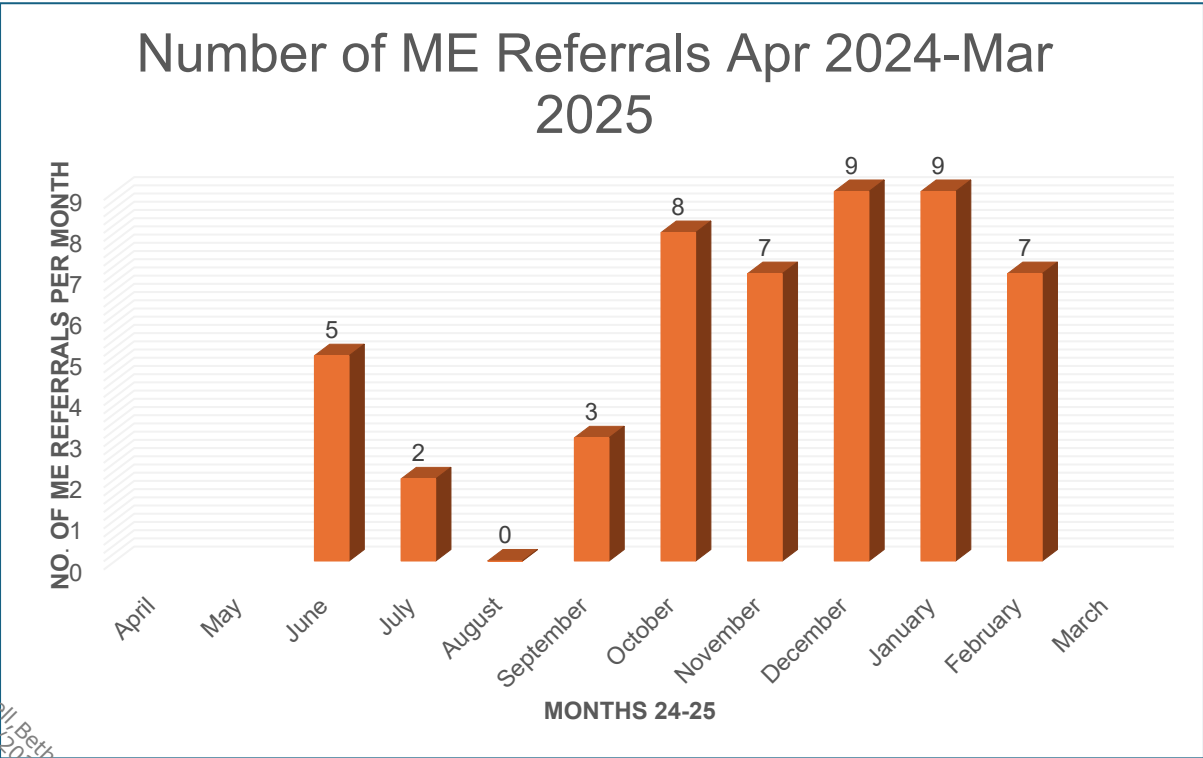
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In May 2024, the PTHB Mortality Review (MR) process was strengthened in response to further roll out of the Medical Examiner (ME) service. The ME service now provides external scrutiny of all deaths of Powys residents. All referrals raised by the Medical Examiners are monitored by the Bereavement Clinical Lead ahead of review by the Multi-Disciplinary Team (MDT) Review Panel. This is a diverse group of professionals, including both clinical and non-clinical staff, with representation from the quality, safety, and risk management teams ensuring a holistic approach.

The panel may recommend further investigation in some cases and considers what can be learned from each case. Feedback is provided to teams where important learning is identified, and action plans are drawn up when need for improvement is identified.

All decisions and actions stemming from the Mortality Review process are recorded in the All-Wales Learning from Mortality Reviews System, ensuring that the learning is tracked and accessible for future reference and improvement.

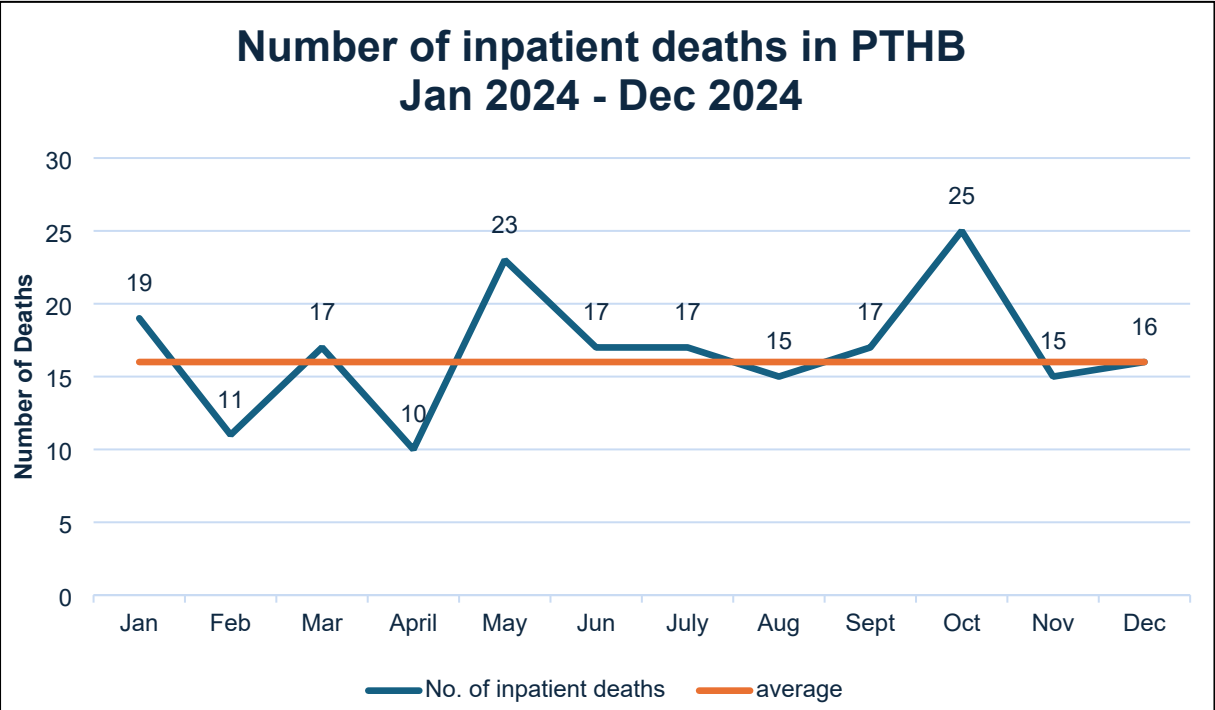
Since the expansion of the ME service in September 2024 there has been a marked increase in the number of reports received into the Health Board. The data indicates that the number of reports has nearly doubled compared to previous months.



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While the number of reports has increased, it is important to note several key points:

- During this period, all the referrals received by the Health Board were classified as of no or low concern and did not require further investigation.
- A number of the issues raised relate to care provided in other Health Boards (15 in total). Detail from these reviews is shared with the commissioning team to be fed back in commissioning quality discussions with other Health Boards.
- 11 of the reports received involved Nursing Homes. In these cases,



any learning is referred to the Local Authority, who commission the care for feedback and support of any actions.

The total number of deaths among Powys residents from 1 January 2024 – 31 December 2024 was 2,107. Of these 1,511 occurred in the community while 195 were inpatient deaths within PTHB wards. The average number of in-patient deaths in PTHB community hospitals for 2024 is 16 patients per calendar month. This is lower than 2022 and 2023 which saw averages of 21 patients per calendar month.

The remaining deaths took place in neighbouring Health Boards across England and Wales.

Next Steps include strengthening communication with External Health Boards and Nursing Homes, which will be facilitated through commissioning quality processes and by working collaboratively with the local authority, and Implementation of Action Plans and Learning from Mortality Reviews which will inform future clinical audits.

Learning From Experience Group

The Learning from Experience group continues to develop. During 2024-25, it has considered several key items; the newly published All Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy, learning from the roll out of the Medical Examiner service, learning from clinical audits and reflections and learning from quality improvement initiatives in the Mental Health team. For the latter, it was suggested that elements of improved practice be promoted across the Health Board as examples of good practice to be adopted by other service groups.

Work was planned to strengthen local induction programmes. This included sharing of key messages from learning form events.

Work has also commenced to review how information is shared most effectively. Whilst tools such as the 7 minute briefing are increasingly used, several on line forums are being developed. It is intended that these will help to reach a wider audience.

Plans for next year are to invite the antimicrobial pharmacist to share learning from their important work and to consider how this is promoted across the wider system including primary care and community teams.

EXECUTIVE PORTFOLIOS

In May 2022, the Board approved an updated Scheme of Delegation and Reservation of Powers. This document set out the delegation of responsibility to Executive Directors. The allocation of responsibilities is based on ensuring an appropriate alignment of accountabilities and authority within each Executive Directorate and Executive Director portfolio, and to also ensure that Executive Directorates focus on their core responsibility. Interim arrangements were put in place in 2023 and a full review of the allocation of responsibilities was undertaken in 2024. The revised delegations took effect from May 2024.

An overview of Executive Director portfolios is set out in **Figure 9**.

Figure 9: Executive Portfolios

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Executive Medical Director – Full Year

-Clinical Leadership and Engagement	-Library Services (to 30.04.2024)
-Medicines Management	-Individual Patient Commissioning
-Caldicott Guardian	-Medical Royal College Standards Compliance
-Clinical Audit	-Innovation and Service Improvement
-Medical Legislation & National Policy	-Admission to the performers list
-Professional Medical & Dental Workforce Standards Education, Regulation and Revalidation	-Human Tissue Issues
-Blood Safety & Quality	-Research and Development
-Organ Donation	-Resuscitation
-Clinical Networks	-Mortality Review
-NICE compliance	The following item from 01.05.2024 to 31.05.2025: Chief Clinical Informatics Officer

Executive Director of Nursing – From 01.04.2024 to 30.04.2024

Executive Director of Nursing, Quality, Women and Family Health from 01.05.2024 – 31.03.2025

-Professional leadership of Nursing and Midwifery, including standards, education, regulation, revalidation, and supervision of midwives	-Funded nursing care and continuing health care strategy
-Quality, Patient Experience & Satisfaction Raising Concerns and Putting Things Right	-Safeguarding Adults and Children
-Patient Safety Alerts	-Nutrition & Hydration
-Decontamination	-Deprivation of Liberty Safeguards
	-Infection Prevention and Control
	-Children and Young People Services
	-Volunteering
	-Carers (to 30.04.2024)

Executive Director of Finance, Information and IT 01.04.2024 – 30.04.2024

Executive Director of Finance, Capital and Support Services 01.05.2024 – 31.03.2025

-Statutory Financial duties including annual accounts	-Liaison with External Financial Auditors
-Financial Planning	-Asset Accounting
-Financial Management, monitoring and reporting	-Information Governance (to 30.04.2025)
-Financial systems and controls	<u>The following items from 01.04.2024 – 29.09.2024</u>
-Procurement	

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- Counter Fraud
- Charitable Funds accounting
- HCRW & CHC financial arrangements
- Delivery of IM&T strategy and services (to 30.04.2024)
- Provision of clinical and management information systems, ICT Infrastructure, and telephony (to 30.04.2024)
- Business intelligence, data quality & clinical coding (to 30.04.2024)
- Provision of Financial Services to Executive Directorates

- Primary Care Out of Hours arrangements
 - Operationalisation of continuing health care
 - Primary Care contractor performance management
 - Primary Care Development, including Clusters
 - Removal of violent patients from GMS services
 - Enhanced Services
- The following items from 01.05.2024:
Responsibility for Estates, Facilities and Support Services (see below)

Executive Director of Therapies and Health Science – 01.04.2024 – 30.04.2024

Executive Director of Allied Health Professions, Health Science and Digital 01.05.2024 – 31.03.2025

- Professional leadership of Therapies and Health Sciences
- Lead for Radiology, radiography, stroke and Neurological services
- Medical Devices
- Human Rights

The following items from 01.04.2024 – 30.04.2024:

- Chief Clinical Informatics Officer
- Facilities and Support Services - Logistics
- Health and Safety

The following items from 01.05.2024 – 31.03.2025

- Delivery of IM&T strategy and services
- Provision of clinical and management information systems, ICT Infrastructure, and telephony
- Business intelligence, data quality & clinical coding
- Library Services

Executive Director of Public Health - Full Year

- Health Improvement Strategy
- Health Needs Assessment
- Public Health Planning
- Public Health Monitoring & Surveillance
- Outbreak Control
- Civil Contingency, Emergency Planning and Business Continuity

- Armed Forces and Veterans
- Prudent Health and care
- Well-being of Future generations Act
- Professional Leadership of Public Health workforce
- Executive Director of Public Health Annual Report

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-Provision of Public Health Advice

The following item from
01.05.2024 – 31.03.2025
-Carers

Executive Director of Workforce and Organisational Development –
01.04.2024 – 30.04.2024

Executive Director of People and Culture – 01.05.2024 – 31.03.2025

-Employment and staff relations & engagement
-Workforce Planning
-Workforce Policies and Practices
-Employee Health and Well-being including Occupational Health Services
-Trade Union Partnership arrangements
-Workforce Information Management Systems
-Values and Standards of Behaviour Framework
-Raising concerns
-Disclosure and Barring Arrangements

-Tackling Violence and Aggression
-Employee Record Management
-Hosted Functions Lead
-Equality and Diversity
-Welsh Language provision
-Hosting arrangements HCRW
-Volunteering

The following items from
01.05.2024-31.03.2025
-Health and Safety
-Library Services
Responsibility for Strategic Improvement and Transformation (see below)

Executive Director of Operations, Community Care and Mental Health –
01.03.2024 to 29.09.2024

Executive Director Primary Care, Community and Mental Health –
30.09.2024 – 31.03.2025

-Delivery of primary and community services
-Integration agenda
-Access of RTT targets, and oversight of ambulance service performance
-Oversight of Performance of Ambulance Service
-Delayed transfer of care
-Operationalisation of Medicines Management
-Operationalisation of Continuing Health Care

The following items from
30.09.2024-31.03.2025
-Primary Care Out of Hours arrangements
-Operationalisation of continuing health care
-Primary Care contractor performance management
-Primary Care Development, including Clusters
-Removal of violent patients from GMS services

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-Funded nursing Care

Executive Director of Planning, Performance and Commissioning Full Year

-Commissioning, including performance management of commissioned services & relationship with WHSSC	-Professional leadership of performance management, commissioning, capital estates and service change
-Cross-border healthcare	-Third Sector
-Performance Management	-Planning arrangements

Director of Corporate Governance – Full Year

-Risk and Assurance Framework	-Board Level lead for Communications and Engagement
-Board and Committee arrangements	-Public Inquiries
-Board Development	-Board level Lead for Health Board Charity
-Production of Annual Governance Statement and AGM	-Compliance with national guidance on service delivery change
-Compliance with Standing Orders	-Continuous engagement with CVB on matters relating to service change
-Legislation and Legal Services	<u>The following items from 01.05.2024 – 31.03.2025:</u>
-Use of Common Seal	-Information Governance
-Registers of Interests and Gifts and Hospitality	
-Policies Management	
-Internal and External Audit Liaison	

Associate Director of Capital Estates and Property (overseen by Chief Executive) to 30.05.2024

-Estates including environmental sustainability	-Operational Capital and Estates
-Development and delivery of the Capital Programme	-Senior Responsible Officer for the North Powys Programme
-Climate Change and Decarbonisation	-Operational Capital and Estates
-Agile Working Transformation	

Associate Director of Estates, Facilities and Support Services (overseen by Executive Director Finance, Capital and Support Services) 01.05.2024 – 31.03.2025

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- Estates including environmental sustainability
- Development and delivery of the Capital Programme
- Climate Change and Decarbonisation
- Agile Working Transformation

- Operational Capital and Estates
- Senior Responsible Officer for the North Powys Programme (to 30.04.2024)
- Operational Capital and Estates
- Facilities and Support Services logistics
- Site Leadership and Management

Director of Strategic Improvement and Transformation (overseen by Executive Director of People and Culture) 01.05.2024 – 31.03.2025 (NB role recruited to 14.10.2024)

- Service Improvement
- Transformation and Value

- Senior Responsible Officer for the North Powys Programme

Staff and Staff Engagement

The Local Partnership Forum is a formal advisory group providing opportunity for two-way discussion and collaboration between staff and the Health Board management, ensuring action is considered and taken in response to feedback. Engagement with staff side has been key to ensuring collaboration on range of staffing and well-being initiatives.

A summary of activity includes:

- Executive Director of People and Culture reports and workforce performance reports including:
 - Chat 2 Change
 - Team Climate
 - Internationally Educated Nurses
 - Nurse Retention
 - Employee Wellbeing and Occupational Health
 - Clinical Leadership Immersive Programme
 - Vacancy assessment tool
 - Welsh Language sessions for primary care and patient services staff
- Updates on the implementation of the non-pay parts of the 2022-2024 collective agreement
- A focus on the workforce elements of the Integrated Plan
- Business Efficiencies and improvements
- NHS Staff Survey results
- Agile Working Policy
- Updates on Temporary Service Change
- Lessons learnt on Section 33 agreement

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- Update on the Admin Review
- The approach to the 2025/2026 Annual Plan
- Discussion on various topics including Band 2 and Band 3 Nursing Workforce and Speaking Up Safely

INFORMATION GOVERNANCE & RECORDS MANAGEMENT

Information Governance (IG) is the way in which the Health Board manages all information personal, and sensitive information relating to our patients, services users and employees. It sets out the requirements and standards that the Health Board must achieve to ensure it fulfils its obligations to handle information securely, efficiently, and effectively in line with legislation.

Records Management refers to the process of organising and managing records (both paper and digital) throughout their lifecycle, ensuring their accessibility and usability for efficient and effective decision making.

GOVERNANCE ARRANGEMENTS

Well-established governance arrangements are in place to ensure that all information created is managed in line with all relevant information governance law, regulations, records management standards and Information Commissioner Office (ICO) guidance. These arrangements include:

- An Audit, Risk and Assurance Committee who help support and drive the Information Governance and Records Management agenda.
- The information governance team whose role it is to support and drive the board agenda and provide assurance that effective information governance and records management best practice mechanisms are in place to maintain accountability.
- a Caldicott Guardian who is the responsible person for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing.
- a Senior Information Risk Owner (SIRO) who is responsible for setting up an accountability framework within the organisation to achieve a consistent and comprehensive approach to information risk assessment.
- a Data Protection Officer whose role it is to ensure the Health Board is compliant with data protection legislation.
- a Chief Clinical Information Officer whose role it is to ensure strategic alignment between clinical requirements and IT systems.
- Assistant Director of Digital Technology and Data Operations whose role and Team collaborate with Information to ensure compliance with relevant legislation and standards (UK GPDR and NIS Regulations)

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- Information Asset Owners (IAOs) are in place for all service areas. They have been assisting the IG team in a programme of compiling a full asset register for the health board, where all information asset registers are in the process of being uploaded. The roles are also acting as Information Governance leads to champion data protection within their service areas.
- Information Governance and Records Management Group which aims to promote good Information Governance and Records Management practice across the Organisation and support and advise Information Asset Owners in their management of assets
- Digital Governance Board - a group of digital experts who review and approve the procurement of any local new or existing digital solution to ensure compliance with relevant legislation and standards (UK GDPR and NIS Regulations) thus avoiding PTHB being put at un-necessary risk, such as from a Cyber Attack, loss of data, incident/breach of patient's data, fine from the information Commissioner's Officer (ICO) or National Cyber Security Centre.
- National Collaboration – NHS Wales IG and Records Management experts work collaboratively on national programmes to ensure consistency and processes in IG and Records Management are streamlined, align to the strategic direction of NHS Wales and their local organisations plans. This has proven to be extremely effective and maintains the stance that patient care is at the heart of all the work we do.

The IG Team have responsibilities for in the following areas:

- Records Management both health and corporate,
- Compliance with the Freedom of Information Act including co-ordinating FOIA requests and the Publication Scheme,
- Compliance with the Accountability Principle within the UK General Data Protection Regulation and having appropriate technical and organisational measures in place to meet these requirements such as:
 - Adopting and implementing data protection policies and procedures;
 - Taking a 'data protection by design and default' approach;
 - Putting written contracts in place with organisations that process personal data on our behalf;
 - Maintaining documentation of our processing activities;
 - Implementing appropriate security measures;
 - Recording and, where necessary, reporting personal data breaches;

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- Carrying out data protection impact assessments for uses of personal data that are likely to result in high risk to individuals' interests;
- Appointing a data protection officer; and
- adhering to relevant codes of conduct and signing up to certification scheme
- Access to Personal information requests (Subject Access Requests), 3rd party requests from Police, Courts etc
- Risk Management
- Delivering training, advice and support to PTHB staff

Our Accountability, Performance and Assurance is demonstrated and maintained by:

- Quarterly Assurance and Performance reports to Audit, Risk and Assurance Committee, including key performance indicators.
- Completion of the annual NHS Wales Information Governance Toolkit
- Detailed operational IG and Records Management work plan.
- A suite of IG, Records Management and information security policies, procedures, and guidance documents.
- Up to date and informative Intranet pages for the Health Board's employees with guidance and awareness.
- Implementing a comprehensive IG and Records Management Training Needs Analysis for all staff
- Staff undertaking a NHS Wales IG, Records Management and Cyber Security Mandatory Training module which all new starters are expected to complete within the first 6 weeks of starting and every 2 years thereafter. A process is also in place to target any staff non-compliant with their mandatory IG, Records Management and Cyber training.
- Reviewing and investigating all IG related incidents (Personal Data breaches), including proactive reporting to the ICO if applicable.
- Weekly auditing and monitoring take place of Health Board's Clinical systems for inappropriate accesses to patients' personal data through the National Intelligent Integrated Audit Solution (NIIAS) platform.
- An Information Asset Register (IAR) used to capture and manage information assets across the Health Board and is also used as the Health Board's Register of Processing Activities.
- Having a Data Protection Officer, SIRO and Caldicott Guardian who work collaboratively to ensure compliance.

We have continued to reinforce awareness of key principles of data protection legislation as well as other applicable standards. Ways in which we reinforce awareness and maintain our accountability with UK GDPR are:

- Involvement in assuring new and existing systems via Digital Governance Board
- Collaborating with services to identify and develop information sharing agreements

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- Data Protection Impact Assessments
- Breach Management by reviewing and monitoring IG related incidents
- Providing tailored training sessions.
- Issuing tailored alerts
- Bespoke training sessions
- Updating the internal and external webpages
- Providing advice as part of digital transformation
- Better presence in meetings/groups
- Close working relationships with colleagues throughout Wales and across the border through national groups.
- Engagement with staff and monitoring compliance with mandatory IG and Records Management training

As of 31 March 2025, staff compliance with this training was at 77.30% and work will continue to support staff to ensure compliance improves as compliance has dropped below the NHS Wales benchmark of 85%.

The Health Board continues to be proactive in using the NHS Wales Information Governance and Records management support framework to ensure consistency of policy, standards and interpretation of the law and regulation across NHS Wales's organisations. This has proven to be most beneficial.

PERSONAL DATA INCIDENTS

A personal data incident is a breach of security leading to the accidental or unlawful destruction, loss, alteration, un-authorised disclosure of, or access to personal data. In line with General Data Protection Regulation (GDPR) requirements, all personal data incidents must be reviewed daily, and any incidents deemed significant must be formally reported to the ICO within 72 hours, no personal data incidents were reported to the ICO. Figures on the number of IG related breaches are reported to our Audit, Risk and Assurance Committee.

Two IG related complaints were received relating to how their requests to exercise their rights under UK GDPR were handled. Following a response, no further action was taken.

Breach reporting - During 2024/25, there were 172 information governance related incidents recorded by staff on the Health Board's DATIX Incident Reporting System: an increase of 28 from the previous year. These incidents are of varying level of concern such as mis-directed emails, records management, physical security related incidents but none were reported as major incidents and reported to the ICO.

FREEDOM OF INFORMATION ACT

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The Freedom of Information Act 2000 (FOIA) gives the public right of access to a variety of records and information held by public bodies and provides commitment to greater openness and transparency in the public sector. During the period 1 April 2024 to 31 March 2025 the Health Board received a total of 477 requests for information, with 428 of these answered within the 20-day timeframe. Six requests for internal review were received and responded to with no further action being taken by the requestor. As a Health Board we are committed to complying with the FOIA by making information readily available via our Publication Scheme which can be found on the Health Board's [website](#):

REQUESTS FOR PERSONAL INFORMATION

UK GDPR and Access to Health Records Act (AHRA) and other legislation give individuals, family members and third parties the right to access their own or someone else's personal data. The health board has a statutory timeframe in which to respond (one calendar month) for the majority of these requests. During the period 1 April 2024 to 31 March 2025, the Health Board responded to 814 requests for personal information.

WELSH INFORMATION GOVERNANCE (IG) TOOLKIT

The Health Board is required to undertake the NHS Wales Information Governance Toolkit for Health Boards and Trusts, and all NHS Wales organisations must complete this to provide assurance that they are practising good data security, and that personal information is handled correctly. The Toolkit submission deadline for this reporting period was achieved. An information governance workplan is in place which the team will continue to work to during 2024/25.

Our position against the Welsh Information Governance Toolkit for 2024/25 against demonstrated a good level of assurance and work will continue this next year to address any areas to improve compliance for next year's submission.

INFORMATION (DATA) SECURITY

To support this for our Digital Systems and applications, the Health Board's Digital Governance Board (DGB) a group of experts consider and approve the procurement of any local new or existing digital solution to ensure complies with relevant legislation and standards (UK GDPR and NIS Regulations) thus reducing the threat of PTHB being put at un-necessary risk, such as from a Cyber-attack, loss of data, incident/breach of patient's data, financial penalty from the ICO or NCSU.

Over the last 12 months, the team has continued to see a positive increase in the number of services voluntarily contacting the IG department for

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support with updating existing, or drafting new, information sharing agreements to support patient care with our external partners. The team has worked closely with services to review existing agreements to ensure we meet our legislated obligations.

DATA PROTECTION IMPACT ASSESSMENTS AND DATA SHARING AGREEMENTS

This year 42 Data Protection Impact Assessments have been developed and completed and 19 information sharing agreements.

RECORDS MANAGEMENT

Over the past year, significant strides have been made in records management, reflecting a dedicated effort to enhance efficiency and compliance. Substantial improvements have been achieved through collaboration with internal audit, ensuring robust oversight and accuracy. Processes surrounding the archiving of health records have been successfully streamlined, reducing complexities and improving accessibility. Auditing, scoping, and risk-assessing storage areas have been prioritised, resulting in safer and more secure management of valuable records. These accomplishments highlight a focused and proactive approach to advancing records management standards.

DATA PROTECTION OFFICER (DPO)

This role is responsible for ensuring that the application of data protection and confidentiality legislation is consistently observed, and any weaknesses in current practices are identified and remedied where possible. Since 2018, the DPO has provided data protection advice across the Health Board. Common themes include clarity around internal and cross-organisational information sharing and assessing privacy risks. Updates and issues are discussed with the Health Board's Medical Director/Caldicott Guardian and Senior Information Risk Owner (SIRO).

The Audit, Risk and Assurance Committee monitors and seeks assurance against our information governance and records management performance.

Over the last 12 months, the Data Protection Officer has continued to support the Health Board in complying with data protection legislation in ensuring appropriate technical and organisational measures are implemented. A considerable amount of work has been undertaken by the Information Governance and Records Management Team to integrate data protection into our processing activity and business practices from the design stage right through the lifecycle.

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PLANNING ARRANGEMENTS

The organisation's planning arrangements in 2024/2025 form a key part of the Performance Report section of the Annual Report. Further detail can be found throughout the Performance Report.

DISCLOSURE STATEMENTS

Equality, Diversity, and Inclusion

The organisation's approach to Equality, Diversity, and Inclusion in 2024/2025 forms a key part of the organisations work. The Equalities, Diversity and Inclusion Annual Report 2024/2025 will be considered for approval at Board in July 2025 and then published to the Health Board's website where the 2023/2024 Report can be found - [Equality - Powys Teaching Health Board \(nhs.wales\)](#)

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Note 9.7 to the Annual Accounts provides details of the scheme, how it operates and the entitlement of employees.

Carbon Reduction Delivery Plans

As referenced on page 45 the Health Board has a Decarbonisation Action Plan which sets out how the Health Board will deliver against national commitments and our locally let priorities.

The organisation has undertaken risk assessments and is planning to ensure that the organisation's obligations under the Climate Change Act and Adaptation Reporting requirements are complied with. During 2024/25, the organisation was compliant with its requirements.

Data Security

A summary in relation to personal data incidents which required formal reporting to the Information Commissioner's Office (ICO) is provided on page XXX of this report. No personal data incidents were reported.

Quality of Data used by the Board

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The Health Board continually reviews the quality of data that it is using within the organisation including for decision making and assurance at Board level. Each of the separate data quality strands within the organisation are reviewed frequently that span across the main domains including finance, operational, workforce, quality, and safety data. However, it is a continuous process spanning an array of data systems and datasets including new systems being implemented. The Performance Report includes a Statement on Data Quality on page XX.

MINISTERIAL DIRECTIONS AND WELSH HEALTH CIRCULARS

Welsh Government has issued a number of Ministerial Directions in 2024/25. A record of the Ministerial Directions given is available via the following link: [Health and social care | Topic | GOV.WALES](#). A record of the Welsh Health Circulars given is available via the following link: [Health circulars: 2024 to 2027 | GOV.WALES](#)

Receipt of Welsh Health Circulars are logged, and a lead Executive Director identified to oversee the implementation of the required action or to develop the required response. The Audit, Risk and Assurance Committee received regular update reports on the implementation status of Welsh Health Circulars in 2024/25. From this work it was evidenced that the Health Board was not impeded by any significant issues in implementing the actions required. This work is overseen by the Director of Corporate Governance / Board Secretary.

Appendices 3a/3b (page XXX) provide an overview of Ministerial Directions and Welsh Health Circulars received during 2024/25 and their implementation status as of March 2025.

Post Payment Verification

In accordance with the Welsh Government directions the Post Payment Verification (PPV) Team, (a role undertaken for the Health Board by the NHS Shared Services Partnership), in respect of General Medical Services Enhanced Services and General Ophthalmic Services has carried out its work under the terms of the service level agreement (SLA), and in accordance with NHS Wales agreed protocols. The Work of the PPV Team is reported to the Board's Audit, Risk and Assurance Committee with papers available on the Health Board's [website](#).

Review of Effectiveness of System of Internal Control

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As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board receives assurance on the effectiveness of the system of internal control from a number of internal and external sources, these include:

- Board Assurance Framework;
- Delivery of Internal and External Annual Audit Plans;
- Audit Wales Structured Assessment;
- Audit Recommendation Tracking;
- Local Counter Fraud and Post Payment Verification Activity;
- Independent inspections and regulation, provided for example by Health Inspectorate Wales;
- Engagement with Commissioners;
- Engagement with staff, patients, and other key stakeholders;
- Welsh Government review and advisement; and
- the Committees of the Board, in particular the Audit, Risk and Assurance Committee.

Internal Audit

Internal Audit provide me as Accountable Officer and the Board through the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The Head of Internal Audit Annual Opinion provides assurance on governance, risk management and the system of internal control and is based on the risk-based audit programme. The opinion contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement. A summary of the Head of Internal Opinion 2024/2025 is provided below.

Head of Internal Audit Opinion for 2024/2025

At the time this report was compiled the Head of Internal Audit Opinion was yet to be finalised, this aspect of the report will be included in due course.

PLACE HOLDER: 90 LIMITED ASSURANCE REVIEWS

Counter Fraud

In line with the Government Functional Standard 013 Counter Fraud NHS Requirements the Local Counter Fraud Specialist (LCFS) and Executive Director of Finance agreed a work plan for 2024/25 at the beginning of the financial year. This was approved by the Audit, Risk and Assurance Committee in March 2024.

Following introduction of new Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22, the Health Board's Counter Fraud Work Plans have been aimed at ensuring compliance for the first enforcement year of the new standards in 2023/24.

There was 1 Standard Component that was Amber rated at the start of 2024/25:

Component 3 - Fraud bribery and corruption risk assessment

This Component was rated as Amber due to the requirements for maturity of this area of work to enable demonstration of continuous monitoring of fraud risk at a senior level, evidence of subsequent risk mitigation and that review of resources has been undertaken to ensure levels are suitable for this purpose.

Work Plan actions were included in the 2024/25 workplan to address this and aimed to uplift to Green rating. Work has been undertaken in this area and rating is now at Green level at the end of 2024/25. Actions have been included to consolidate this position within the Counter Fraud Work Plan 2025/26.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 1.2 FTE of accredited counter fraud specialist resource supplemented by 0.2 FTE admin support which translate to 308 days deliverable for counter fraud activity. This SLA arrangement remains in place for 2025/26.

Audit Wales Structured Assessment

At the time this report was compiled the Audit Wales Structured Assessment was yet to be finalised, this aspect of the report will be included in due course.

MODERN SLAVERY ACT 2015: TRANSPARENCY IN SUPPLY CHAINS

The Welsh Government's Code of Practice: Ethical Employment in Supply Chains was published in May 2017 to highlight the need, at every stage of the supply chain, to ensure good employment practices exist for all

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employees, both in the UK and overseas. It is expected that all NHS Wales organisations will sign up for the Code.

The Health Board fully endorses the principles and requirements of the Code and the Modern Slavery Act 2015 and is committed to playing its role as a major public sector employer, to eradicate unlawful and unethical employment practices, such as:

Modern Slavery and Human rights abuses;

- the operation of blacklist/prohibited lists;
- false self-employment;
- unfair use of umbrella schemes and zero hours' contracts; and
- paying the Living Wage.

The following actions are already in place which meet the Code's commitments:

- We follow the All-Wales procedure for staff to raise concerns (Whistleblowing), which provides the workforce with a fair and transparent process, to empower and enable them to raise suspicions of any form of malpractice by either our staff or suppliers/contractors working on University Health Board premises;
- We have a target in place to pay our suppliers within 30 days of receipt of a valid invoice;
- We comply with the six NHS pre-employment check requirements to verify that applicants meet the preconditions of the role they are applying for. This includes a right to work check;
- We do not engage or employ staff on zero hours' contracts;
- We have an Equality, Diversity and Human Rights Policy in place which ensures that no potential applicant, employee, or worker engaged is in any way unduly disadvantaged in terms of pay, employment rights, employment, or career opportunities;
- We also seek assurances from suppliers, via the tender process, that they do not make use of blacklists/prohibited lists. We also require confirmation and assurances that they do not make use of blacklist/prohibited list information;
- In accordance with Transfer of Undertaking (Protection of Employment) Regulations any Health Board staff member who may be required to transfer to a third party will retain their NHS Terms and Conditions of Service;
- We use the Modern Slavery Act (2015) compliance tracker by way of contracts procured by NHS Wales Shared Services Partnership (NWSSP) on behalf of the Health Board. NWSSP is equally committed to ensuring that procurement activity conducted on behalf of NHS Wales is undertaken in an ethical way. On our behalf, they ensure that workers within the supply chains through which they source our goods and services are treated fairly, in line with

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Welsh Government's Code of Practice for Ethical Employment in Supply Chains. Further detail on this area of work is available at:

[Ethical Employment & TISC Reports \(Transparency in Supply Chains\) - NHS Wales Shared Services Partnership](#)

The Health Board continues to work in partnership with relevant stakeholders and trade union partners to develop and implement actions which set out our commitment to ensure the principles of ethical employment within our supply chains are implemented and adhered to.

Conclusion

As Accountable Officer for Powys Teaching Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board, including its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place, during the year, a system of providing assurance aligned to corporate objectives to assist with identification and management of risk. As a result of a number of complex pressures including demand for our services, system pressures, cost of living and inflation as well as national and international economic and other pressures, Powys Teaching Health Board has remained in 'Enhanced Monitoring' as part of NHS Wales Escalation and Intervention arrangements during 2024/2025 for planning and finance.

During 2024/2025, we proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Further work will be undertaken in 2025/26 to ensure implementation of recommendations arising from audit reviews, particularly where a limited assurance rating is applied. Work will continue in 2025/2026 to continue to embed risk management and the assurance framework across the organisation. Implementation of the Board's Annual Governance Programme will see a further maturing of the Board's effectiveness and the system of internal control in 2025/2026.

This Annual Governance Statement confirms that Powys Teaching Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board, including the Executive Team, has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board and Director of Corporate Governance / Board Secretary, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective, and appropriate, and are designed to meet

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patient needs and expectations.

SIGNED BY:

DATE:

**HAYLEY THOMAS
CHIEF EXECUTIVE**

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Appendix 1: Board and Board Committee Membership - and Attendance at Board (2024-25)

Name	Position and Area of Expertise	Board and Board Committee Membership	Attendance 2024-25	Board Champion Role
Carl Cooper	Chair	Chair of the Board	10/10	
		Chair of Board In-Committee	11/11	
		Chair of the Charitable Funds Committee	4/4	
		Chair of the Remuneration and Terms of Service Committee	4/4	
Ronnie Alexander	Independent Member [General]	Member of the Board	6/10	
		Member of Board In-Committee	7/11	
		Member of the Audit, Risk and Assurance Committee	5/5	
		Chair of the Delivery and Performance Committee	4/6	
		Member of Planning, Partnerships and Population Health Committee	4/4	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Steve Elliot	Independent Member [Finance] (From 17/04/2024)	Member of the Board	9/9	
		Member of Board In-Committee	9/10	
		Chair of the Audit, Risk and Assurance Committee	5/5	
		Delivery and Performance Committee	5/6	
		Member of the Remuneration and Terms of Service Committee	1/1	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
		Workforce and Culture Committee (attended to ensure a quorum)	1/1	
Mick Giannasi	Independent Member (Directly appointed)	Member of the Board	9/10	
		Member of Board In-Committee	9/11	
		Member of the Delivery and Performance Committee	3/5	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Rhobert Lewis	Independent Member [General]	Member of the Board	10/10	
		Member of Board In-Committee	11/11	
		Vice Chair of the Charitable Funds Committee	3/4	
		Member of the Remuneration and Terms of Service	4/4	

		Chair of the Audit, Risk and Assurance Committee (to October 2024)	3/3	
		Chair of the Planning, Partnerships and Population Health Committee	3/4	
		Vice Chair of the Delivery and Performance Committee	5/6	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Jennifer Owen-Adams	Independent Member [Third Sector]	Member of the Board Member of Board In-Committee	7/10 6/11	
		Vice Chair of the Patient Experience, Quality and Safety Committee	4/5	
		Member then from September 2024 Chair of the Workforce and Culture Committee	4/4	
		Member of the Planning, Partnerships and Population Health Committee	4/4	
		Member of the Remuneration and Terms of Service (from September 2024)	0/2	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	0/1	
Ian Phillips	Independent Member [Information Technology] (to 22.08.2024)	Member of the Board Member of Board In-Committee	4/4 4/6	Digital & Data
		Member of the Patient Experience, Quality and Safety Committee	2/2	
		Member of the Planning, Partnerships and Population Health Committee	1/2	
		Chair of the Workforce and Culture Committee	1/1	
		Member of the Remuneration and Terms of Service	2/2	
Cathie Poynton	Independent Member [Trade Union]	Member of the Board Member of Board In-Committee	8/10 9/11	
		Member of the Workforce and Culture Committee	2/4	
		Member of the Charitable Funds Committee	4/4	
		Member of the Delivery and Performance Committee	5/6	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Ian Thomas		Member of the Board Member of Board In-Committee	3/3 3/3	

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	Independent Member (From 06.01.2025)	Patient Experience, Quality and Safety Committee (attended to ensure a quorum)	1/1	
Chris Walsh	Independent Member [Local Authority]	Member of the Board Member of Board In-Committee	6/10 7/11	
		Member of Workforce and Culture Committee	3/4	
		Member of Audit, Risk and Assurance Committee	4/5	
Kirsty Williams	Vice Chair	Vice Chair of the Board Vice-Chair of the Board	9/10 10/11	Infection Prevention and Control Armed Forces and Veterans Mental Health Children and Young People
		Chair of the Patient Experience, Quality and Safety Committee	5/5	
		Vice Chair of the Remuneration and Terms of Service Committee	4/4	
		Member of the Delivery and Performance Committee	5/6	
		Member of the Planning, Partnerships and Population Health Committee	3/4	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	0/1	
		Workforce and Culture Committee (attended to ensure a quorum)	1/1	
Simon Wright	Independent Member [University]	Member of the Board Member of Board In-Committee	9/10 9/11	
		Member of the Patient Experience, Quality and Safety Committee	4/5	
		Vice-Chair of the Planning, Partnerships and Population Health Committee	3/5	
Hayley Thomas	Chief Executive	Board Board In-Committee	10/10 11/11	
		Joint Chair Local Partnership Forum	2/4	
		Remuneration and Terms of Service Committee	3/4	
		Committees attended: Audit, Risk and Assurance Committee	3/4	
		Delivery and Performance Committee	3/6	
		Patient Experience, Quality and Safety Committee	2/5	
		Planning, Partnerships and Population Health Committee	3/5	
		Workforce and Culture Committee	0/4	
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		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee		
Mererid Bowley	Executive Director of Public Health	Board	10/10	Emergency Planning
		Board In-Committee	8/11	
		Planning, Partnerships and Population Health Committee	4/4	
David Farnsworth (to 02.06.2024)	Interim Executive Director of Operations, Community Care and Mental Health	Board	2/2	
		Board In-Committee	3/3	
		Patient Experience, Quality and Safety Committee	0/1	
Joy Garfitt (to 30.09.2024) ¹	Interim Executive Director of Operations, Community Care and Mental Health	Board	0/5	
		In-Committee	0/7	
		Patient Experience, Quality and Safety Committee	0/3	
Pete Hopgood	Executive Director of Finance, Estates and Support Services (Interim Executive Director Primary Care (part year)) Deputy Chief Executive	Board	10/10	
		In-Committee	9/11	
		Audit, Risk and Assurance Committee	4/4	
		Charitable Funds Committee	3/4	
		Delivery and Performance Committee	3/3	
		Patient Experience, Quality and Safety Committee	1/3	
Nicola Johnson (from 07.09.2024)	Executive Director of Planning, Performance and Commissioning	Board	5/5	
		Board In-Committee	4/4	
		Delivery and Performance Committee	3/3	
		Planning, Partnerships and Population Health Committee	2/2	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Elaine Lorton (from 30.09.2024)	Executive Director of Primary, Community Care and Mental Health	Board	4/5	
		Board In-Committee	3/4	
		Delivery and Performance Committee	3/3	
		Patient Experience, Quality and Safety Committee	2/2	
		Planning, Partnerships and Population Health Committee	2/2	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
		Board	8/10	

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Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	Board In-Committee	8/11	
		Charitable Funds Committee	1/3	
		Delivery and Performance Committee	4/4	
		Patient Experience, Quality and Safety Committee	3/3	
		Planning, Partnerships and Population Health Committee	3/3	
Stephen Powell (to 06.10.2024)	Interim Director of Planning and Performance	Board Board In-Committee	5/5 6/7	
		Delivery and Performance Committee	2/3	
		Planning, Partnerships and Population Health Committee	2/2	
Claire Roche	Executive Director of Nursing, Quality, Women and Family Health	Board Board In-Committee	7/10 8/11	Children and Young People Putting Things Right
		Patient Experience, Quality and Safety Committee	3/5	
		Delivery and Performance Committee	2/2	
		Planning, Partnerships and Population Health Committee	2/2	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Debra Wood-Lawson	Executive Director of People and Culture	Board Member of Board In-Committee	7/10 7/11	Raising Concerns Equality
		Workforce and Culture Committee	4/4	
Kate Wright	Executive Medical Director	Board Board In-Committee	9/10 10/11	Caldicott Guardian
		Patient Experience, Quality and Safety Committee	4/4	
		Delivery and Performance Committee	3/3	
		Workforce and Culture Committee	3/3	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	
Helen Bushell	Director of Corporate Governance / Board Secretary	Board Board In-Committee	10/10 10/11	Counter Fraud
		Charitable Funds Committee	3/4	
		Audit Risk and Assurance Committee	5/5	
		Delivery and Performance Committee	5/6	
		Patient Experience, Quality and Safety Committee	5/5	

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		Planning, Partnerships and Population Health Committee	3/4	
		Workforce and Culture Committee	3/4	
		Joint meeting of Delivery and Performance Committee and Planning, Partnerships and Population Health Committee	1/1	

1 – JG was in post but absent from work for part of the period due to ill health

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Appendix 2: Table of Quoracy

Board / Committee	Dates:											Quorate
Board	11 April 2024	22 May 2024	11 July 2024	24 July 2024	25 September 2024	10 October 2024	27 November 2024	10 January 2025	29 January 2025	26 March 2025		Yes
Board In-Committee	11 April 2024	22 May 2024	30 May 2024	24 July 2024	7 August 2024	21 August 2024	25 September 2024	27 November 2024	29 January 2025	06 March 2025	26 March 2025	Yes
Audit, Risk and Assurance Committee	14 May 2024	09 July 2024	08 October 2024	14 January 2025	11 March 2025							Yes
Charitable Funds Committee	10 June 2024	09 September 2024	02 December 2024	17 March 2025								Yes
Charitable Funds Extra Ordinary Meeting	20 January 2025											Yes
Delivery and Performance Committee (D&P)	07 May 2024	27 June 2024	29 August 2024	22 October 2024	05 December 2024	06 February 2025						Yes
Patient Experience, Quality and Safety Committee	16 April 2024	30 July 2024	05 September 2024	07 November 2024	11 February 2025							Yes

Planning, Partnerships and Population Health Committee (PPPH)	16 May 2024	13 August 2024	14 November 2024	04 February 2025								Yes
Remuneration and Terms of Service Committee	14 April 2024	11 July 2024	19 September 2024	26 March 2025								Yes
Workforce and Culture Committee	04 June 2024	03 October 2024	10 December 2024	13 March 2025								Yes
Joint D&P and PPPH	17 March 2025											Yes

Committee	Dates:												Quorate
Executive Committee	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	
	03 10 17	02 08 15 29	12	10 15 17 24 31	07 21	04 18 24	02 16 30	12 20 26	11 18	08 15 22	05 19	05 19	Yes

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PART B: REMUNERATION AND STAFF REPORT

This report contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc and has been compiled by the Directorate of Finance, Capital & Support Services and the People and Culture Directorate

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Background

The remuneration and staff report sets out the organisation's remuneration policy for Executive Directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to Executive Directors and senior managers and where relevant the link between performance and remuneration. The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared under the headings in SI2008 No 410 to the extent that they are relevant. The definition of "Senior Managers" for these purposes is:

"those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual Executive Directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and terms of service for Executive Directors and the Chief Executive are agreed and kept under review by the Remuneration and Terms of Service Committee. The Committee also seeks assurance in relation the annual performance of the Chief Executive and individual Executive Directors (the latter with the advice of the Chief Executive).

In 2024/2025, the Remuneration and Terms of Services Committee was chaired by the Health Board's Chair, Carl Cooper, and the membership included the following Independent Members:

- Kirsty Williams, Vice Chair of the Board
- Ian Phillips, Independent Member (ICT) to 22/08/2024
- Rhobert Lewis, Independent Member (General) to 09/10/2024
- Steve Elliot, Independent Member (Finance) from 10/10/2024
- Jennifer Owen Adams, Independent Member (Third Sector) from 23/08/2024

Meetings are minuted and decisions fully recorded.

The meeting is attended by the Chief Executive, Executive Director of People and Culture and Director of Corporate Governance / Board Secretary with appropriate corporate governance support.

Independent Members' Remuneration

Remuneration for Independent Members is decided by the Welsh Government, which also determines their tenure of appointment.

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PLACE HOLDER: 102-107 REMUNERATION TABLES ETC

Staff Numbers
Number of Employed Staff

As at 31 March 2025, the total number staff employed by the Health Board stood at 2,065.15 Whole Time Equivalents (WTE), which includes 59.00 WTE Health Care Support Workers (HCSW) – Aspiring Nurses, of which 36.5 WTE are in training and 22.5 WTE are being worked on the Wards/Community. The table below provides the average WTE of staff employed by the Health Board in 2023/2024 and 2024/2025 broken down by staffing group. This excludes the hosted service Health and Care Research Wales.

Staff Group	2023/24	2024/25
Add Prof Scientific and Technic	82.54	83.21
Additional Clinical Services	413.44	431.13
Administrative and Clerical	561.89	576.84
Allied Health Professionals	148.62	162.24
Estates and Ancillary	161.88	165.81
Healthcare Scientists	9.21	10.21
Medical and Dental	34.36	39.55
Nursing and Midwifery Registered	565.96	595.15
Students	1.00	1.00
Grand Total	1,978.91	2065.15

Overall, on average, the Health Board has seen an increase of **86.24 WTE** in the number of staff employed in 2024/2025 when compared to 2023/2024. Despite this success, recruiting to a number of clinical roles, in particular Nursing and Medical roles, continues to be challenging. There is an increase overall of 19.77 WTE in the number of Registered Nurse staff employed by the Health Board. Registered Nurse vacancy levels within the wards has increased, with an overall vacancy deficit (excluding absence) of **29%** at March 2024, decreasing to **19%** as at March 2025. The Health Board has also continued to develop the Aspiring Nurse programme, to grow our own internal pipeline to address the deficits. (The percentage deficit excludes Aspiring Nurses.)

Staffing Composition

As of 31 March 2025, the Health Board employed 2,512 substantive employees (excluding bank workers) which equated to 2065.15 WTE. The number (headcount) of female and male employees of the Health Board are as follows:

	Female	Male
Headcount	2,122	390
Percentage	84%	16%

Of this staffing composition, at 31 March 2025, the Executive Team consisted of nine members of the Board (inclusive of the Chief Executive Officer).

The Director of Corporate Governance/Board Secretary (a non-voting member of Board) is a member of the Executive Team and is included in the staffing composition below:

	Female	Male
Headcount	9	1
Percentage	90%	10%

Sickness Absence Data

Information on sickness absence for 2023/2024 and 2024/2025 is provided within the table below:

Staff Group	2023/24	2024/25
WTE Days Lost Long Term	28,280.58	28,817.04
WTE Days Lost Short Term	9,873.91	10,689.17
Total WTE Days Lost	38,154.49	39,506.21
Total Staff Years (AVG WTE Staff Absent)	104.53	108.24
Average Working Days Lost	19.58	19.32
Total Staff Employed in Period (Headcount)	2,306	2,445
Total Staff Employed in Period with no Absence (Headcount)	909	951
Percentage of Staff with no Sick Leave	39%	39%

The Health Board’s overall rolling sickness absence rate for 2024/2025 is 5.29%, compared to 5.35% in 2023/2024.

Staff Policies

Powys Teaching Health Board has a policy framework in place which covers policies and procedures that apply to employees and workers engaged with the Health Board. All workforce related policies are actively monitored, developed, and agreed in partnership with our Trade Union colleagues. The Equality Impact Assessment policy is applied throughout the financial year for the development of policies and procedures.

- for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities;
- for continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- otherwise for the training, career development and promotion of disabled persons employed by the Health Board

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All staff policies include a requirement to undertake an analysis of the impact of the policy in respect of equality. In conjunction with this approach, the *All Wales Managing Attendance at Work Policy* and *Recruitment and Selection Policy* were utilised to ensure fair consideration was given to applications for employment made by a disabled person and for supporting their continued employment.

Other Employee Matters

HEALTH AND SAFETY GROUP

The Health and Safety Group is a strategic group responsible for supporting and scrutinising the management of health and safety across the organisation. The focus during 2024/25 has continued to focus on the five themes which were identified in the previous twelve months.

The Key Themes:

1. Assurance and Reporting Arrangements
2. Achieving Health and Safety excellence in reporting incidents and learning:
3. Developing a Health and Safety Culture by Training and Development
4. Achieving Excellence in Training Compliance
5. Strengthen Inspection.

All policies were updated in Q2 of 2024/25 to reflect the move of the Health & Safety team from the Support Services Directorate to the People and Culture Directorate.

Two policies have been reviewed, updated, and approved by the Health and Safety Group in the past year. These have been communicated through Powys Announcements and are "live" on the intranet. These policies are:

- The Management of Contractors (HSP-008)
- First Aid at Work (HSP-018)

Also due for review in this twelve-month period was the organisation's Health and Safety Policy HSP-001. This will policy encompass proposed changes in governance arrangements for Health and Safety, along with the reviewed risk-based approach for manager and supervisors Health and Safety training across the organisation.

A fundamental role of the Health and Safety Group (HSG) is to monitor the review and learning from accidents and incidents. A summary report is provided at each quarter with details of incidents at departmental level.

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Discussion at HSG focuses on ensuring robust review at departmental level of the incidents ensuring appropriate closure and learning. Review of data output from Datix is also assisting in improving the quality of the data input. As the membership of the Group has matured, “near misses” are also being reported which further strengthens the Health and Safety culture of the organisation.

An Internal Audit review of the work of the Health and Safety Group, associated subgroups and policy framework resulted in a rating of ‘Reasonable Assurance.’ The Audit recommendations will be complete once the organisations H&S Policy has been approved, and changes implemented which will be completed in quarter one of the new financial year.

There has been no enforcement activity from the Health and Safety Executive in 2024/25, and work has been ongoing to ensure continuous improvement in many areas to mitigate the risks of any HSE intervention.

The partnership arrangement with Aneurin Bevan Health Board, for the delivery of prevention management of violence and aggression training has continue, contributing to improved compliance levels.

IOSH Working Safely was delivered as part of the managers development programme, and 20 members of staff attended the IOSH Managing Safety course. Further work is being undertaken to ensure training a proactive approach and positive health and safety culture, continues to be fostered and embedded across the organisation.

Looking ahead, the Health and Safety Group Workplan for 2025/26 there will continue to be a focus on the five themes and will build on a continuous improvement cycle reporting back to the Health and Safety Group, Executive Committee and into the Delivery and Performance Committee of Board.

Expenditure on Consultancy

As disclosed in note 3.3 (page XX) of its financial statements, the Health Board spent £0.902M on consultancy services during 2024/25 compared to £0.902M in 2023/24.

Off Payroll Engagement

For all off-payroll engagements as of 31 March 2025, for more than £245 per day:

No. of existing engagements as of 31 March 2025	7
Of which, the number that have existed:	0
for less than one year at time of reporting.	0
for between one and two years at time of reporting.	0
for between two and three years at time of reporting.	0
for between three and four years at time of reporting.	1

for four or more years at time of reporting.	6

	Number
Number. of new engagements, between 1 April 2024 and 31 March 2025	0
Of which...	
<i>No. assessed as caught by IR 35</i>	0
<i>No. assessed as not caught by IR 35</i>	<5
<i>No. engaged directly (via PSC contracted to department) and on the departmental payroll.</i>	0
<i>No. of engagements reassessed for consistency / assurance purposes during the year</i>	0
<i>No. of engagements that saw a change to IR35 status following consistency review</i>	0

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

Numbers that are between 1 and 4 are referred to as less than 5 (<5) to protect the potential identification of individuals.

There have been no-off payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2024 and 31 March 2025.

Exit Packages and Severance Payments

This disclosure reports the number and value of exit packages taken by staff leaving in the year. This disclosure is required to strengthen accountability in the light of public and Parliamentary concern about the incidence and cost of these payments.

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Exit packages cost band (including any special payment element)				
Exit package band	Number of compulsory redundancies (Whole numbers only)	Number of other departures (Whole numbers only)	Total number of exit packages (Whole numbers only)	Number of departures where special payments have been made (Whole numbers only)
less than £10,000	N/A			
£10,000 to £25,000	N/A			
£25,000 to £50,000	N/A			
£50,000 to £100,000	N/A			
£100,000 to £150,000	N/A			
£150,000 to £200,000	N/A			
more than £200,000	N/A			
Total				

Redundancy and other departure costs if paid would have been paid in accordance with the provisions of the NHS Agenda for Change Terms and Conditions and NHS Voluntary Early Release Scheme (VERS). Exit costs in this note are accounted for in full in the year of departure on a cash basis in this note as specified in EPN 380 Annex 13C.

Should the Health Board have agreed early retirements, the additional costs would have been met by the Health Board and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension's scheme and are not included in the table.

PLACE HOLDER: 116 REGULARITY OF EXPENDITURE

PLACE HOLDER: 117 FEES AND CHARGES

PLACE HOLDER: 118 COMPLAINE WITH COST ALLOCATION

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PART C: SENEDD CYMRU/WELSH PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

This report contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long-term expenditure trends, and the audit certificate and report.

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The Certificate and report of the Auditor General for Wales to the Senedd

At the time this report was compiled the Head of Internal Audit Opinion was yet to be finalised, this aspect of the report will be included in due course.

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item:

Audit Risk and Assurance Committee		13 th May 2025
Subject:	Draft Annual Accounts 2024-25	
Approved and presented by:	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:		
The purpose of this paper is to provide the Audit, Risk & Assurance Committee with the draft Annual Accounts 2023/24		
RECOMMENDATION(S):		
The Audit Committee is asked to: - • RECEIVE and NOTE the contents of the Annual Accounts; • NOTE the accounts will be subject to a statutory audit by Audit Wales (External Audit) • NOTE that following the audit process the audit accounts will return to ARAC at its meeting on 17th July 2025 for further consideration and onward recommendation to the Board for signature of the Financial Accounts for year ended 31st March 2025		
Approve/Take Assurance	Discuss	Note
N	Y	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:

There is a requirement on an annual basis to provide Annual Audited Accounts to Welsh Government. This paper outlines the work to date and further steps required in this regard.

DETAILED BACKGROUND AND ASSESSMENT:

The Teaching Health Board (THB) was required to submit a draft unaudited set of annual accounts to the Welsh Government (WG) and Audit Wales by 2 May 2025. Audit Wales will undertake the statutory audit of the annual accounts.

The THB is required to submit an audited set of annual accounts to the Welsh Government by 30th June 2025. The final audited accounts are required to be approved by the Audit Risk and Assurance Committee and the THB Board; this is scheduled to take place on 17th June 2025 for the ARAC and the date for the Board meeting is yet to be confirmed. The Accounts will then be signed by the Auditor General for Wales prior to the 30th June 2025.

Financial targets and statutory duties

The THB has achieved/not achieved the following financial targets and statutory duties for 2024/25:

- Operational in-year financial balance has NOT been achieved, reporting a deficit of £15.753M (Achievement of Operational Financial Balance, Note 2.1 page 27).
- Cash contained within cash limit (Statement of Cash Flows, page 7) – Achieved.
- Capital financial balance (Note 2.2. page 27) – Achieved.

The THB has NOT achieved the 3-year duty to ensure that its expenditure does not exceed the aggregate funding allotted to it over a 3-year period in regard to Revenue Funding but has achieved this in relation to Capital Funding. (Note 2.1 & 2.2 Page 27 for both revenue and capital resource limits).

The THB has not met the following administrative (not statutory) target:

- The THB performance at 93.8% did not meet the administrative target of payment of 95% of the number of non-NHS creditors within 30 days this year. (Note 2.4 page 28).

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The THB has met the target dates for preparing and submitting the draft annual accounts to Welsh Government and Audit Wales by 2nd May 2025.

The THB is currently on course to meet the target date to submit the audited accounts to be submitted to Welsh Government by the final submission date of 30th June 2025.

NEXT STEPS:

- Audit Wales to undertake statutory Audit of Annual Accounts
- Outcome of Audit work to be published in an ISA 260 Report to be provided to Audit Risk and Assurance Committee for its meeting on 15th June 2025
- Board approval of the accounts and Auditor General for Wales opinion on the accounts prior to submission deadline to Welsh Government of 30th June 2025

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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POWYS TEACHING HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Powys Teaching Local Health Board was established under the Local Health Boards (Establishment) (Wales) Order 2003 (S.I. 2003/148 (W.18))

As a statutory body governed by Acts of Parliament the LHB is responsible for :

- agreeing the action which is necessary to improve the health and health care of the population of Powys;
- supporting and financing General Practitioner-led purchasing of the services needed to meet agreed priorities, including charter standards and guarantees;
- supporting and funding the contractor professions;
- the commissioning of health promotion, emergency planning and other regulatory tasks;
- the stewardship of resources including the financial management and monitoring of performance in critical areas;
- eliciting and responding to the views of local people and organisations and changing and developing services at a pace and in ways that they will accept;
- providing Hospital and Community Healthcare Services to the residents of Powys.

In addition, it is also responsible for hosting specific functions in respect of the accounts of the former Health Authorities mostly significantly in respect of clinical negligence. The LHB also hosts the functions of Health and Care Research Wales (HCRW).

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2024-25. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the primary statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the Local Health Board which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1st April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

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Statement of Comprehensive Net Expenditure
for the year ended 31 March 2025

	Note	2024-25 £000	2023-24 £000
Expenditure on Primary Healthcare Services	3.1	83,495	78,993
Expenditure on healthcare from other providers	3.2	246,036	219,145
Expenditure on Hospital and Community Health Services	3.3	151,717	147,888
		481,248	446,026
Less: Miscellaneous Income	4	(16,909)	(16,222)
LHB net operating costs before interest and other gains and losses		464,339	429,804
Investment Revenue	5	0	0
Other (Gains) / Losses	6	(9)	(2)
Finance costs	7	54	21
Net operating costs for the financial year		464,384	429,823

Details of the Health Board's performance against its revenue and capital allocations over the last three financial periods are provided in Note 2 on page 27.

The notes on pages 8 to 76 form part of these accounts.

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Other Comprehensive Net Expenditure

	2024-25 £000	2023-24 £000
Net (gain) / loss on revaluation of property, plant and equipment	(1,206)	(2,996)
Net (gain)/loss on revaluation of right of use assets	0	0
Net (gain) / loss on revaluation of intangibles	0	0
(Gain) / loss on other reserves	0	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	0	0
Net (gain)/loss on revaluation of financial assets held for sale	0	0
Impairment and reversals	0	0
Transfers between reserves	0	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Other comprehensive net expenditure for the year	(1,206)	(2,996)
Total comprehensive net expenditure for the year	463,178	426,827

The notes on pages 8 to 76 form part of these accounts.

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Statement of Financial Position as at 31 March 2025

	Notes	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Property, plant and equipment	11	109,189	100,138
Right of Use Assets	11.3	1,515	1,063
Intangible assets	12	154	0
Trade and other receivables	15	196	32
Other financial assets	16	0	0
Total non-current assets		111,054	101,233
Current assets			
Inventories	14	197	211
Trade and other receivables	15	10,924	10,317
Other financial assets	16	0	0
Cash and cash equivalents	17	629	215
		11,750	10,743
Non-current assets classified as "Held for Sale"	11	0	0
Total current assets		11,750	10,743
Total assets		122,804	111,976
Current liabilities			
Trade and other payables	18	(50,068)	(47,113)
Other financial liabilities	19	0	0
Provisions	20	(3,803)	(3,921)
Total current liabilities		(53,871)	(51,034)
Net current assets/ (liabilities)		(42,121)	(40,291)
Non-current liabilities			
Trade and other payables	18	(720)	(267)
Other financial liabilities	19	0	0
Provisions	20	(803)	(576)
Total non-current liabilities		(1,523)	(843)
Total assets employed		67,410	60,099
Financed by :			
Taxpayers' equity			
General Fund		16,781	10,514
Revaluation reserve		50,629	49,585
Total taxpayers' equity		67,410	60,099

The financial statements on pages 2 to 7 were approved by the Board on xx xx 2025 and signed on its behalf by:

Chief Executive and Accountable Officer Date:

The notes on pages 8 to 76 form part of these accounts.

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Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2025

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2024-25			
Balance as at 31 March 2024	10,514	49,585	60,099
NHS Wales Transfer	0	0	0
RoU Asset Transitioning Adjustment	0	0	0
Impact of IFRS 16 on PPP/PFI Liability	0	0	0
Balance at 1 April 2024	10,514	49,585	60,099
Net operating cost for the year	(464,384)		(464,384)
Net gain/(loss) on revaluation of property, plant and equipment	0	1,206	1,206
Net gain/(loss) on revaluation of right of use assets	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0
Impairments and reversals	0	0	0
Other Reserve Movement	0	0	0
Transfers between reserves	162	(162)	0
Release of reserves to SoCNE	0	0	0
Transfers to/from LHBs	0	0	0
Total recognised income and expense for 2024-25	(464,222)	1,044	(463,178)
Net Welsh Government funding	462,906		462,906
Notional Welsh Government Funding	7,583		7,583
Balance at 31 March 2025	16,781	50,629	67,410

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government. The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £7.579M

Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £0.004M

The notes on pages 8 to 76 form part of these accounts.

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Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2024

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2023-24			
Balance at 31 March 2023	11,604	46,625	58,229
NHS Wales Transfer	0	0	0
RoU Asset Transitioning Adjustment	0	0	0
Balance at 1 April 2023	11,604	46,625	58,229
Net operating cost for the year	(429,823)		(429,823)
Net gain/(loss) on revaluation of property, plant and equipment	0	2,996	2,996
Net gain/(loss) on revaluation of right of use assets	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0
Impairments and reversals	0	0	0
Other reserve movement	0	0	0
Transfers between reserves	0	0	0
Release of reserves to SoCNE	36	(36)	0
Transfers to/from LHBs	0	0	0
Total recognised income and expense for 2023-24	(429,787)	2,960	(426,827)
Net Welsh Government funding	424,092		424,092
Notional Welsh Government Funding	4,605		4,605
Balance at 31 March 2024	10,514	49,585	60,099

.Notional Welsh Government funding line includes the 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split:

Notional 6.3% staff employer pension £4.600M

Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £0.005M

The notes on pages 8 to 76 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2025

		2024-25	2023-24
		£000	£000
Cash Flows from operating activities	Notes		
Net operating cost for the financial year		(464,384)	(429,823)
Movements in Working Capital	27	(889)	5,745
Other cash flow adjustments	28	15,441	14,701
Provisions utilised	20	(1,851)	(8,609)
Net cash outflow from operating activities		(451,683)	(417,986)
Cash Flows from investing activities			
Purchase of property, plant and equipment		(10,655)	(6,847)
Proceeds from disposal of property, plant and equipment		0	0
Purchase of intangible assets		(154)	0
Proceeds from disposal of intangible assets		0	0
Payment for other financial assets		0	0
Proceeds from disposal of other financial assets		0	0
Payment for other assets		0	0
Proceeds from disposal of other assets		0	0
Net cash inflow/(outflow) from investing activities		(10,809)	(6,847)
Net cash inflow/(outflow) before financing		(462,492)	(424,833)
Cash Flows from financing activities			
Welsh Government funding (including capital)		462,906	424,092
Capital receipts surrendered		0	0
Capital grants received		0	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		0	0
Capital element of payments in respect of on-SoFP PFI		0	0
Capital element of payments in respect of Right of Use Assets		0	(312)
Cash transferred (to)/ from other NHS bodies		0	0
Net financing		462,906	423,780
Net increase/(decrease) in cash and cash equivalents		414	(1,053)
Cash and cash equivalents (and bank overdrafts) at 1 April 2024		215	1,268
Cash and cash equivalents (and bank overdrafts) at 31 March 2025		629	215

The notes on pages 8 to 76 form part of these accounts.

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Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHBs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2024-25 Manual for Accounts. The accounting policies contained in that manual follow the 2024-25 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FReM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred. Only non-NHS income may be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales' organisations are required to account for their staff employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see the Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

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1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use

- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1st April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

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Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated, for All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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1.7.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale,

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within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1st April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets, applying the treatment described in section 1.7 instead.

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The LHB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 The LHB as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2023-24 and 2024-25. The WRPS is hosted by Velindre University NHS Trust.

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1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1st April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

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1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

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Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the LHB not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budgets

The NHS Wales organisation has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1st April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of 0.5%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

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1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

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1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHB's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.3. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised.

Prior year treatment

It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

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1.26.4 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes as from 1st April 2023.

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023-24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement - the future PPP liability will need to be remeasured at 1st April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.26.5. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHB's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.6. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHB's SoFP.

1.26.7. Other assets contributed by the LHB to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value. Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2023, Standard is UK endorsed and adopted by the FReM. The date of initial application is the beginning of the annual reporting period in which IFRS 17 is first applied. In central government the date of initial application is 1 April 2025.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

1.30. Accounting standards issued that have been adopted early

During 2024-25 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

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1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the 'Powys Teaching Local Health Board and other related charities', it is considered for accounting standards compliance to have control of 'Powys Teaching Local Health Board and other related charities' as a subsidiary and therefore is required to consolidate the results of the 'Powys Teaching Local Health Board and other related charities' within the statutory accounts of the NHS Wales organisation.

The determination of control is an accounting standard test of control and there has been no change to the operation of the 'Powys Teaching Local Health Board and other related charities' or its independence in its management of charitable funds.

Whilst there is a requirement to consolidate the results of the 'Powys Teaching Local Health Board and other related charities' within the statutory accounts of the LHB. The LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes.

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2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1st April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1st April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years;
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

Annual financial performance

	2022-23	2023-24	2024-25	Total
	£000	£000	£000	£000
Net operating costs for the year	395,697	429,823	464,384	1,289,904
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,609	1,859	1,833	5,301
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0
Less any non funded revenue consequences of IFRS 16	0	0	0	0
Total operating expenses	397,306	431,682	466,217	1,295,205
Revenue Resource Allocation	390,304	419,699	450,464	1,260,467
Under /(over) spend against Allocation	(7,002)	(11,983)	(15,753)	(34,738)

Powys Teaching Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2022-23 to 2024-25.

The Health Board received £9m cash-only support from Welsh Government during 2024-25 with the accumulated cash-only support as at 31st March 2025 being £20.850m. This support has been provided by Welsh Government to assist the Health Board with making payments to staff and suppliers; there is no requirement for this cash to be repaid.

2.2 Capital Resource Performance

	2022-23	2023-24	2024-25	Total
	£000	£000	£000	£000
Gross capital expenditure	13,211	6,650	14,608	34,469
Add: Losses on disposal of donated assets	0	0	0	0
Less NBV on disposal of property, plant and equipment, right of use and intangible assets	0	0	0	0
Adjustment for transfers (to)/from NHS Trusts	0	0	0	0
Less capital grants received	0	0	0	0
Less donations received	(527)	(195)	(141)	(863)
Less IFRS16 Peppercorn income	0	0	0	0
Less initial recognition of RoU Asset Dilapidations	0	0	0	0
Charge against Capital Resource Allocation	12,684	6,455	14,467	33,606
Capital Resource Allocation	12,752	6,481	14,517	33,750
(Over) / Underspend against Capital Resource Allocation	68	26	50	144

Powys Teaching Health Board has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2022-23 to 2024-25.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2024-2027 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB did not submit an Integrated Medium Term Plan for the period 2024-2027 in accordance with the NHS Wales Planning Framework.

The Powys Teaching Health Board submitted an Annual Plan for 2024/25.

The plan was not approved, so the LHB has failed to meet this statutory duty.

The Minister for Health and Social Services extant approval	
Status	Not Approved
Date	

The LHB has not met its statutory duty to have an approved financial plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2024-25	2023-24
Total number of non-NHS bills paid	52,868	54,338
Total number of non-NHS bills paid within target	49,586	50,281
Percentage of non-NHS bills paid within target	93.8%	92.5%
The LHB has not met the target.		

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3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2024-25 Total £000	2023-24 Total £000
General Medical Services	44,737		44,737	42,120
Pharmaceutical Services	5,727	(3,397)	2,330	2,140
General Dental Services	9,307		9,307	8,999
General Ophthalmic Services	767	1,564	2,331	1,786
Other Primary Health Care expenditure	1,894		1,894	1,302
Prescribed drugs and appliances	22,896		22,896	22,646
Total	85,328	(1,833)	83,495	78,993

Return of excess funds from primary care contractors are included in the figures above

Included within other notes to the accounts

Additional Primary Care Expenditure	Positive	0	0
Additional Primary Care Income	Negative	-1,202	-1,202
Overall total		82,293	77,791

1. General Medical Services includes £0M (£0.169m 2023/24) of staff related costs in respect of a Health Board managed GP Practice, the practice transferred to another provider on 1st July 2023. 2. The negative non cash limited balance on Pharmaceutical services relate to prescriptions for Powys residents being dispensed in non Powys pharmacies. The effect of this is a net outflow for Powys LHB.

3.2 Expenditure on healthcare from other providers

	2024-25 £000	2023-24 £000
Goods and services from other NHS Wales Health Boards	50,483	46,385
Goods and services from other NHS Wales Trusts	3,284	3,139
Goods and services from Welsh Special Health Authorities	1,235	415
Goods and services from other non Welsh NHS bodies	82,084	76,901
Goods and services from NWJCC /WHSSC and EASC	58,939	52,776
Local Authorities	3,067	2,605
Voluntary organisations	1,901	1,897
NHS Funded Nursing Care	2,782	2,279
Continuing Care	33,047	28,806
Private providers	4,868	1,217
Specific projects funded by the Welsh Government	0	0
Other	4,346	2,725
Total	246,036	219,145

From 1st April 2024, the 7 Health Boards in Wales have established the NHS Wales Joint Commissioning Committee (NWJCC) which is hosted by Cwm Taf Morgannwg University Health Board, secures the provision of highly specialised healthcare and commissions ambulance services. It replaced Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and National Collaborative Commissioning Unit (NCCU) which operated until 31st March 2024. These arrangements include funding of services operated through a risk sharing arrangement. The LHB payment for the NWJCC commissioning arrangements for the year ended 31st March 2025 is £58.939m (2023/24: £52.776m).

The increase in goods and services from other non Welsh NHS bodies results from increased costs for contracts with English NHS providers. The most significant increases are Wye Valley NHS Trust £4.141m, Shrewsbury and Telford NHS Foundation NHS Trust £1.187m and Robert Jones and Agnes Hunt Orthopaedic Hospital £0.998m in comparison to 2023/24 expenditure.

The increase in Local Authorities expenditure during 2024/25 is mainly in relation to pass through of funding in respect of 50 Day Winter Challenge (23/24 £0.000m) funded by Welsh Government where equivalent funding was not provided during 23/24.

The increase in Continuing Health Care expenditure during 2024/25 has resulted from an increase in the number of cases and cost per case compared to 2023/24.

The increase in Private Providers is due to the lack of capacity within NHS settings for more complex needs placements. The THB has seen increasing demand in this area in comparison to 23/24.

Other Expenditure includes Regional Integration Fund expenditure of £6.712M (2023/24: £5.976M) which aims to drive and enable integrated and collaborative working between social services, health, housing, the third and independent sectors to support underpinning principles of integration and prevention.

Other Expenditure also includes a negative balance which relates to the write back of liabilities from the Statement of Financial Position that have been assessed as no longer payable, which relate to previous years. The 2024/25 value of write backs is less than 2023/24 mainly relating to an agreed outcome on historic Continuing Health Care cases being settled at a lesser amount than had been provided during 23/24.

3.3 Expenditure on Hospital and Community Health Services

	2024-25	2023-24
	£000	£000
Directors' costs	1,876	1,896
Operational Staff costs	126,749	115,477
Single lead employer Staff Trainee Cost	0	0
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	6,290	5,767
Supplies and services - general	1,680	1,504
Consultancy Services	479	922
Establishment	2,128	1,949
Transport	867	886
Premises	6,988	6,803
External Contractors	0	0
Depreciation	4,979	4,651
Depreciation Right of Use assets (RoU)	363	528
Amortisation	0	0
Fixed asset impairments and reversals (Property, plant & equipment)	706	7,717
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	326	323
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	188	76
Research and Development	0	0
Expense related to short-term leases	0	0
Expense related to low-value asset leases (excluding short-term leases)	0	0
Other operating expenses	(1,902)	(611)
Total	151,717	147,888

**3.4 Losses, special payments and irrecoverable debts:
charges to operating expenses**

	2024-25	2023-24
	£000	£000
Increase/(decrease) in provision for future payments:		
Clinical negligence;		
Secondary care	619	(4,209)
Primary care	75	2,247
Redress Secondary Care	50	(78)
Redress Primary Care	0	0
Personal injury	950	409
All other losses and special payments	1	24
Defence legal fees and other administrative costs	99	309
Gross increase/(decrease) in provision for future payments	1,794	(1,298)
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	(1)	(36)
Less: income received/due from Welsh Risk Pool	(1,605)	1,410
Total	188	76

	2024-25	2023-24
	£	£
Permanent injury included within personal injury £:	103,987	(49,262)

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4. Miscellaneous Income

	2024-25 £000	2023-24 £000
Local Health Boards	2,172	2,325
NWJCC/ WHSC and EASC	56	51
NHS Wales trusts	1,053	520
Welsh Special Health Authorities	988	1,221
Foundation Trusts	0	0
Other NHS England bodies	1,020	672
Other NHS Bodies	0	0
Local authorities	0	0
Welsh Government	6,131	5,404
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	1,202	1,007
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	42	31
Other income from activities	1,533	1,906
Patient transport services	0	0
Education, training and research	437	603
Charitable and other contributions to expenditure	0	0
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	105	195
Receipt of Government granted assets	36	0
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care income generation schemes	0	0
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	75	483
Right of Use Asset Sub-leasing rental income	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	69	70
Other income:		
Provision of laundry, pathology, payroll services	0	0
Accommodation and catering charges	203	136
Mortuary fees	0	5
Staff payments for use of cars	0	0
Business Unit	0	0
Scheme Pays Reimbursement Notional	24	(98)
Other	1,763	1,691
Total	16,909	16,222

Welsh Government miscellaneous income includes funding received on behalf of the hosted function of Health and Care Research Wales within the THB. This has increased to £4.777m from an amount of £4.568M received in 23/24.

The Receipt of Donated and Government Grant Assets of £0.141m (2023/24: £0.195m) relates to contributions from Charitable Organisations and Welsh Government Energy Service to capital schemes and equipment. This is further detailed in Note 11.

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5. Investment Revenue

	2024-25 £000	2023-24 £000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	0	0

6. Other gains and losses

	2024-25 £000	2023-24 £000
Gain/(loss) on disposal of property, plant and equipment	9	0
Gain/(loss) on disposal other than by sale of right of use assets	0	2
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	9	2

7. Finance costs

	2024-25 £000	2023-24 £000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	40	9
Interest on obligations under PFI contracts;		
main finance cost	0	0
contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	40	9
Provisions unwinding of discount	14	12
Other finance costs	0	0
Total	54	21

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8. Future charges to Statement of Comprehensive Net Expenditure (SoCNE)

LHB as lessee

As at 31st March 2025 the Health Board had 15 leases agreements in place in respect of vehicles.

The periods in which the remaining agreements will expire are shown below:

	2024-25	2024-25	2024-25	2023-24
	Low Value & Short Term	Other	Total	Total
Payments recognised as an expense	£000	£000	£000	£000
Minimum lease payments	0	51	51	70
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	0	51	51	70
Total future minimum lease payments				
Payable	£000	£000	£000	£000
Not later than one year	0	56	56	34
Between one and five years	0	65	65	28
After 5 years	0	0	0	0
Total	0	121	121	62

LHB as lessor

	2024-25	2023-24
Rental revenue	£000	£000
Rent	55	52
Contingent rents	0	0
Total revenue rental	55	52
Total future minimum lease payments		
Receivable	£000	£000
Not later than one year	55	49
Between one and five years	39	39
After 5 years	17	28
Total	110	116

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9. Employee benefits and staff numbers

9.1 Employee costs	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2023-24
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	91,075	478	11,137	0	0	0	102,690	96,232
Social security costs	8,428	0	0	0	0	0	8,428	7,680
Employer contributions to NHS Pension Scheme	19,174	0	0	0	0	0	19,174	15,101
Other pension costs	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	118,677	478	11,137	0	0	0	130,292	119,013
Charged to capital							442	438
Charged to revenue							129,850	118,575
							130,292	119,013
Net movement in accrued employee benefits (untaken staff leave)							0	0

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2023-24
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	649	2	0	0	0	0	651	627
Medical and dental	37	1	11	0	0	0	49	43
Nursing, midwifery registered	588	3	42	0	0	0	633	619
Professional, Scientific, and technical staff	84	0	3	0	0	0	87	90
Additional Clinical Services	425	0	28	0	0	0	453	450
Allied Health Professions	157	0	9	0	0	0	166	153
Healthcare Scientists	11	0	1	0	0	0	12	8
Estates and Ancillary	167	0	0	0	0	0	167	165
Students	1	0	0	0	0	0	1	0
Total	2,119	6	94	0	0	0	2,219	2,155

9.3. Retirements due to ill-health

	2024-25	2023-24
Number	6	5
Estimated additional pension costs £	726,940	138,760

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be borne by the NHS Pension Scheme.

9.4 Employee benefits

The Teaching Health Board does not have an employee benefit scheme

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9.5 Reporting of other compensation schemes - exit packages
9.5.1 Exit Packages Costs and Numbers

	2024-25	2024-25	2024-25	2024-25	2023-24
Exit packages cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Number of departures where special payments have been made	Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	1
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	2

	2024-25	2024-25	2024-25	2024-25	2023-24
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	5,872
£10,000 to £25,000	0	0	0	0	13,043
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	18,915

Total Exit Costs Paid in Year	Total paid in year	Total paid in year
	2024-25	2023-24
	£	£
Exit costs paid in year	0	18,915
Total	0	18,915

There have been no exit packages within the year.

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9.5 Reporting of other compensation schemes - exit packages continued

9.5.2 Analysis of other departures	2024-25	2024-25
	Agreements	Total value of
Type of other departures	Number	agreements
		£
Voluntary redundancies including early retirement contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring Welsh Government Approval**	0	0
Other please specify	0	0
Other please specify	0	0
Total	0	0

There have been no exit packages within the year

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9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2024-25 £000 Chief	2024-25 £000 Employee	2024-25 £000 Ratio	2023-24 £000 Chief	2023-24 £000 Employee	2023-24 £000 Ratio
Total pay and benefits	Executive	Employee	Ratio	Executive	Employee	Ratio
25th percentile pay ratio	177	28	6.3:1	177	28	6.3:1
Median pay	177	37	4.8:1	177	36	4.9:1
75th percentile pay ratio	177	49	3.6:1	177	48	3.7:1
Salary component of total pay and benefits						
25th percentile pay ratio	177	28		177	28	
Median pay	177	37		177	36	
75th percentile pay ratio	177	49		177	48	
	Highest Paid Director	Employee	Ratio	Highest Paid Director	Employee	Ratio
Total pay and benefits	Director	Employee	Ratio	Director	Employee	Ratio
25th percentile pay ratio	177	28	6.3:1	177	28	6.3:1
Median pay	177	37	4.8:1	177	36	4.9:1
75th percentile pay ratio	177	49	3.6:1	177	48	3.7:1
Salary component of total pay and benefits						
25th percentile pay ratio	177	28		177	28	
Median pay	177	37		177	36	
75th percentile pay ratio	177	49		177	48	

In 2024-25, 6 (2023-24, 2) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £23,920 to £221,386 (2023-24, £22,720 to £216,219).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial Year Summary

9.6.2 Percentage Changes	2023-24 to 2024-25	2022-23 to 2023-24
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	3	(2)
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	3	(2)
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	2	9
Performance pay and bonuses	0	0

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9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2024-25 tax year (2023-24 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

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10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2024-25	2024-25	2023-24	2023-24
NHS	Number	£000	Number	£000
Total bills paid	2,023	201,408	1,852	181,449
Total bills paid within target	1,527	191,401	1,298	169,971
Percentage of bills paid within target	75.5%	95.0%	70.1%	93.7%
Non-NHS				
Total bills paid	52,868	126,874	54,338	118,008
Total bills paid within target	49,586	118,081	50,281	112,735
Percentage of bills paid within target	93.8%	93.1%	92.5%	95.5%
Total				
Total bills paid	54,891	328,282	56,190	299,457
Total bills paid within target	51,113	309,482	51,579	282,706
Percentage of bills paid within target	93.1%	94.3%	91.8%	94.4%

The Teaching Health Board performance at 93.8% has not met the administrative target of payment 95% of the number of non-nhs creditors paid within 30 days nor did it in 2023/24

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2024-25	2023-24
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

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11.1 Property, plant and equipment

2024-25

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	12,631	81,633	1,565	4,575	7,912	410	5,315	0	114,041
Indexation	134	1,145	28	0	0	0	0	0	1,307
Additions									
- purchased	0	1,660	35	8,343	2,009	102	1,250	0	13,399
- donated	0	89	0	0	52	0	0	0	141
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	2,571	0	(2,571)	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	327	0	0	0	0	0	0	327
Impairments	0	(1,033)	0	0	0	0	0	0	(1,033)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(495)	(14)	(558)	0	(1,067)
At 31 March 2025	12,765	86,392	1,628	10,347	9,478	498	6,007	0	127,115
Depreciation at 1 April 2024	0	5,478	122	0	5,833	357	2,113	0	13,903
Indexation	0	99	2	0	0	0	0	0	101
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(485)	(14)	(558)	0	(1,057)
Provided during the year	0	3,215	69	0	685	26	984	0	4,979
At 31 March 2025	0	8,792	193	0	6,033	369	2,539	0	17,926
Net book value at 1 April 2024	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138
Net book value at 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Net book value at 31 March 2025 comprises :									
Purchased	12,765	74,386	1,435	10,347	3,311	129	3,468	0	105,841
Donated	0	3,214	0	0	134	0	0	0	3,348
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Asset financing :									
Owned	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
On-SoFP MIMS Funded PPP contracts	0	0	0	0	0	0	0	0	0
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189

The net book value of land, buildings and dwellings at 31 March 2025 comprises :

	£000
Freehold	91,800
Long Leasehold	0
Short Leasehold	0
	91,800

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.

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The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

The reclassification in year relates to the bringing into use of buildings that were previously Assets under construction. The main part of this reclassification relates to Bronllys Roof Project at £1.445m

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11.1 Property, plant and equipment

2023-24

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	13,043	67,872	1,478	18,245	8,525	424	6,194	0	115,781
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	13,043	67,872	1,478	18,245	8,525	424	6,194	0	115,781
Indexation	(403)	3,477	88	0	0	0	0	0	3,162
Additions									
- purchased	0	1,429	(1)	3,175	362	0	1,178	0	6,143
- donated	0	40	0	0	155	0	0	0	195
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	16,845	0	(16,845)	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	583	0	0	0	0	0	0	583
Impairments	(9)	(8,291)	0	0	0	0	0	0	(8,300)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(322)	0	0	(1,130)	(14)	(2,057)	0	(3,523)
At 31 March 2024	12,631	81,633	1,565	4,575	7,912	410	5,315	0	114,041
Depreciation at 31 March bf	0	2,725	52	0	6,186	345	3,288	0	12,596
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Depreciation at 1 April 2023	0	2,725	52	0	6,186	345	3,288	0	12,596
Indexation	0	163	3	0	0	0	0	0	166
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(322)	0	0	(1,118)	(14)	(2,056)	0	(3,510)
Provided during the year	0	2,912	67	0	765	26	881	0	4,651
At 31 March 2024	0	5,478	122	0	5,833	357	2,113	0	13,903
Net book value at 1 April 2023	13,043	65,147	1,426	18,245	2,339	79	2,906	0	103,185
Net book value at 31 March 2024	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138
Net book value at 31 March 2024 comprises :									
Purchased	12,631	72,863	1,443	4,575	1,923	53	3,202	0	96,690
Donated	0	3,292	0	0	156	0	0	0	3,448
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2024	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138
Asset financing :									
Owned	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2024	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138

The net book value of land, buildings and dwellings at 31 March 2024 comprises :

	£000
Freehold	90,229
Long Leasehold	0
Short Leasehold	0
	<u>90,229</u>

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.

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The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

The reclassification in year relates to the bringing into use of buildings that were previously Assets under construction. The main part of this reclassification relates to the Machynlleth Hospital Reconfiguration Project at £15.948m

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Powys Health

11. Property, plant and equipment (continued)**Disclosures:****Disclosures:****i) Donated Assets**

Powys LHB has received the following donated assets during the year. £0.036m from the Welsh Government Energy Service to implement EV charging points and £0.106m of various contributions from the LHB charity and Hospital League of Friends in respect of small refurbishment schemes or provision of medical equipment.

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ii) Valuations

The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

There has also been a valuation of the Bronllys Hospital Roof project upon it being brought into use during the year. Details of this are included in note 13.

iii) Asset Lives

Depreciated as follows:

- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation

There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs

There have not been write downs.

vi) Market Value

The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.

There are not assets held for sale or sold in the period.

viii) IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

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11. Property, plant and equipment

11.2 Non-current assets held for sale	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2024	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2025	0	0	0	0	0	0
Balance brought forward 1 April 2023	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2024	0	0	0	0	0	0

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11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most are individually insignificant, however, xxx are significant in their own right:

- Glan Irfon lease held under Land and Buildings - NBV at 31 March 2025 £0.424m

- Presteigne Health Centre lease held under Land and Buildings - NBV at 31 March 2025 £0.430m

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2024-25									
Cost or valuation at 1 April 2024	0	1,574	0	0	671	0	0	0	2,245
Additions	0	505	0	0	409	0	0	0	914
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(70)	0	0	(29)	0	0	0	(99)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2025	0	2,009	0	0	1,051	0	0	0	3,060
Depreciation at 1 April 2024	0	735	0	0	447	0	0	0	1,182
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	200	0	0	163	0	0	0	363
At 31 March 2025	0	935	0	0	610	0	0	0	1,545
Net book value at 1 April 2024	0	839	0	0	224	0	0	0	1,063
Net book value at 31 March 2025	0	1,074	0	0	441	0	0	0	1,515
RoU Asset Total Value Split by Lessor									
Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Market Value Leases	0	0	0	0	0	0	0	0	0
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0

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11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, one is significant in its own right:

Glan Irfon lease held under Land and Buildings - NBV at 31 March 2024 £0.456m

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2023-24									
Cost or valuation at 31 March 2023	0	1,796	0	0	528	0	0	0	2,324
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	0
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	0	1,796	0	0	528	0	0	0	2,324
Additions	0	110	0	0	202	0	0	0	312
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	-332	0	0	-59	0	0	0	-391
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2024	0	1,574	0	0	671	0	0	0	2,245
Depreciation at 31 March 2023	0	418	0	0	236	0	0	0	654
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	0
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Depreciation at 1 April 2023	0	418	0	0	236	0	0	0	654
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	317	0	0	211	0	0	0	528
At 31 March 2024	0	735	0	0	447	0	0	0	1,182
Net book value at 1 April 2023	0	1,378	0	0	292	0	0	0	1,670
Net book value at 31 March 2024	0	839	0	0	224	0	0	0	1,063
RoU Asset Total Value Split by Lessor									
Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercorn Leases	0	456	0	0	0	0	0	0	456
Other Public Sector Market Value Leases	0	136	0	0	0	0	0	0	136
Private Sector Peppercorn Leases	0	57	0	0	0	0	0	0	57
Private Sector Market Value Leases	0	191	0	0	224	0	0	0	415
Total	0	839	0	0	224	0	0	0	1,063

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11.3 Right of Use Assets continued

Quantitative disclosures

	2024-25	2024-25	2024-25	2024-25	2023-24
	Land	Buildings	Other	Total	Total
Maturity analysis	£000	£000	£000	£000	£000
Contractual undiscounted cash flows relating to lease liabilities					
Less than 1 year	0	141	224	365	283
2-5 years	0	357	240	597	272
> 5 years	0	209	0	209	0
Less finance charges allocated to future periods	0	-102	-24	-126	-10
Total	0	605	440	1,045	545
Lease Liabilities (net of irrecoverable VAT)				2024-25	2023-24
Current				325	278
Non-Current				720	267
Total				1,045	545
Amounts Recognised in Statement of Comprehensive Net Expenditure				2024-25	2023-24
Depreciation				363	528
Impairment				0	0
Variable lease payments not included in lease liabilities - Interest expense				40	9
Sub-leasing income				0	0
Expense related to short-term leases				0	0
Expense related to low-value asset leases (excluding short-term leases)				0	0
Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)					
Interest expense				(40)	0
Repayments of principal on leases				0	(312)
Total				(40)	(312)

The Teaching Health Board leases land, buildings and equipment where required to deliver core services.

Where an extension option exists within a lease, the Teaching Health Board has assessed on an individual contract basis and reflected any extension period within the reported liabilities where it is reasonably certain that the option will be exercised.

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12. Intangible non-current assets

2024-25

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	0	0	0	0	0	154	154
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Gross cost at 31 March 2025	0	0	0	0	0	154	154
Amortisation at 1 April 2024	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Amortisation at 31 March 2025	0	0	0	0	0	0	0
Net book value at 1 April 2024	0	0	0	0	0	0	0
Net book value at 31 March 2025	0	0	0	0	0	154	154
NBV at 31 March 2025							
Purchased	0	0	0	0	0	154	154
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2025	0	0	0	0	0	154	154

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12. Intangible non-current assets

2023-24

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2023	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	0	0	0	0	0	0	0
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Gross cost at 31 March 2024	0	0	0	0	0	0	0
Amortisation at 31 March bf	0	0	0	0	0	0	0
NHS Wales Transfers	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0
Amortisation at 1 April 2023	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Amortisation at 31 March 2024	0	0	0	0	0	0	0
Net book value at 1 April 2023	0	0	0	0	0	0	0
Net book value at 31 March 2024	0	0	0	0	0	0	0
NBV at 31 March 2024							
Purchased	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2024	0	0	0	0	0	0	0

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Additional Disclosures re Intangible Assets

Disclosures:

i) Donated Assets

The LHB has not received any donated intangible assets during the year.

ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of LHB professional s and Finance staff.

iv) Additions during the period

There is currently one intangible asset under construction during the year relating the Radiology Informatics System Programme(RISP) which is due to go live during 2025/26.

v) Disposals during the period

There have been no disposal of intangible assets during the year.

vi) Transfers into other NHS Bodies

The LHB has not received any intangible assets transferred from another NHS body.

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13 . Impairments

	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	1,033	0	0	0	0	1,033
Reversal of Impairments	(327)	0	0	0	0	(327)
Total of all impairments	706	0	0	0	0	706

Analysis of impairments charged to reserves in year :

Impairments charged to the Statement of Comprehensive Net Expenditure	706	0	0	0	0	706
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	706	0	0	0	0	706

	2023-24 Property, plant & equipment £000	2023-24 Right of Use Assets £000	2023-24 Intangible assets £000	2023-24 Held for sale assets £000	2023-24 Financial Assets £000	2023-24 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	8,300	0	0	0	0	8,300
Reversal of Impairments	(583)	0	0	0	0	(583)
Total of all impairments	7,717	0	0	0	0	7,717

Analysis of impairments charged to reserves in year :

Statement of Comprehensive Net Expenditure	7,717	0	0	0	0	7,717
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	7,717	0	0	0	0	7,717

Within the healthcare segment of the Teaching Health Board, there is one downward impairments in year totalling £1.033m charged to the statement of Comprehensive Net Expenditure. This includes the downward valuation of £1.033m as a result of the initial valuation for the bringing into use the Roof Project at Bronllys Hospital.

There is a reversal of impairment of £0.327m during 2024/25 which has occurred as a result of an increase arising on revaluations due to indexation applied during the year that reversed an impairment for the same assets previously recognised as impairments in expenditure. In these cases it is credited to expenditure to the extent of the decrease previously charged there

Impairment funding to cover adjustments required is provided to the Teaching Health Board by Welsh Government on an annual basis.

14.1 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	156	152
Consumables	35	54
Energy	0	0
Work in progress	0	0
Other	6	5
Total	197	211
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2025 £000	31 March 2024 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	3
Reversal of write-downs that reduced the expense	0	0
Total	0	3

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15. Trade and other Receivables

Current	31 March	31 March
	2025	2024
	£000	£000
Welsh Government	1,868	642
NWJCC/ WHSSC and EASC	132	147
Welsh Health Boards	201	212
Welsh NHS Trusts	736	784
Welsh Special Health Authorities	299	334
Non - Welsh Trusts	421	1,080
Other NHS	39	0
2019-20 Scheme Pays - Welsh Government Reimbursement	5	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	1,277	1,413
NHS Wales Primary Sector FLS Reimbursement	2,383	2,293
NHS Wales Redress	117	74
Other	0	0
Local Authorities	801	1,206
Capital receivables - Tangible	126	58
Capital receivables - Intangible	0	0
Other receivables	2,460	1,791
Provision for irrecoverable debts	(612)	(613)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	671	896
Other accrued income	0	0
Sub total	10,924	10,317
Non-current		
Welsh Government	0	0
NWJCC/WHSSC and EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	43	32
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	127	0
NHS Wales Primary Sector FLS Reimbursement	26	0
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Capital receivables - Tangible	0	0
Capital receivables - Intangible	0	0
Other receivables	0	0
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Sub total	196	32
Total	11,120	10,349

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15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2025 £000	31 March 2024 £000
By up to three months	200	385
By three to six months	22	28
By more than six months	2	87
	<u>224</u>	<u>500</u>

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(613)	(650)
Transfer to other NHS Wales body	0	0
Amount written off during the year	0	0
Amount recovered during the year	68	60
(Increase) / decrease in receivables impaired	(67)	(23)
Bad debts recovered during year	<u>0</u>	<u>0</u>
Balance at 31 March	<u>(612)</u>	<u>(613)</u>

In determining whether a debt should be impaired, consideration is given to the age of the debt, historic collectability rates and the results of actions already taken including referral to the Health Board's credit agencies.

Receivables VAT

Trade receivables	0	0
Other	<u>0</u>	<u>0</u>
Total	<u>0</u>	<u>0</u>

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16. Other Financial Assets

	Current		Non-current	
	31 March	31 March	31 March	31 March
	2025	2024	2025	2024
	£000	£000	£000	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Deposits	0	0	0	0
Loans	0	0	0	0
Derivatives	0	0	0	0
Other (Specify)				
Right of Use Asset Finance Sublease	0	0	0	0
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Total	0	0	0	0
RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure			2024-25	2023-24
RoU Sub-leasing income			0	0

17. Cash and cash equivalents

	2024-25	2023-24
	£000	£000
Balance at 1 April	215	1,268
Net change in cash and cash equivalent balances	414	(1,053)
Balance at 31 March	629	215
Made up of:		
Cash held at GBS	568	143
Commercial banks	59	70
Cash in hand	2	2
Cash and cash equivalents as in Statement of Financial Position	629	215
Bank overdraft - GBS	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in Statement of Cash Flows	629	215

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18. Trade and other payables

Current	31 March 2025 £000	31 March 2024 £000
Welsh Government	67	25
NWJCC/WHSSC and EASC	781	615
Welsh Health Boards	5,661	4,501
Welsh NHS Trusts	1,045	1,311
Welsh Special Health Authorities	0	545
Other NHS	4,023	5,953
Taxation and social security payable / refunds	956	855
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	1,087	1,053
Non-NHS payables - Revenue	6,742	7,178
Local Authorities	2,791	2,086
Capital payables- Tangible	6,297	3,344
Capital payables- Intangible	154	0
Overdraft	0	0
Rentals due under operating leases	0	0
RoU Lease Liability	325	278
Obligations under finance leases, HP contracts		
Imputed finance lease element of on SoFP PFI contracts	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Pensions: staff	1,710	1,562
Non NHS Accruals	18,109	17,696
Deferred Income:		
Deferred Income brought forward	111	483
Deferred Income Additions	284	111
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	(75)	(483)
Other creditors	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Sub Total	50,068	47,113
Non-current		
Welsh Government	0	0
NWJCC/WHSSC and EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Other NHS	0	0
Taxation and social security payable / refunds	0	0
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	0	0
Non-NHS payables - Revenue	0	0
Local Authorities	0	0
Capital payables- Tangible	0	0
Capital payables- Intangible	0	0
Overdraft	0	0
Rentals due under operating leases	0	0
RoU Lease Liability	720	267
Obligations under finance leases, HP contracts		
Imputed finance lease element of on SoFP PFI contracts	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Pensions: staff	0	0
Non NHS Accruals	0	0
Deferred Income :		
Deferred Income brought forward	0	0
Deferred Income Additions	0	0
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	0	0
Other creditors	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Sub Total	720	267
Total	50,788	47,380

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The NHS aims to pay all invoices within the 30 day period directed by the Welsh Government.

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18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	31 March	31 March
	2025	2024
	£000	£000
Between one and two years	0	0
Between two and five years	0	0
In five years or more	0	0
Sub-total	0	0

19. Other financial liabilities

Financial liabilities	Current		Non-current	
	31 March	31 March	31 March	31 March
	2025	2024	2025	2024
	£000	£000	£000	£000
Financial Guarantees:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Derivatives at fair value through SoCNE	0	0	0	0
Other:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Total	0	0	0	0

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20. Provisions

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
Clinical negligence:-									
Secondary care	297	0	0	0	721	(320)	(102)	0	596
Primary care	2,252	0	0	0	75	0	0	0	2,327
Redress Secondary care	70	0	0	0	75	(19)	(25)	0	101
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	482	0	0	0	961	(1,324)	(55)	13	77
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	277	0	0	(46)	116	(50)	(163)		134
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0			0	9	(4)	0	0	5
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	543		0	0	300	(114)	(166)		563
Total	3,921	0	0	(46)	2,258	(1,832)	(511)	13	3,803
Non Current									
Clinical negligence:-									
Secondary care	0	0	0	0	0	0	0	0	0
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	501	0	0	0	44	0	0	0	545
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	43	0	0	46	146	(19)	0		216
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	32			0	10	0	0	0	42
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	0		0	0	0	0	0		0
Total	576	0	0	46	200	(19)	0	0	803
TOTAL									
Clinical negligence:-									
Secondary care	297	0	0	0	721	(320)	(102)	0	596
Primary care	2,252	0	0	0	75	0	0	0	2,327
Redress Secondary care	70	0	0	0	75	(19)	(25)	0	101
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	983	0	0	0	1,005	(1,324)	(55)	13	622
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	320	0	0	0	262	(69)	(163)		350
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	32			0	19	(4)	0	0	47
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	543		0	0	300	(114)	(166)		563
Total	4,497	0	0	0	2,458	(1,851)	(511)	13	4,606

Expected timing of cash flows:

	In year to 31 March 2026	Between 1 April 2026 31 March 2030	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	596	0	0	596
Primary care	2,327	0	0	2,327
Redress Secondary care	101	0	0	101
Redress Primary care	0	0	0	0
Personal injury	77	248	297	622
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	134	216	0	350
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
2019-20 Scheme Pays - Reimbursement	5	42	0	47
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	563	0	0	563
Total	3,803	506	297	4,606

The Teaching Health Board estimates that in 2025/26 and beyond it will receive £3.930m from the Welsh Risk Pool in respect of Losses and Special Payments.

£0.082m (2023/24: £0.667m) of the provision total relates to the probable liabilities of former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust)

Contingent Liabilities are directly linked to these claims in Note 21.

Included within 'other' at 31st March 2025 is £0.316m relating to a liability for two historic continuing care cases with the Local Authority. Also included within 'other' at 31st March 2025 is £0.247m relating to retrospective continuing health care claims (2023/24 £0.113m).

Included within the Redress Secondary Care line and Defence Legal Fees and Other Administration is a provision for expected payments in respect of redress arrangements under the Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The amount of provision in relation to this at 31st March 2025 is £0.103m (including defence costs (2023/24: £0.072m) and all payments are expected to be fully reimbursed from the Welsh Risk Pool.

There is an amount of £0.048m (2023/24: £0.032m) in respect of 2019-20 Scheme Pays - Reimbursement. The discharge of this provision in future years will be funded by Welsh Government.

20. Provisions (continued)

	At 1 April 2023	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2024
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	11,875	(8,370)	0	0	4,187	(7,369)	(26)	0	297
Primary care	8	0	0	0	2,252	(3)	(5)	0	2,252
Redress Secondary care	153	0	0	0	30	(5)	(108)	0	70
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	227	0	0	(9)	593	(205)	(135)	11	482
All other losses and special payments	0	0	0	0	24	(24)	0	0	0
Defence legal fees and other administration	110	0	0	18	316	(135)	(32)		277
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	0
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	2,607		0	0	505	(713)	(1,856)		543
Total	14,980	(8,370)	0	9	7,907	(8,454)	(2,162)	11	3,921
Non Current									
Clinical negligence:-									
Secondary care	0	0	0	0	0	0	0	0	0
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	691	0	0	9	0	(150)	(49)	0	501
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	36	0	0	(18)	25	0	0		43
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	135			0	0	(5)	(98)	0	32
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	0		0	0	0	0	0		0
Total	862	0	0	(9)	25	(155)	(147)	0	576
TOTAL									
Clinical negligence:-									
Secondary care	11,875	(8,370)	0	0	4,187	(7,369)	(26)	0	297
Primary care	8	0	0	0	2,252	(3)	(5)	0	2,252
Redress Secondary care	153	0	0	0	30	(5)	(108)	0	70
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	918	0	0	0	593	(355)	(184)	11	983
All other losses and special payments	0	0	0	0	24	(24)	0	0	0
Defence legal fees and other administration	146	0	0	0	341	(135)	(32)		320
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	135			0	0	(5)	(98)	0	32
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	2,607		0	0	505	(713)	(1,856)		543
Total	15,842	(8,370)	0	0	7,932	(8,609)	(2,309)	11	4,497

The Teaching Health Board estimates that in 2024/25 it will receive £3.217m from the Welsh Risk Pool in respect of Losses and Special Payments.

£0.667m (2022/23: £11.924m) of the provision total relates to the probable liabilities of former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust)

Contingent Liabilities are directly linked to these claims in Note 21.

Included within 'other' at 31st March 2024 is £0.429m relating to a liability for an historic continuing care case with the Local Authority. Also included within 'other' at 31st March 2024 is £0.113m relating to retrospective continuing health care claims (2022/23 £0.134m).

Included within the Redress Secondary Care line and Defence Legal Fees and Other Administration is a provision for expected payments in respect of redress arrangements under National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The amount of Provision in relation to this at 31st March 2024 is £0.072m including defence costs (2022/23: £0.155m) and all payments are expected to be fully reimbursed from the Welsh Risk Pool.

There is an amount of £0.032m (2022/23: £0.156m) in respect of 2019-20 Scheme Pays - Reimbursement. The discharge of this provision in future years will be funded by Welsh Government.

21. Contingencies

21.1 Contingent liabilities

	2024-25 £'000	2023-24 £'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	5,101	13,858
Primary care	883	240
Redress Secondary care	0	0
Redress Primary care	0	0
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	377	315
Continuing Health Care costs	0	0
Other	5,000	0
Total value of disputed claims	11,361	14,413
Amounts (recovered) in the event of claims being successful	(6,333)	(14,163)
Net contingent liability	5,028	250

Legal Claims for alleged medical or employer negligence: £1.312m of the £6.361m relates solely to the former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust). £4.166m of the £6.361M relates to Powys Teaching Health Board cases. Legal advice has established that these claims are not likely to result in payments. In the unlikely event that amounts are payable, all payments over a threshold of £0.025m will be reimbursed to Powys Teaching Health Board by the Welsh Risk Pool for Powys Teaching Health Board cases and reimbursed in full for former Health Authority and Primary Care cases.

An invoice for £5m from Wye Valley NHS Trust has been received during March 2025. It has the description “Recognition of discussions regarding parity of funding with English commissioners inc remoteness uplift, PFI and inflation”. The Health Board strongly refutes the charge and is awaiting backing information giving the rationale for the sum sought.

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21.2 Remote Contingent liabilities	2024-25 £000	2023-24 £000
Guarantees	0	0
Indemnities	110	361
Letters of Comfort	0	0
Total	110	361

All of the £0.110m relates solely to the former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust). Legal advice has established that these claims are not likely to result in payments. In the unlikely event that amounts are payable, all payments will be reimbursed in full by the Welsh Risk Pool.

21.3 Contingent assets	2024-25 £000	2023-24 £000
please give details	0	0
Total	0	0

22. Capital commitments

Contracted capital commitments at 31 March		
The disclosure of future capital commitments not already disclosed as liabilities in the accounts.		
	2024-25 £000	2023-24 £000
Property, plant and equipment	1,633	1,133
Right of Use Assets	0	0
Intangible assets	0	0
Total	1,633	1,133

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23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2025	
	Number of cases	£
Clinical negligence:-		
Secondary Care	9	228,086
Primary Care	0	0
Redress Secondary Care	6	24,744
Redress Primary Care	0	0
Personal injury	11	1,409,030
All other losses and special payments	5	1,376
Total	31	1,663,236

23.2 Analysis of number of cases and associated amounts paid out during the financial year

L&R Case reference number	Case Type	In year cases in excess of £300,000		Cumulative amount
		Number of cases	£	
Cases in excess of £300,000:				
PI/123/0005/JAM	Personal Injury	1	816,161	1,189,716

	Number of cases	£	£
Sub-total	1	816,161	1,189,716
All other cases paid in year	30	847,075	17,843,363
Total cases paid in year	31	1,663,236	19,033,079

23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	No. of cases	£
Cumulative amount up to £300k	9	70,719
Cumulative amount greater than £300k	0	0
Total	9	70,719

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24. Right of Use lease obligations**24.1 Obligations (as lessee)****Amounts payable under right of use asset leases:****2024-25**

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	141	224	365
Between one and five years	0	357	240	597
After five years	0	209	0	209
Less finance charges allocated to future periods	0	(102)	(24)	(126)
Minimum lease payments	0	605	440	1,045
Included in:				
Current borrowings	0	117	208	325
Non-current borrowings	0	488	232	720
	0	605	440	1,045
Present value of minimum lease payments				
Within one year	0	117	208	325
Between one and five years	0	295	232	527
After five years	0	193	0	193
Present value of minimum lease payments	0	605	440	1,045
Included in:				
Current borrowings	0	117	208	325
Non-current borrowings	0	488	232	720
	0	605	440	1,045

2023-24

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2024	2024	2024	2024
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	179	104	283
Between one and five years	0	181	91	272
After five years	0	0	0	0
Less finance charges allocated to future periods	0	(5)	(5)	(10)
Minimum lease payments	0	355	190	545
Included in:				
Current borrowings	0	177	101	278
Non-current borrowings	0	178	89	267
	0	355	190	545
Present value of minimum lease payments				
Within one year	0	177	101	278
Between one and five years	0	178	89	267
After five years	0	0	0	0
Present value of minimum lease payments	0	355	190	545
Included in:				
Current borrowings	0	177	101	278
Non-current borrowings	0	178	89	267
	0	355	190	545

24.2 Right of Use Assets receivables (as lessor)

The Health Board did not hold any Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets :

	31 March 2025 £000	31 March 2024 £000
Gross Investment in leases		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Minimum lease payments	<u>0</u>	<u>0</u>
Included in:		
Current financial assets	0	0
Non-current financial assets	<u>0</u>	<u>0</u>
Present value of minimum lease payments		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Present value of minimum lease payments	<u>0</u>	<u>0</u>
Included in:		
Current financial assets	0	0
Non-current financial assets	<u>0</u>	<u>0</u>

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25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The Health Board did not have any PFI Schemes that were deemed to be off-statement of financial position at the balance sheet date.

Commitments under off-SoFP PFI contracts	Off-SoFP PFI contracts	Off-SoFP PFI contracts
	31 March 2025 £000	31 March 2024 £000
Total payments due within one year	0	0
Total payments due between 1 and 5 years	0	0
Total payments due thereafter	0	0
Total future payments in relation to PFI contracts	0	0
Total estimated capital value of off-SoFP PFI contracts	0	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	£000
	0

Contract start date:

Contract end date:

The Teaching Health Board has no PFI Schemes off -statement of financial position

Total obligations for on-Statement of Financial Position PFI contracts due:

2024-25	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact Finance Charge	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000
Total payments due within one year	0	0	0	0
Total payments due between 1 and 5 years	0	0	0	0
Total payments due thereafter	0	0	0	0
Total future payments in relation to PFI contracts	0	0	0	0
2023-24	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact Finance Charge	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2024 £000	31 March 2024 £000	31 March 2024 £000	31 March 2024 £000
Total payments due within one year	0	0	0	0
Total payments due between 1 and 5 years	0	0	0	0
Total payments due thereafter	0	0	0	0
Total future payments in relation to PFI contracts	0	0	0	0
31/03/2025				
£000				
Total present value of obligations for on-SoFP PFI contracts	0			

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25.3 Charges to expenditure	2024-25	2023-24
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

	On / Off-statement of financial position
PFI Contract	
Number of PFI contracts which individually have a total commitment > £500m	0
PFI Contract	

25.5 The Teaching Health Board did not have any Public Private Partnerships during the year

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26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Health Board is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Health Board has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Health Board in undertaking its activities.

Currency risk

The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the United Kingdom and Sterling based. The Health Board does not have any overseas operations. The Health Board therefore has low exposure to currency rate fluctuations.

Interest rate risk

Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk

The Health Board is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The Health Board is not, therefore, exposed to significant liquidity risks.

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27. Movements in working capital

	2024-25 £000	2023-24 £000
(Increase)/decrease in inventories	14	(64)
(Increase)/decrease in trade and other receivables - non-current	(164)	(12)
(Increase)/decrease in trade and other receivables - current	(607)	7,817
Increase/(decrease) in trade and other payables - non-current	453	(241)
Increase/(decrease) in trade and other payables - current	2,955	(2,732)
Total	2,651	4,768
Adjustment for accrual movements in fixed assets - creditors	(3,107)	485
Adjustment for accrual movements in fixed assets - debtors	68	24
Adjustment for accrual movements in right of use assets - creditors	(500)	566
Adjustment for accrual movements in right of use assets - debtors	0	0
Other adjustments	(1)	(98)
	(889)	5,745

28. Other cash flow adjustments

	2024-25 £000	2023-24 £000
Depreciation	5,342	5,179
Amortisation	0	0
(Gains)/Loss on Disposal	(9)	0
Impairments and reversals	706	7,717
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	(105)	(66)
Government Grant assets received credited to revenue but non-cash	(36)	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	0
Non-cash movements in right of use assets	0	2
Non-cash movements in provisions	1,960	(2,736)
Other movements	7,583	4,605
Total	15,441	14,701

Other movements are Notional funding received for the

- LHB notional 9.4% Staff Employer Pension Contributions and
- 2019/20 Pensions Annual Allowance Charge Compensation Scheme

funded directly to the NHSBA Pensions Division by Welsh Government.

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29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on xx xx xxxx; post the date the financial statements were certified by the Auditor General for Wales.

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30. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material revenue and capital transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Party	Board Member Interests	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government		3	468,214	67	1,868
Aneurin Bevan University Health Board		15,387	204	1,221	30
Betsi Cadwaladr University Health Board		4,530	510	434	60
Cardiff & Vale University Health Board		2,416	44	421	20
Cwm Taf Morgannwg University Health Board		8,059	12	1,953	8
Hywel Dda University Local Health Board		10,579	543	630	53
Public Health Wales NHS Trust		154	1,195	26	160
Swansea Bay University Health Board		11,802	1,436	1,003	32
Velindre University NHS Trust (inc. WRP)		4,791	1,212	1,012	572
Welsh Ambulance Services Trust		(3)	66	7	3
NHS Wales Joint Commissioning Committee (NWJCC)	Ian Phillips Independent Chair of Welsh Kidney Network (Sub- Committee of NWJCC)	59,168	80	781	132
Health Education and Improvement Wales (HEIW)		0	2,246	0	279
Digital Health & Care Wales (DHCW)		1,793	437	0	20
Powys County Council	Councillor Chris Walsh, Councillor, Powys County Council	16,937	2,830	2,791	801
Neath Port Talbot College Group	Rhobert Lewis Chair of Neath Port Talbot College Group	3	14	3	0
Powys Association of Voluntary Organisations	Carl Cooper Retired as CEO of Powys Association of Voluntary Organisations	1,415	0	316	0
Freedom Leisure	Close relative is senior manager for Freedom Leisure with lead responsibility for South Powys.	0	0	0	0
Social Care Wales	Michael Giannasi Chair of the Board of Social Care Wales Carl Cooper Board Member Social Care Wales	0	4	0	0
		137,034	479,047	10,665	4,038

Powys LHB has hosted the following functions on behalf of NHS Wales on which it receives income from the Welsh Government and other LHB's:

- Residual Clinical Negligence
- Community Health Councils
- Health and Care Research Wales (HCRW)

Powys LHB also has material transactions with English NHS Trusts with whom it commissions healthcare including:

- Shrewsbury and Telford Hospitals NHS Trust
- Wye Valley NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Powys LHB has also received items donated from the Powys LHB Charitable Fund, for which the Board is the Corporate Trustee.

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31. Third Party assets

The LHB held £160 cash at bank and in hand at 31 March 2025 (31st March 2024, £3,490) which relates to monies held by the LHB on behalf of patients. This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

None of this cash was held in Patients' Investment Accounts in either 2024-25 or 2023-24

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32. Pooled budgets

Provision of Care Home Accommodation Functions (Funded Nursing Care)

Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 for one financial year

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 31 of the Health Act 1999. The health related function which is subject to these arrangements is the provision of care by a registered nurse in care homes, which is a service provided by the NHS Body under section 2 of the National Health Service Act 1977. In accordance with the Social Care Act 2001 Section 49 care from a registered nurse is funded by the NHS regardless of the setting in which it is delivered. (Circular 12/2003)
The agreement will not affect the liability of the parties for the exercise of their respective statutory functions and obligations. The partnership agreement operates in accordance with the Welsh Government Guidance NHS Funded Nursing Care 2004.

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	2,449	2,108

Source of overall funding/contributions:

Welsh Government		
Powys Teaching Health Board	2,449	2,108
Powys County Council		
Other		

Pooled partnership expenditure

Of the £2.449m funding received £2.782m has been issued to pooled budget partners; reported in Account Note 3.2.
Powys THB has utilised £2.782m; reported in Account Note 3.2.

	2024-25		2023-24	
	£000	%	£000	%
Powys Teaching Health Board	2,782	100%	2,279	100%
Powys County Council				
Other				
Total	2,782		2,279	
Net surplus/(deficit)	(334)		(170)	
Cumulative surplus/(deficit)	(504)			

Pooled Partnership Income

No income has been received in relation to activities resulting from Pooled budget.

	2024-25	2023-24
	£000	£000
Please specify source of income	0	0
Total	0	0

Asset disclosure

	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

Provision of Community Equipment

Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 for one financial year

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in respect of lead commissioning from a pooled fund for the provision of community equipment in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the host partner for the purposes of the Regulations. The purpose of the agreement is to facilitate the provision of a community equipment service and the development of this service in Powys. The service is provided from a pooled fund and is within the THB's and the Council's powers.

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	1,350	1,350

Source of overall funding/contributions:

Welsh Government		
Powys Teaching Health Board	675	675
Powys County Council	675	675
Other		

Pooled partnership expenditure

Of the £1.350m funding received £1.350m has been issued to pooled budget partners; reported in Account Notes 3.2 and 3.3.
Powys THB has utilised £0.675m; reported in Account Note 3.3.

	2024-25		2023-24	
	£000	%	£000	%
Powys Teaching Health Board	675	50%	664	50%
Powys County Council	675	50%	664	50%
Other	0			
Total	1,350		1,328	
Net surplus/(deficit)	0		22	
Cumulative surplus/(deficit)	22			

Pooled Partnership Income

No income has been received in relation to activities resulting from Pooled budget.

	2024-25	2023-24
	£000	£000
Please specify source of income	0	0
Total	0	0

Asset disclosure

	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

32. Pooled budgets

Provision of Section 33 Joint Agreement for the provision of IT Services
Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 a period of 3 months

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006.
The agreement will not affect the liability of the parties for the exercise of their respective statutory functions and obligations.
Powys County Council is the lead commissioner and the host partner for the purposes of the regulations.
The purpose of the agreement is to facilitate the provision of ICT services within Powys.

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	172	2,063

Source of overall funding/contributions:

Welsh Government		
Powys Teaching Health Board	69	829
Powys County Council	103	1,234
Other		

Pooled partnership expenditure
Of the £0.172m funding received £0.177m has been issued to pooled budget partners; reported in Account Notes 3.2 and 3.3.
Powys THB has utilised £0.063; reported in Account Notes 3.2 and 3.3.

	2024-25		2023-24	
	£000	%	£000	%
Powys Teaching Health Board	63	31%	740	33%
Powys County Council	140	69%	1,492	67%
Other				
Total	203		2,232	
Net surplus/(deficit) before income	(31)		(169)	
Cumulative surplus/deficit	(200)			

Pooled Partnership Income
£0.023k income has been received in relation to services provided; reported in the Account Notes of Powys County Council.

	2024-25	2023-24
	£000	£000
Please specify source of income		
Local Authority	25	293
Total	25	293
Net surplus/(deficit)	(6)	124

Asset disclosure	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

Provision of Section 33 Joint Agreement for the provision of a Reablement Service
Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 for one financial year

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in respect of lead commissioning from a pooled fund for the provision of an effective and sustainable joint reablement service which meets the needs of the Powys communities in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the host partner for the purposes of the Regulations. This service is provided from a pooled fund and is within the THB's and the Council's powers.

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	1,241	1,241

Source of overall funding/contributions:

Welsh Government		
Powys Teaching Health Board	828	828
Powys County Council	413	413
Other		

Pooled partnership expenditure
Of the £1.241m funding received £1.241m has been issued to pooled budget partners; reported in Account Note 3.2 and 3.3.
Powys THB has utilised £0.828m; reported in Account Notes 3.2 and 3.3.

	2024-25		2023-24	
	£000	%	£000	%
Powys Teaching Health Board	509	41%	509	41%
Powys County Council	732	59%	732	59%
Other				
Total	1,241		1,241	
Net surplus/(deficit)	0		0	
Cumulative surplus/(deficit)	0			

Pooled Partnership Income
No income has been received in relation to activities resulting from Pooled budget.

	2024-25	2023-24
	£000	£000
Please specify source of income		
Total	0	0

Asset disclosure	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

32. Pooled budgets

Provision of Section 33 Joint Agreement for the provision of Tier 2/3 Psycho-social Treatment Services

Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 for one financial year

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the lead commissioner and the host partner for the purposes of the Regulations. The agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations. The purpose of the agreement is to provide a Tier 2 and 3 service provision for drug and alcohol users and their concerned others.

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	975	952
Source of overall funding/contributions:		
Welsh Government		
Powys Teaching Health Board	130	122
Powys County Council	845	830
Other		

Pooled partnership expenditure

Of the £0.975m funding received £0.967m has been issued to pooled budget partners; reported in Account Note 3.2.
Powys THB has utilised £0.122m reported in Account Note 3.2.

	£000	%	£000	%
Powys Teaching Health Board	122	13%	122	13%
Powys County Council	845	87%	830	87%
Other				
Total	967		952	
Net surplus/(deficit)	8		0	

Cumulative surplus/(deficit) 8

Pooled Partnership Income

No income has been received in relation to activities resulting from Pooled budget.

	2024-25	2023-24
	£000	£000
Please specify source of income	0	0
Total		

Asset disclosure

	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

Provision of Section 33 Joint Agreement for the provision of Personal Care at Glan Irfon Integrated Health and Social Care Unit, Builth Wells

Pooled Budget Partners Powys Teaching Health Board & Powys County Council
Host Body Powys County Council
Agreement Commenced 1st April 2025 for one financial year

Powys Teaching Health Board (PTHB) and Powys County Council (PCC) have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006. The agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations. The purpose of the agreement is to facilitate the provision of person centred care at Glan Irfon, for 12 residents within the short stay shared care rehabilitation unit with in-reach clinical, nursing and rehabilitation support (registered under CSSIW for Residential Care).

	2024-25	2023-24
	£000	£000
Overall Funding/Contributions	610	610
Source of overall funding/contributions:		
Welsh Government		
Powys Teaching Health Board	305	305
Powys County Council	305	305
Other		

Pooled partnership expenditure

Of the £0.610m funding received £0.680m has been issued to pooled budget partners; reported in Account Note 3.2.
Powys THB has utilised £0.640m; reported in Account Note 3.2.

	2024-25	%	2023-24	%
	£000		£000	
Powys Teaching Health Board	340	50%	340	50%
Powys County Council	340	50%	340	50%
Other				
Total	680		680	
Net surplus/(deficit)	(79)		(79)	

Cumulative surplus/(deficit) (140)

Pooled Partnership Income

No income has been received in relation to activities resulting from Pooled budget.

	2024-25	2023-24
	£000	£000
Please specify source of income	0	0
Total		

Asset disclosure

	31 March	31 March
	2025	2024
	£000	£000
Total Asset NBV value of PPE	0	0
Split for pooled budget partners		
Powys Teaching Health Board	0	0
Powys County Council	0	0
Other	0	0

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

2024-25

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note					
Expenditure on Primary Healthcare Services	3.1	83,495	0	0	0	83,495
Expenditure on healthcare from other providers	3.2	245,678	0	358	0	246,036
Expenditure on Hospital and Community Health Services	3.3	146,181	25	5,592	(81)	151,717
		475,354	25	5,950	(81)	481,248
Less: Miscellaneous Income	4	11,854	0	5,136	(81)	16,909
THB net operating costs before interest and other gains and losses		463,500	25	814	0	464,339
Investment Income	5	0	0	0	0	0
Other (Gains) / Losses	6	(9)	0	0	0	(9)
Finance costs	7	54	0	0	0	54
THB Net Operating Costs		463,545	25	814	0	464,384
Add Non Discretionary Expenditure	3.1	1,833	0	0	0	1,833
Revenue Resource Limit	2.1	449,610	25	829	0	450,464
Under / (over) spend against Revenue Resource Limit		(15,768)	0	15	0	(15,753)

2023/24

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note					
Expenditure on Primary Healthcare Services	3.1	78,993	0	0	0	78,993
Expenditure on healthcare from other providers	3.2	218,101	0	1,044	0	219,145
Expenditure on Hospital and Community Health Services	3.3	143,253	25	4,675	(65)	147,888
		440,347	25	5,719	(65)	446,026
Less: Miscellaneous Income	4	11,174	0	5,113	(65)	16,222
THB net operating costs before interest and other gains and losses		429,173	25	606	0	429,804
Investment Income	5	0	0	0	0	0
Other (Gains) / Losses	6	(2)	0	0	0	(2)
Finance costs	7	21	0	0	0	21
THB Net Operating Costs		429,192	25	606	0	429,823
Add Non Discretionary Expenditure	3.1	1,859	0	0	0	1,859
Revenue Resource Limit	2.1	419,068	25	606	0	419,699
Under / (over) spend against Revenue Resource Limit		(11,983)	0	0	0	(11,983)

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34. Other Information**34.1. 9.4% Staff Employer Pension Contributions - Notional Element**

The value of notional transactions is based on estimated costs for the twelve month period 1st April 2024 to 31st March 2025. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2024 and February 2025 alongside Health Board data for March 2025.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

	2024-25 £000	2023-24 £000
Statement of Comprehensive Net Expenditure for the year ended 31 March 2025		
Expenditure on Primary Healthcare Services	109	67
Expenditure on healthcare from other providers	0	0
Expenditure on Hospital and Community Health Services	7,470	4,533

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

Net operating cost for the year	7,579	4,600
Notional Welsh Government Funding	7,579	4,600

Statement of Cash Flows for year ended 31 March 2025

Net operating cost for the financial year	7,579	4,600
Other cash flow adjustments	7,579	4,600

2.1 Revenue Resource Performance

Revenue Resource Allocation	7,579	4,600

3. Analysis of gross operating costs**3.1 Expenditure on Primary Healthcare Services**

General Medical Services	3	2
Pharmaceutical Services	0	0
General Dental Services	94	51
Other Primary Health Care expenditure	12	14

3.2 Expenditure on healthcare from other providers

	0	0
	0	0

3.3 Expenditure on Hospital and Community Health Services

Directors' costs	116	76
Staff costs	7,463	4,457

9.1 Employee costs**Permanent Staff**

Employer contributions to NHS Pension Scheme	7,579	4,600
Charged to capital	26	18
Charged to revenue	7,553	4,582

18. Trade and other payables**Current**

Pensions: staff	0	0

28. Other cash flow adjustments

Other movements	7,579	4,600

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Other

34.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

	£000
Liability for incurred claims @ 1 April 2024	0
Liability for remaining payments @ 31 March 2025	0
	0
Arising during year	0
Utilised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE
/ STATEMENT OF COMPREHENSIVE INCOME *Delete as appropriate

	£000
Insurance Income	0
Insurance expenditure	0

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THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst

Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda Item: 5.2

Audit, Risk and Assurance Committee

13 May 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 reports.			
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	Y	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:

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

The following audit reports have been finalised since the March 25 meeting of the Committee:

- GMS Unified Contract Assurance Framework (Substantial Assurance)
- Business Continuity Planning (Substantial Assurance)
- Information Governance Follow-up (Substantial Assurance)
- Pharmacy Stores (Reasonable Assurance)
- Risk Management & Assurance (Reasonable Assurance)
- Llandrindod Wells Phase 2 (Reasonable Assurance)
- Partnership Governance Framework (Advisory)

The Executive summaries for each of the final reports are included within the progress report, and the full copies of the reports are also included as separate items within the agenda.

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 2024/25 plan was formally approved by the Audit, Risk and Assurance Committee at its March 24 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
May 2025

NWSSP Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board



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3.Delivery of the 2024/25 Internal Audit Plan 3

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Appendix A Assignment Status Schedule

Appendix B Report Response Times

Appendix C Key Performance Indicators

Appendix D Assurance Ratings

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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 2024/25 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 2024/25 was agreed by the Audit, Risk & Assurance Committee in March 2024 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Outcomes from Completed Audit Reviews

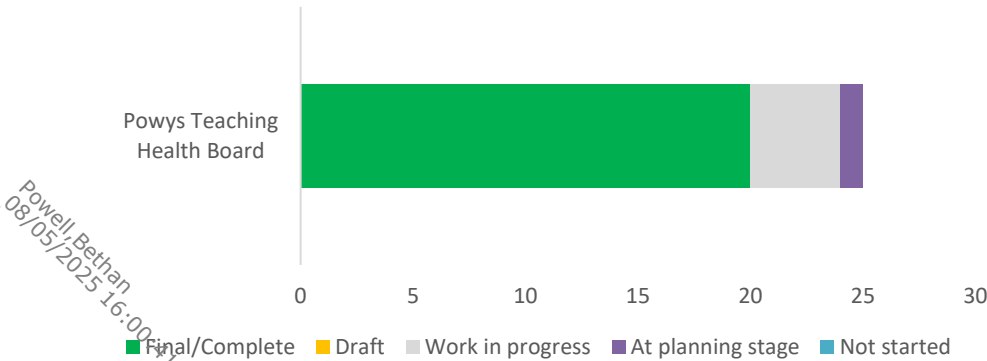
Seven assignments from the 2024/25 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The Executive Summaries from the final reports are provided in Section five. The full reports are included separately within the agenda for information.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
GMS Unified Contract Assurance Framework	Substantial	
Business Continuity Planning		
Information Governance Follow-up		
Pharmacy Stores	Reasonable	
Risk Management & Assurance		
Llandrindod Wells Phase 2		
Partnership Governance Framework	Advisory	

3. Delivery of the 2024/25 Internal Audit Plan

There are a total of 24 reviews included within the 2024/25 Internal Audit Plan, and overall progress to date is summarised below.



The illustration above shows that nineteen audits from the 2024/25 plan have been finalised so far this year.

In addition, there are four audits that are currently work in progress with a further one 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 the audit from the 2023/24 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2023/24. The outcome from that audit will feed into the 2024/25 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).

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4. Final Report Summaries

4.1 GMS Unified Contract Assurance Framework

Purpose

To review the processes for managing the GMS Unified Contract Assurance Framework, and the monitoring and reporting arrangements in place in respect of its implementation.

Overview

A new Unified Contract for GMS Service was negotiated over 18 months as part of a tripartite approach with Welsh Government, NHS Wales and the General Practitioners Committee (Wales) (GPCW).

The NHS (GMS Contracts) (Wales) Regulations 2023 (2023 Regulations) underpinning the Unified Contract came into effect on 1 October 2023.

The Unified Contract for GMS will simplify what services all GP practices in Wales must provide and how they evidence assurance of delivery.

The key aims of the Unified Contract are:

- to make it easier for patients and healthcare professionals to understand responsibilities for the provision of services;
- to reduce administrative bureaucracy, freeing up time and resource for service delivery; and
- to enable use of data and technology to help plan resources and delivery of services.

The GMS Unified Contract Assurance Framework (the “Framework”) is in use across NHS Wales and by general medical services (GMS) contractors to provide assurance of delivery of the GMS Unified Contract. The Framework has been developed taking account of the context of the new Health and Care Quality Standards for Wales (2023).

The Framework is a governance process for the evaluation of assurance on services delivered through the Unified Contract, in the context of the Duty of Quality legislation, and has three components:

- A nationally agreed data set for quality, safety, governance and contract management. This comprises of a national set of indicators, a practice assurance return, CGPSAT and IG toolkit.
- A nationally agreed process for assessing contractors’ compliance against contractual requirements; and
- A nationally agreed escalation ladder for managing concerns, including an appeals procedure.

We have concluded **Substantial** assurance on this area. This reflects the significant work undertaken within the Health Board to ensure that the requirements of the Framework were complied with in delivering the 2023/24 cycle.

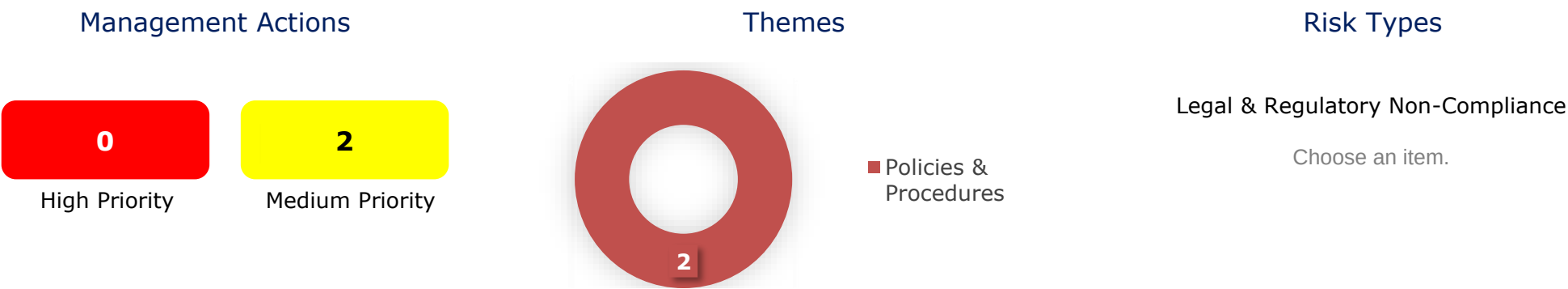
The matters requiring management attention include:

- Absence of a Standard Operating Procedure (SOP) documenting the process for the determination and finalisation of Practice Visit Assessment Report Assurance Ratings.
- Lack of an overall assurance rating for the Practice Visit Assessment reports completed as part of the 2023/24 cycle.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

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	Up to date procedure documents are in place setting out the Health Board’s processes in relation to the Framework.		1	Reasonable
2	An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board.		-	Substantial
3	Visits are carried out to those practices prioritised for further assessment, with timely verbal and written feedback provided, action plans agreed and monitored, and follow-up reviews planned.		-	Substantial
4	The stages of the Framework’s Escalation Ladder are appropriately utilised for those practices where a breach or remedial notice may ultimately be issued by the Health Board.		2	Reasonable
5	The Health Board receives regular reporting and assurance in respect of the new GMS unified contract performance and patient access to primary care GMS services.		-	Substantial



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4.2 Business Continuity Planning

Purpose

The purpose of this review was to establish if the Health Board had appropriate arrangements in place to ensure effective business continuity across all areas and services.

Overview

NHS organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential services will be maintained and normal services restored as soon as possible. As a Category 1 responder with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response. An audit of Business Continuity Planning was undertaken in 2023/24, focusing on arrangements at a corporate level. This audit considered the effectiveness of Business Continuity Planning arrangements at an operational level.

We have concluded **Substantial Assurance** on this area. The matters requiring management attention include:

- The key contact details were missing and / or out of date for some service BCP's
- Testing of service area BCP's was not being undertaken in accordance with BCP policy and guidance

Full details of the matters arising are detailed within the Findings & Agreed Action Plan.

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	There are appropriate operational business continuity plans and supporting processes in place, which cover all of the Health Board's critical operations.		1	Reasonable
2	Relevant operational staff are aware of business continuity plans and the actions required during an incident.		-	Substantial
3	Appropriate command structure and communications are in place in the event of a continuity event occurring.		-	Substantial
4	The Health Board has processes in place for testing operational plans and incorporating lessons learned from recent events.		2	Reasonable

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Management Actions

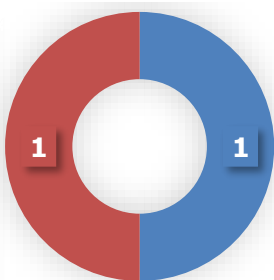


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Lessons Learnt

Risk Types

- Quality or Safety Issues
- Legal & Regulatory Non-Compliance
- Choose an item.
- Choose an item.

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4.3 Information Governance Follow-up

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the limited assurance Information Governance review (PTH-2324-09) that was reported as part of our 2023/24 work programme.

Overview of findings

Management have made good progress in addressing the recommendations, and implementing the management actions detailed in the previous Internal Audit Report.

Of the six recommendations made, five have been closed and one is partially complete.

An Information Governance (IG) and Records Management Activity Tracker has been constructed on a Power BI platform. However, implementation of the Tracker has been delayed, and the planned full needs assessment has therefore not been completed.

Line management responsibilities have been assigned to the two Band 6s within the Information Governance team.

Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) have now been identified across the Health Board and will also be acting as IG Leads for their areas. A training package outlining their roles and responsibilities has been developed and is being delivered.

The new Information Asset Register (IAR) platform has been set-up and has been widely publicised to staff across the Health Board. Procedures and guidance are in place for the IAR, and the population of assets has begun.

An Information Governance & Records Management Operational Group has been established to further promote and co-ordinate good practice across the Organisation.

IG Performance Reports are now being submitted Quarterly to the Executive Committee and 6 monthly to the Audit, Risk & Assurance Committee.

Due to the progress made on the recommendations, we have classified the follow-up audit as Substantial Assurance.

Follow-up Report Classification

		Trend
Substantial	Follow up: All high priority recommendations implemented with excellent progress on the medium priority recommendations.	

Progress Summary

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 IG Team Resources	High		Medium
2 IG Team Line Management	Medium		Closed
3 IAO and IAA Responsibilities	High		Closed
4 IG Leads / Champions	Medium		Closed
5 Information Asset Register	Medium		Closed
6 IG Reporting Arrangements	Medium		Closed

4.4 Pharmacy Stores

Purpose
The overall scope of the audit was to review the policies and procedures in place regarding the Pharmacy Stores.

Overview
Appropriate storage and management arrangements are necessary to ensure that the quality of medicines/vaccines is maintained and so prevent potential harm to patients.
The current arrangements and procedures for the ordering, receipt, storage and distribution of medicines/vaccines were established during the Covid-19 Pandemic in response to the emergency situation.
The Main Pharmacy Store, which was the focus of our review, is situated in Hafren ward on the Bronllys site. This then delivers vaccines into wards, departments and vaccination centres across the Health Board.
We have concluded **Reasonable** assurance on this area. The matters requiring management attention include:

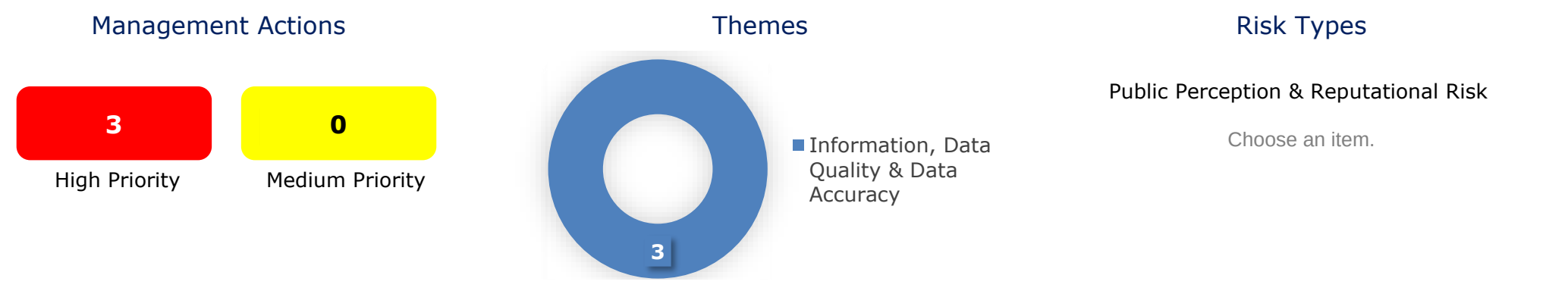
- A lack of supporting documentation for the ordering, receipt and distribution of vaccine stock;
- Inadequate and / or incomplete recording of information within the stock management spreadsheets; and
- Inadequate stock reconciliation procedures, including a lack of book to physical stock reconciliations.

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

- While each vaccine spreadsheet is broadly similar in structure, they have been set up separately and are not identical templates.
- A separate spreadsheet should be set up for each annual vaccination programme.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	-	Substantial
2 The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	1, 2, 3	Limited
3 Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	-	Substantial



4.5 Risk Management & Assurance

Purpose

The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risks and to also review the risk management arrangements in the People & Culture Directorate and the Mental Health & Learning Disability Service.

Overview

The Health Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board’s governance and system of internal controls. The Board is committed to having a risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements, meeting objectives and promoting its values.

At the time of our review the Health Board was undertaking substantial changes to its risk management framework. As well as continuing to develop the use of the Datix Cloud software to record and manage its key risks, the Health Board was revising its overall approach in the recognition that the Board Assurance Framework (BAF) is undergoing further development and also that there is too large a gap between the risks contained in the Corporate Risk Register and those that are managed at Directorate and Service level. The Health Board is therefore developing a sub-component of the BAF that will sit alongside a new Strategic Risk Register, which will replace the current Corporate Risk Register. An Organisational Risk Register is also to be introduced to sit in between the Strategic Risk Register and those at a Directorate level.

The key current concern is therefore development of the BAF, but as stated above this is currently being addressed. Notwithstanding this concern, the reporting of the current key risks through the Board and its sub-committees is working effectively. Given that the known areas of weakness are the subject of documented plans (i.e. the documentation of a BAF, and the introduction of both a Strategic and Organisational Risk Register), we have not raised findings in these areas, and we have concluded reasonable assurance overall. The only matter requiring management attention, over and above the detailed work already underway, is the need to ensure that Directorates and Services have a consistent and accurate approach to recording their risks. The implementation of the DatixCloudIQ system should largely address this but we recommend that this is supported by updated training and guidance.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

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	There is appropriate guidance in place which is up to date and accessible to all staff.		-	Reasonable
2	There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.		-	Substantial
3	There are appropriate processes in place for reviewing, monitoring and reporting of risks. Risks are escalated when appropriate.		1	Reasonable
4	There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.		-	Reasonable
5	The audit will identify the progress of implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (PHTB-2324-01).		-	Reasonable



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4.6 Llandrindod Wells Phase 2

Purpose

The overall objective of this audit was to evaluate the progression and delivery of the Llandrindod Wells Phase 2 project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Overview

The review noted that at the time of the audit fieldwork the project was on schedule to be delivered on time, and with no quality issues identified. The project benefited from good overall governance, with robust reporting channels and clear ongoing engagement with stakeholders ensuring they were informed of progress and key milestones/events, which was paramount given that the work was taking place in a live clinical setting. At the time of Audit fieldwork, the latest cost report indicated that the project would be delivered within budget.

We have concluded reasonable assurance on this area. We have identified two matters for reporting in our review:

- The Project risk register did not incorporate costs in line with the requirements of the PTHB Capital Procedures.
- KPIs were not completed in respect of the THB’s advisers or the Supply Chain Partner.
- Despite contractual obligations, a performance bond was not provided by the Supply Chain Partner.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Project Performance- achievement of the project’s key delivery objectives (time, cost, and quality).	-	Substantial
2	Governance - To obtain assurance that adequate governance arrangements exist including management ownership, defined roles and responsibilities, and clearly defined accountability & delegation arrangements.	-	Substantial
3	Project Management & Reporting - Assurance that appropriate recognised project management tools have been developed and are utilised to ensure effective oversight and delivery of the project. That appropriate project monitoring and reporting arrangements are demonstrated.	1	Reasonable
4	Contractual Appointments – assurance that the Supply Chain Partner and any advisers are appropriately appointed with standardised forms of contracts.	2,3	Reasonable
5	Financial Management – To confirm adequate cost control systems are operated, both internally and by the External Cost Adviser. Supply Chain Partner and Advisor payments are progressed in accordance with the contractual requirements and valuations are appropriately evaluated and approved. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.	1	Substantial

Management Actions

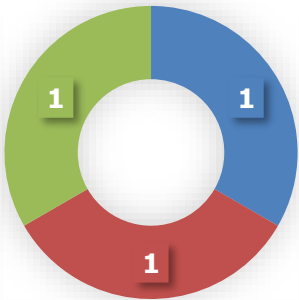


High Priority



Medium Priority

Themes



- Risk Management
- Quality, Safety & Patient Experience
- Financial Management and Control

Risk Types

- Financial Loss
- Quality or Safety Issues

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4.7 Partnership Governance Framework

Purpose

To establish and assess the current position and future plans towards development of a Partnership Governance Framework (the 'Framework').

Overview

The Partnership Governance Framework has only just been approved by the Executive Committee and will now start to be implemented. Therefore, our review was limited to the work done thus far on populating the framework and the plans for its operation. This appears to be reasonable, and the Health Board is approaching the implementation of the framework in stages with Phase One limited to the 14 Statutory Partnerships. As the framework is extended to cover "Partnerships by Choice" it will become increasingly important to ensure that the time and investment in maintaining the framework is justified by the value that it delivers. In particular, the Health Board needs to ensure that reporting on individual partnerships is proportionate to their importance to the Health Board, and also that current reporting mechanisms are not disrupted and/or duplicated.

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Report Classification

Assurance
not applicable



Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

- 1 There is a clear plan and timeline in place for the development and delivery of the Framework.
- 2 All existing and planned partnerships and collaborations have been identified and documented to inform development of the Framework.
- 3 The partnerships and collaborations have been mapped against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes.
- 4 A partnership register has been developed with robust plans for ongoing review and maintenance.
- 5 The planned format and content of the Framework is appropriate to ensure effective ongoing governance and management of the Health Boards partnerships and collaborations.

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ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2023/24 Plan								
Integrated Performance Framework	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.		Planning, Performance and Commissioning			Final Report	Substantial	October
2024/25 Plan								
Integrated Plan Development Process	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	13	Planning, Performance and Commissioning	1		Final Report	Reasonable	October
Cleaning Standards	Review of processes and controls in place to ensure compliance with national cleaning standards.	21	Finance, Capital and Support Services	1		Final Report	Reasonable	October
Core Financial Systems – Treasury Management	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	15	Finance, Capital and Support Services	2		Final Report	Substantial	January
Staff Retention	Review and assessment of the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.	11	People and Culture	2/3		Final Report	Reasonable	January
Capital Systems	A review of the arrangements in place for the selection and award of advisers and contractors at health board projects; to include the use of local, regional, and national framework arrangements, adequacy of contractual arrangements applied etc.	26	Finance, Capital and Support Services	2		Final Report	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Energy Management	Determine the adequacy of and operational compliance with, the established systems for the management and control of energy consumption within the Health Board, will also take account of other supporting regulatory and procedural requirements.	25	Finance, Capital and Support Services	2		Final Report	Reasonable	January
Board & Committee Structure / Effectiveness	Evaluate the Health Board's Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	2	Corporate Governance / Board Secretary	2		Final Report	Substantial	January
Deprivation of Liberties Safeguards (DoLS)	Review of the arrangements for ensuring compliance with DoLS requirements including role of Best Interest Assessors. Will need to consider potential scope of this audit further.	10	Nursing, Quality, Women and Family Health	3		Final Report	Limited	January
Records Management	Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.	18	Corporate Governance / Board Secretary	3		Final Report	Substantial	January
Community Cardiology	Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.	24	Primary, Community Care and Mental Health	3		Final Report	Reasonable	March
Additional Learning Needs Legislation	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	19	Nursing, Quality, Women and Family Health	2/3		Final Report	Reasonable	March
Patient Flow and Discharge Management	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.	6	Primary, Community Care and Mental Health	1		Final Report	Reasonable	March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
GMS Unified Contract Assurance Framework	Review of the processes for managing the GMS Unified contract performance framework and monitoring and reporting performance.	16	Primary, Community Care and Mental Health	3		Final Report	Substantial	May
Pharmacy Stores	Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing.	4	Medical	4		Final Report	Reasonable	May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance / Board Secretary	4		Final Report	Reasonable	May
Follow-up: Information Governance	Follow-up of 23/24 Limited Assurance report.	17	Corporate Governance / Board Secretary	3		Final Report	Substantial	May
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Following on from the 23/24 audit of the corporate level arrangements.	23	Public Health / Primary, Community Care and Mental Health	3		Final Report	Substantial	May
Partnership Governance Framework	To establish and assess the current position and future plans towards development of a Partnership Governance Framework.	12	Planning, Performance and Commissioning / Corporate Governance	4		Final Report	Advisory	May
Capital Project – Llandrindod Wells Phase 2	To assess the THB's processes, procedures and operational management of the delivery of the Llandrindod Wells redevelopment programme.	27	Finance, Capital and Support Services	4		Final Report	Reasonable	May
Contract Management	To assess whether the Health Board has appropriate contract management arrangements in place.	14	Finance, Capital and Support Services	3		Work in Progress		July
Cancer Tracking – Service Delivery	Review the effectiveness of the structures and processes in place to provide sustainable cancer services that deliver the suspected cancer pathway standards.	5	Medical	3/4		Work in Progress		July

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Quality & Safety Governance (Duty of Quality)	Review of the Health Board's arrangements for quality monitoring and reporting through the Integrated Quality Report, as part of ensuring compliance with the Duty of Quality.	9	Nursing, Quality, Women and Family Health	4		Work in Progress		July
Medical Devices - Mattresses	to review the processes and controls in place across the Health Board to ensure that mattresses are subject to appropriate checks and maintenance.	20	Allied Health Professions, Health Sciences & Digital	4		Work in Progress		July
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.	7	Primary, Community Care and Mental Health	2/3	4	Planning		October 25

Reviews removed from the plan

Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	3	Corporate Governance / Board Secretary	The Director of Corporate Governance / Board Secretary identified that a new system for management of policies had been approved for implementation during 2024/25, so the audit was deferred to 2025/26 to provide assurance on the new system. Approved by July 24 ARAC.				
Local Primary Mental Health Support Services	Review of how the Local Primary Mental Health Support Services are structured, managed and delivered.	8	Primary, Community Care and Mental Health	Removed from the 24/25 plan due to significant delay in agreeing the scope of the audit which meant resource was no longer available to deliver. Approved by January 25 ARAC.				
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	22	Finance, Capital and Support Services	Deferred 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. Approved by March 25 ARAC				
Estates Condition Follow-up	Follow-up of 23/24 Limited Assurance report.	28	Finance, Capital and Support Services	Removal from the 24/25 plan, due to the funding constraints in addressing the underlying issues. Approved by March 25 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
Integrated Performance Framework	Substantial	Final	29/07/24	19/08/24	15/08/24	15/08/24	G
Integrated Plan Development Process	Reasonable	Final	22/08/24	13/09/24	30/09/24	30/09/24	R
Cleaning Standards	Reasonable	Final	20/09/24	11/10/24	27/09/24	30/09/24	G
Core Financial Systems – Treasury Management	Substantial	Final	25/10/24	15/11/24	15/11/24	19/11/24	G
Staff Retention	Reasonable	Final	28/10/24	18/11/24	07/11/24	08/11/24	G
Board & Committee Structure/Effectiveness	Substantial	Final	28/11/24	19/12/24	03/12/24	03/12/24	G
Capital Systems	Reasonable	Final	14/10/24	04/11/24	19/11/24	21/11/24	R
Energy Management	Reasonable	Final	29/10/24	19/11/24	05/12/24	05/12/24	R
Deprivation of Liberties Safeguards	Limited	Final	10/12/24	03/01/25	23/12/24	30/12/24	G
Records Management	Substantial	Final	12/12/24	07/01/25	06/01/25	06/01/25	G
Community Cardiology	Reasonable	Final	05/02/25	26/02/25	18/02/25	18/02/25	G
Additional Learning Needs Legislation	Reasonable	Final	19/02/25	12/03/25	27/02/25	27/02/25	G
Patient Flow and Discharge Management	Reasonable	Final	06/02/25	27/02/25	27/02/25	27/02/25	G
GMS Unified Contract Assurance Framework	Substantial	Final	20/03/25	10/04/25	10/04/25	10/04/25	G
Medicines Management (Pharmacy Stores)	Reasonable	Final	01/04/25	24/04/25	09/04/25	10/04/25	G
Risk Management	Reasonable	Final	14/04/25	08/05/25	23/04/25	24/04/25	G

Business Continuity Planning	Substantial	Final	17/04/25	12/05/25	25/04/25	25/04/25	G
Information Governance Follow-up	Substantial	Final	23/04/25	15/05/25	30/04/25	01/05/25	G
Partnership Governance Framework	Advisory	Final	25/04/25	15/05/25	30/04/25	01/05/25	G
Llandrindod Wells	Reasonable	Final	14/03/25	04/04/25	02/05/25	06/05/25	R

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KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	May 2024	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	A	68% 13 from 19	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	95% 19 from 20	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	80% 16 from 20	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 20 from 20	80%	v>20%	10%<v<20%	v<10%

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Assurance Ratings

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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GMS Unified Contract Assurance Framework

Final Internal Audit Report 2024/25

Powys Teaching Health Board



Substantial Assurance

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GIG MRU
NHS
Wales

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Review Reference

PTH-2425-16

Fieldwork

January – March 2025

Executive Sign Off

10th April 2025

Audit Committee

May 2025

Executive Lead

Elaine Lorton, Executive Director of Primary
Care and Mental Health

Audit Team

Ian Virgill, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit

Stuart Bodman, Principal Internal Auditor

Executive Summary

Purpose

To review the processes for managing the GMS Unified Contract Assurance Framework, and the monitoring and reporting arrangements in place in respect of its implementation.

Overview

A new Unified Contract for GMS Service was negotiated over 18 months as part of a tripartite approach with Welsh Government, NHS Wales and the General Practitioners Committee (Wales) (GPCW).

The NHS (General Medical Services Contracts) (Wales) Regulations 2023 (2023 Regulations) underpinning the Unified Contract came into effect on 1 October 2023.

The Unified Contract for GMS will simplify what services all GP practices in Wales must provide and how they evidence assurance of delivery.

The key aims of the Unified Contract are:

- to make it easier for patients and healthcare professionals to understand responsibilities for the provision of services;
- to reduce administrative bureaucracy, freeing up time and resource for service delivery; and
- to enable use of data and technology to help plan resources and delivery of services.

The GMS Unified Contract Assurance Framework (the "Framework") is in use across NHS Wales and by general medical services (GMS) contractors to provide assurance of delivery of the GMS Unified Contract. The Framework has been developed taking account of the context of the new Health and Care Quality Standards for Wales (2023).

The Framework is a governance process for the evaluation of assurance on services delivered through the Unified Contract, in the context of the Duty of Quality legislation, and has three components:

- A nationally agreed data set for quality, safety, governance and contract management. This comprises of a national set of indicators, a practice assurance return, CGPSAT and IG toolkit.
- A nationally agreed process for assessing contractors' compliance against contractual requirements; and
- A nationally agreed escalation ladder for managing concerns, including an appeals procedure.

We have concluded **Substantial** assurance on this area. This reflects the significant work undertaken within the Health Board to ensure that the requirements of the Framework were complied with in delivering the 2023/24 cycle.

The matters requiring management attention include:

- Absence of a Standard Operating Procedure (SOP) documenting the process for the determination and finalisation of Practice Visit Assessment Report Assurance Ratings.
- Lack of an overall assurance rating for the Practice Visit Assessment reports completed as part of the 2023/24 cycle.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

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	Up to date procedure documents are in place setting out the Health Board's processes in relation to the Framework.	1	Reasonable
2	An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board.	-	Substantial
3	Visits are carried out to those practices prioritised for further assessment, with timely verbal and written feedback provided, action plans agreed and monitored, and follow-up reviews planned.	-	Substantial
4	The stages of the Framework's Escalation Ladder are appropriately utilised for those practices where a breach or remedial notice may ultimately be issued by the Health Board.	2	Reasonable
5	The Health Board receives regular reporting and assurance in respect of the new GMS unified contract performance and patient access to primary care GMS services.	-	Substantial

Management Actions



High Priority



Medium Priority

Themes



■ Policies & Procedures

Risk Types

Legal & Regulatory Non-Compliance

Choose an item.

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Findings & Agreed Action Plan

Objective 1: Up to date procedure documents are in place setting out the Health Board’s processes in relation to the Framework.

Reasonable

Overview / Summary of Observations

The Health Board Primary Care Team that oversees the management, oversight and GMS Contractor compliance with the Framework has chosen not to create Standard Operating Procedures in respect of these processes.

Instead, they work solely to the Framework Guidance documentation that supports the implementation of the Framework, and given its content, logical structure and ease of use, we agree that there is no need for a separate Health Board SOP as this would largely be a facsimile of the Guidance itself.

Training has been provided by Welsh Government to ensure that Health Board Primary Care staff can undertake GMS Practice Visit Assessments in accordance with the Framework Guidance Appendix A requirements, and this was evidenced through our testing relating to Objectives 2, 3 and 4 of this Report.

Additionally, our testing also confirmed that GMS Unified Contract Practice Managers are conversant with the requirements of, and also their responsibilities relating to, the performance assessment process undertaken by the Health Board and as detailed within Appendix A of the Framework Guidance.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Standard Operating Procedure: Practice Visit Report Assurance Ratings</u> 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. The Framework Guidance states no criteria relating to the assessment of the Assurance Ratings for the twelve Standards to come to a definitive or overall Report Assurance Rating, nor does it provide advice relating to the 'weighting' to be attributed to the Standards regarding their priority towards the determination of a final Report Assurance Rating.	Non-compliance with the requirements of the Unified GMS contract resulting in potential patient harm, reputational damage and financial penalties.	Agreed Action: 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.
			Expected Evidence of Implementation: Confirmation that the national guidance has been received and is being followed.
			Medium Priority
Theme: Policies & Procedures		Control Design	Target Implementation Date: Quarter 3 2025/26

Objective 2: An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board.

Substantial

Overview / Summary of Observations

Our testing identified that the annual assessment cycle for 2023/24 relating to the sixteen GMS Contractor Practices within Powys was appropriately supported by and based upon on data collated from the Primary Care Information Portal (PCIP), and other relevant and appropriate data/information sources in accordance with the Framework requirements.

The GMS Practice assessment process is undertaken by a Health Board Primary Care Assessment Panel that comprises of the GMS Primary Care Team, Assistant Director of Primary Care, Assistant Medical Director, Senior Pharmacist - Medicines Management and the Public Health Head of Service.

Each GMS Practice assessment is formally recorded in a desktop assessment report which states the data sources used in the assessment, and the assessment outcome and supporting justification against each of the Framework Indicator Domains and Enablers and is also recorded in an Action Plan that is shared with the respective GMS Practice.

The outcomes of each desktop assessment report then determines and states the justification as to which Practices are identified for Practice Visit Assessments, and those Practices that are to undergo assessment are reported to the Executive Director of Primary, Community Care and Mental Health via the Directorate Management Team meeting.

As such, five GMS Practices were identified in the 2023/24 assessment cycle as requiring a Practice Visit Assessment and the outcomes of these is discussed in Objective 3 of this Report.

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Overview / Summary of Observations

GMS Contractor Practice visits are formally structured and timetabled and ensure satisfactory prior notice of assessment, agenda of assessment coverage to be undertaken, and the provision of formal written feedback and further actions to be undertaken.

The Primary Care Team maintains a Contract Governance and Assurance Visits Log that timetables GMS Practice Assessment Visits and the issue of the reports and action plans to GMS Contractor Practice Management Teams, and also that of the timescales as prescribed in the Framework Guidance.

All five GMS Practices identified in the 2023/24 assessment cycle as requiring a Practice Visit Assessment were supported by and formally documented within the following:

- A Unified Contract Assurance Framework Outcome and Practice Notification of Visit Letter;
- A Unified Contract Assurance Framework Visit Agenda that summarises the process to be undertaken, the National Indicator Domains to be assessed and the formal reporting outcomes of the assessment undertaken;
- A Contract and Visit Governance Report and covering Health Board Primary Care Department Letter, and Practice Contract and Governance Framework Response Plan (PCGFRP) template to be completed by the GMS Practice Team.

We also note that in accordance with the Framework Guidance, all five GMS Practices were sent their Contract and Governance Visit Assessment Reports within 20 working days of the visit, and each respective submission deadline and date of sending to each Practice were recorded in the Contract Governance and Assurance Visits Log.

All five GMS Contractor Practice visits were fully and formally documented within Contract and Visit Governance Assessment Reports and supported by evidence-based justification to support their assurance levels and supported by Practice Contract and Governance Framework Response Plans (PCGFRPs) that will be subject to compliance monitoring and progress reporting within the Health Board. Additionally, none of the Contract and Governance Visit Assessment Reports stated a 'No Assurance' assessment rating.

We also note that all PCGFRPs were returned to the Health Board in a prompt manner and their assessment findings and improvement action recommendations were uncontested in content by the GMS Practices. The Contract Management Group reviewed the returned PCGFRPs and monitoring of progress towards implementation of the actions will take place as part of the review of the practices 2025/26 Annual Returns.

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Overview / Summary of Observations

None of the five GMS Practice Contract and Governance Visit Assessment Reports required the invocation of the Framework Escalation Ladder, in accordance with the stated requirements of the Guidance We also note that there wasn’t any contentious engagement and / or dialogue with the GMS Contractors at any stage of the Practice Assessment Visits, and all respective Governance Framework Response Plans (PCGFRPs) relating to these Reports were accepted by the respective GMS Contractor Practice Management Teams.

Whilst not applicable during the 2023/24 annual assessment cycle, processes are in place to efficiently and effectively manage any future invocation of the Framework Escalation Ladder and the subsequent monitoring undertaken by the Primary Care Team and Health Board senior management in this respect.

Key Findings		Risk & Impact	Agreed Management Action
2	<u>Overall assurance rating for the Practice Visit Assessment reports</u> 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.	Non-compliance with the requirements of the Unified GMS contract resulting in potential patient harm, reputational damage and financial penalties	Agreed Action: 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.
			Expected Evidence of Implementation: Overall ratings recorded on future reports.
		Theme: Policies & Procedures	Medium Priority
		Control Design	

Objective 5: The Health Board receives regular reporting and assurance in respect of the new GMS unified contract performance and patient access to primary care GMS services.

Substantial

Overview / Summary of Observations

GMS Unified Contract performance activity is appropriately subject to monitoring and reporting at a GMS Contract Management Group meeting which meets monthly and has a current Terms of Reference that outlines its role, responsibilities and reporting arrangements. Reporting is also made to the Directorate Management Team meetings on a monthly basis, one-to-one meetings between the Assistant Director of Primary Care and the Executive Director of Primary, Community Care and Mental Health, and the Delivery and Performance Committee via the Executive Director of Primary, Community Care and Mental Health.

We also note that GMS Unified Contract activity is also provided via monthly Health Board Primary Care Briefing Reports to Welsh Government.

Additionally, a briefing session to Board members relating to the GMS Unified Contract was undertaken in February 2025 that included a presentation of the Unified Contract Assurance reporting process, and also a situation activity progress report summary as at that date.

We also note that reporting of patient accessibility to GMS services is regularly provided via the Delivery and Performance Committee, and in the event that issues relating to patient access are identified through the annual assessment cycle these will also follow the same reporting lines.

However, in the event that the Framework Escalation Ladder criteria are invoked in future annual assessment cycles, this would be subject to discussion at a GMS Contract Management Group meeting and escalated further within the Health Board via the Assistant Director of Primary Care if deemed appropriate.

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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](#)

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

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.

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Public Sector Internal Audit Standards

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Pharmacy Stores

Final Internal Audit Report

2024/25

Powys Teaching Health Board



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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTHB-2425-04

February – March 2025

9th April 2025

May 2025

Kate Wright, Executive Medical Director

Ian Virgil, Head of Internal Audit

Geoffrey Woolley, Principal Internal Auditor

Powell Bethan
08/05/2025 16:00:47



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Partnership
Audit and Assurance Services



Executive Summary

Purpose

The overall scope of the audit was to review the policies and procedures in place regarding the Pharmacy Stores.

Overview

Appropriate storage and management arrangements are necessary to ensure that the quality of medicines/vaccines is maintained and so prevent potential harm to patients.

The current arrangements and procedures for the ordering, receipt, storage and distribution of medicines/vaccines were established during the Covid-19 Pandemic in response to the emergency situation.

The Main Pharmacy Store, which was the focus of our review, is situated in Hafren ward on the Bronllys site. This then delivers vaccines into wards, departments and vaccination centres across the Health Board.

We have concluded **Reasonable** assurance on this area. The matters requiring management attention include:

- A lack of supporting documentation for the ordering, receipt and distribution of vaccine stock;
- Inadequate and / or incomplete recording of information within the stock management spreadsheets; and
- Inadequate stock reconciliation procedures, including a lack of book to physical stock reconciliations.

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

- While each vaccine spreadsheet is broadly similar in structure, they have been set up separately and are not identical templates.
- A separate spreadsheet should be set up for each annual vaccination programme.

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	Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	-	Substantial
2	The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	1, 2, 3	Limited
3	Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	-	Substantial

Management Actions



High Priority



Medium Priority

Themes



■ Information, Data
Quality & Data
Accuracy

Risk Types

Public Perception & Reputational Risk

Choose an item.

Powell, Bethan
08/05/2025 16:00:41

Findings & Agreed Action Plan

Objective 1: Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	Substantial

Overview / Summary of Observations Appropriate and up to date policies and procedures are in place for Pharmacy Stores which are available on the Health Board's intranet and public website. A log is maintained which records when the written policies/procedures were last read in full by staff required to follow them. 'Good Distribution Practice' training is also provided to staff for which an accompanying test must be passed. Both had been completed by the Pharmacy Stores staff within the preceding year.

Objective 2: The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	Limited

Overview / Summary of Observations Pharmacy Stores manages the vaccine stock for each of the three core vaccination programmes i.e. Covid-19, Flu and RSV (Respiratory Syncytial Virus). Vaccine stock is managed using a series of spreadsheets, with a separate spreadsheet set up for each vaccination programme. Each spreadsheet comprises a series of detailed worksheets which record a comprehensive range of relevant information for orders, receipts, storage and distributions.
Ordered The types of vaccines ordered reflect central guidance, they are ordered from known suppliers, and the quantities ordered reflect known requirements. Vaccine orders are completed by the Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores which is a key aspect of the role.
Received When vaccines are delivered to Pharmacy Stores, the items received are checked for consistency with the order and any quantity or quality issues would be immediately followed up with the supplier. Full receipt details, including batch reference and expiry date, are recorded against the order on the vaccination order worksheet. In addition, Pharmacy Stores is required to record vaccine receipts online on the Welsh Immunisation System (WIS). However, copies of orders and delivery notes are not being consistently retained so we were not able to fully validate these processes for all the orders sampled.
Stored

Pharmacy Stores is made up of three rooms. The main room is a preparation area where receipts are checked and distributions are prepared and the other two rooms hold nine large fridges. Access is restricted by a locked door.

The fridges are medical grade with digital temperature displays which are designed to store vaccines within the required +2°C to +8°C range, plus cool packs used to maintain vaccine temperature during distribution. They have glass doors so their content can be viewed without having to open the door.

The high and low temperatures for each fridge are checked and recorded daily on the online Welsh Immunisation System (WIS). If any are outside the required range, then comments should also be added. We checked a sample of temperatures recorded on WIS and confirmed that they were within the required range.

We visited Pharmacy Stores and confirmed that the fridges were operating correctly within the required temperature range and had unique identifier reference numbers attached. Furthermore, each had a label attached confirming it had been calibrated in May 2024 and this was scheduled to be repeated in May 2025.

However, at peak times of the year, some vaccine is initially held at a neighbouring Health Board's hospital prior to being drawn down to Pharmacy Stores. We were informed that this is due to a lack of current available fridge space and therefore, Pharmacy Stores has proposed upgrading to a large capacity walk in cold storage unit. A paper regarding this was produced for wider consideration, and the issue has been added to the department's risk register.

The Health Board has appropriate procedures regarding the use of quarantine stock where special conditions need to be put in place e.g. reduced expiry date where the required temperature range has been exceeded for a limited period. Furthermore, there has been no vaccine wastage which required recording online on WIS.

Distributed

Vaccines are distributed using specialised vaccine carriers which the Health Board has in a variety of sizes.

Vaccination distributions reflect known appointments scheduled at the vaccination centres (Bronllys and Newtown), to whose records Pharmacy Stores has access, or requests from District Nurses, Maternity Services or School Nurses.

Most distributions occur via an NHS Shared Services driver who collects and distributes vaccines, plus District Nurses occasionally collect vaccines personally.

A vaccination delivery template has been developed which records a comprehensive set of information. It accompanies each vaccination distribution and, following sign off by the recipient, the completed version should be returned to Pharmacy Stores for retention. However, these were not present for the majority of deliveries we sampled.

Vaccine distributions are packed in insulated cool boxes along with cool packs which should maintain the required temperature for up to eight hours. Furthermore, most are transferred in temperature controlled vans.

The vaccination centres have medical grade fridges identical to those in Pharmacy Stores and so can hold surplus stock for the next vaccination session.

Distributions to District Nurses and wards comprise individual vials which have been taken from a full box so that excess stock is not distributed.

Again, we were not able to fully validate the delivery processes for all our sample as copies of requests and delivery notes are not consistently retained.

Key Findings		Risk & Impact	Agreed Management Action
1	Lack of supporting documentation. We tested a sample of 8 vaccine orders and 25 distributions and noted the following: • 8/8 supporting orders were not available; • 7/8 supporting delivery notes for orders were not available; • 14/25 supporting requests for distribution were not available; and • 13/25 supporting delivery notes for distribution were not available.	Inadequate support for Pharmacy Stores stock movements.	Agreed Action: Supporting documentation will be retained and appropriately filed for all Pharmacy Stores stock orders and movements so that the accuracy of the details recorded can be fully justified.
	Theme: Information, Data Quality & Data Accuracy	High Priority Control Operation	Expected Evidence of Implementation: Supporting documentation is readily available for all Pharmacy Stores stock movements. Officer: Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. Target Implementation Date: Complete, already implemented.
2	Inadequate recording of information. While the worksheets have a comprehensive set of columns to record relevant information, a small proportion of the cells were empty or had not been completed. We also noted the following issues: • 1/8 receipts showed differences between the supporting delivery note and the vaccine receipts worksheet; • 3/8 receipts were not correctly shown on the stock check worksheet; • Where WIS records were available, as they are only available for three months, while for 2/8 receipts the stock check worksheet was consistent with WIS, only one of these was also consistent with the receipt tested; • Only 9/12 stock check worksheet balances were consistent with WIS; • The stock check worksheet only includes figures, formulae are not used to carry forward and calculate balances.	Inadequate control of Pharmacy Stores stock.	Agreed Action: The Pharmacy Stores stock records will be reviewed and amended so that they accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).

	Furthermore, the figures shown occasionally do not cast correctly; • 11/12 supporting delivery notes had differences compared to the distribution worksheet, one supporting delivery note's file name was incorrect and one supporting delivery note was incorrectly filed; • 7/25 transaction movements were not correctly shown in the stock check worksheet and of the 18 transaction movements that were correctly shown, 3 did not clearly show the breakdown; and • For 13/25 transaction movements which indicated that they included pack down separated vials, information was not correctly shown in the pack down worksheets.		Expected Evidence of Implementation: The Pharmacy Stores stock records accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).
	Theme: Information, Data Quality & Data Accuracy	High Priority	Officer: Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. Target Implementation Date: Complete, already implemented.
3	Inadequate stock reconciliation procedures. While daily and weekly stock checks are performed, they do not include book to physical stock check reconciliations to confirm the accuracy or otherwise of the records. The stock check worksheet closing balance does not show the split between pack down separated vials and non pack down full box balances. The stock check worksheet does not include the earliest expiry date against the closing balance to ensure that any expiry date issues are promptly highlighted.	Incorrectly recorded Pharmacy Stores stock balances.	Agreed Action: Daily and weekly book to physical stock check reconciliations will be performed, with the book and physical stock balances clearly stated along with a reconciliation of the difference between them and the name of the person who completed the stock check. The stock check worksheet closing balances will show the split between pack down separated vials and non pack down full box balances. The stock check worksheet will include the earliest expiry date against the closing balance.
		High Priority	Expected Evidence of Implementation: Records of completed monthly stock check reconciliations.
	Theme: Information, Data Quality & Data Accuracy	Control Design	Officer: Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. Target Implementation Date: Complete, already implemented.

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08/05/2025 16:00:41

Overview / Summary of Observations

The Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores is the Health Board's designated person responsible for identifying standards and regulations to be complied with in relation to Pharmacy Stores. They have a high level of pharmacy knowledge and experience and are supported by a Pharmacy Technician who also has an appropriate level of pharmacy knowledge and experience.

In relation to Pharmacy Stores, the most significant risks that medicines/vaccines are not being managed in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations are:

- Deterioration of vaccines due to inadequate temperature control:

The fridges are temperature controlled medical grade with daily temperature checks which were calibrated in May 2024 and are due to be repeated in May 2025.

- Manufacturer product recall:

The batch references for vaccine stock are on the packaging and recorded in the vaccine programme spreadsheets and on the Welsh Immunisation System (WIS). Therefore, the implications of any recall can be immediately identified and appropriate action taken.

- Quarantine stock:

Pharmacy Stores staff have confirmed that any such stock would be recorded, and a label attached and advice, confirmed in writing, would be obtained from the manufacturer regarding what action should be taken. However, it was also stated that this is generally not a problem in Pharmacy Stores but is more likely to occur at vaccination locations where the vaccine storage is being repeatedly opened and closed.

Furthermore, no vaccine wastage has been recorded by Pharmacy Stores on the Welsh Immunisation System (WIS) in the preceding three months for which records were available, and we have been assured that this is correct.

We have been informed that the Health Board does not hold an MHRA (Medicines and Healthcare products Regulatory Agency) licence as this is only required by manufacturers / distributors and so is not applicable as the Health Board is merely a user which obtains the vaccines for its own use.

Powell Bethan
08/05/2025 16:00:41

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.
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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.

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Business Continuity Planning

Final Internal Audit Report 2024/25

Powys Teaching Health Board



Substantial Assurance

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Powell Bethan
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GIG
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NHS
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Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead

PTH-2425-23
March - April 2025
April 2025
May 2025
Executive Director of Public Health
Executive Director of Primary, Community
Care and Mental Health
Ian Virgill, Head of Internal Audit
Ken Hughes, Audit Manager

Audit Team

Executive Summary

Purpose

The purpose of this review was to establish if the Health Board had appropriate arrangements in place to ensure effective business continuity across all areas and services.

Overview

NHS organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential services will be maintained and normal services restored as soon as possible. As a Category 1 responder with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response. An audit of Business Continuity Planning was undertaken in 2023/24, focusing on arrangements at a corporate level. This audit considered the effectiveness of Business Continuity Planning arrangements at an operational level.

We have concluded **Substantial Assurance** on this area. The matters requiring management attention include:

- The key contact details were missing and / or out of date for some service BCP’s
- Testing of service area BCP’s was not being undertaken in accordance with BCP policy and guidance

Full details of the matters arising are detailed within the Findings & Agreed Action Plan.

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	There are appropriate operational business continuity plans and supporting processes in place, which cover all of the Health Board’s critical operations.		1	Reasonable
2	Relevant operational staff are aware of business continuity plans and the actions required during an incident.		-	Substantial
3	Appropriate command structure and communications are in place in the event of a continuity event occurring.		-	Substantial
4	The Health Board has processes in place for testing operational plans and incorporating lessons learned from recent events.		2	Reasonable

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Management Actions

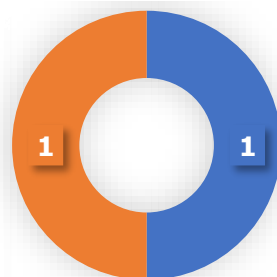
0

High Priority

2

Medium Priority

Themes



■ Information, Data Quality & Data Accuracy

■ Lessons Learnt

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Powell, Bethan
08/05/2025 16:00:41

Findings & Agreed Action Plan

Objective 1: There are appropriate operational business continuity plans and supporting processes in place, which cover all of the Health Board’s critical operations.

Reasonable

Overview / Summary of Observations

The Business Continuity Management Policy requires the Health Board to publish a Corporate Business Continuity Plan (BCP), supporting service level BCP’s and threat specific BCP's such as for severe weather or a pandemic. Service areas are required to complete a high-level Business Impact Assessment (BIA), and this is reviewed annually. The last review was completed in June 2024. The BIA assesses and prioritises services into four categories: Critical; Core; Reduced or Suspended. Only those areas that identify 'critical' services within their BIA are required to then develop a BCP. A separate BCP is required for each critical service identified. A BCP template has been developed as part of the BCP toolkit, and this is available on the PTHB intranet / SharePoint site.

The results of the most recent BIA's undertaken by each service area have been published within the Corporate BCP. Testing confirmed that all service areas had completed the BIA, and all directorates that had identified critical services had developed a BCP for each of the critical services identified, and that these BCP’s were in line with the toolkit template. However key contact and staff details were missing or out of date for some plans.

Key Findings		Risk & Impact	Agreed Management Action
1	Completeness of Service Area BCP’s	BCP's do not contain up to date contact details of key staff causing delays in implementing BCP actions.	Agreed Action: 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.
			Expected Evidence of Implementation: Updated BCP’s.
		Medium Priority	Officers: Assistant Director Community Services Group Assistant Director of Mental Health & Learning Disabilities Services
Theme: Information, Data Quality & Data Accuracy		Control Operation	Target Implementation Date: 30 June 2025

Objective 2: Relevant operational staff are aware of business continuity plans and the actions required during an incident.

Substantial

Overview / Summary of Observations

The directorate BCP leads are responsible for communicating the results of their Business Impact Assessments and, where developed, Business Continuity Plans to all relevant staff within their service areas. This includes all actions required during an incident. A copy of each service area BCP is also held by the Civil Contingencies manager, and a copy is held securely on Resilience Direct, a UK wide secure web platform hosted by the Cabinet Office.

The Civil Contingencies and Emergency Planning section of the PTHB SharePoint site highlights a number of training courses for staff that are delivered by the Civil Contingencies Manager, and a link to an E-learning package 'An Introduction to Emergencies' that is accessed via ESR. The training has been developed to inform and prepare staff to support the Health Board in discharging its responsibilities. The ESR training is not mandatory, but all staff are encouraged to complete the course. The training commenced in 2022/23 and to date 100 staff have completed the training. A Civil Contingencies Training and Education Plan is maintained by the Civil Contingencies Manager, and this sets out the training requirements for all staff and management groups with BCP responsibilities.

Objective 3: Appropriate command structure and communications are in place in the event of a continuity event occurring.

Substantial

Overview / Summary of Observations

The command structure is set out in the Corporate Business Continuity Plan and the Major Incident and Emergency Response Plan and applies to all BCP activity at all levels. The command structure is based on a three-tiered Gold (Strategic) / Silver (Tactical) / Bronze (Operational) structure. There are four levels of response as documented in the Escalation and Response process. Level 1 is the lowest level incident and will result in the implementation of localised business continuity arrangements. Level 2 will require the Gold on-call to be notified (for information) in addition to the implementation of the local BCP. For incidents assessed as level 3 or 4 the Gold on-call and Executive Lead will be notified of the incident. The Gold on-call will then determine the level of response that is required. For a Level 3 incident a Silver Business Continuity Management Group (BCMG) will be established. For a Level 4 incident the Gold on-call will liaise with the Chief Executive Officer to determine if an internal Gold Command is required. These arrangements were tested during our previous review of BCP and were given a substantial assurance opinion.

The Civil Contingencies Emergency Response and Business Continuity Training Plan includes a requirement to carry out a Communications Exercise every 6 months, and our review confirmed this is being done with WAST on a regular basis. The Major incident and Emergency Response Plan contains a section on Liaising with the Media and the use of social media to put messages out directly into the public domain. This states that the Local Resilience Forum Media Cell will usually take the lead in joint agency co-ordination of media information. The Corporate BCP also requires a Communications Lead to be appointed to the internal Silver Business Continuity Management Group (BCMG) to ensure effective communications are put in place in the event of a Level 3 or Level 4 incident.

Overview / Summary of Observations

The Business Continuity Plan template within the BCP toolkit requires the document author to undertake an exercise on an annual basis to test the plan. The testing requirements of BCP's is documented in more detail in the Civil Contingencies Training Plan. A debrief template is included as part of the Business Continuity Plan for completion following a business continuity event. Once completed, a post incident Report is completed and submitted to the Executive Committee for scrutiny and approval. The BCP template is part of the Business Continuity Toolkit that is available to all staff on the Civil Contingencies section of SharePoint.

To date no planned testing of the six operational BCP's in place has been undertaken, although we were informed that both Community Services Group BCP's had been effectively tested during live incidents. A full debrief was also undertaken following Storm Darragh during which the Inpatient BCP was implemented. Following the debrief an incident report with 22 recommendations was prepared and submitted to the Executive Committee for approval on the 5th March 2025. However, we have not received details of any completed or planned testing from either directorate relating to the BCP's they have developed.

A full review was undertaken following the Covid 19 pandemic, and this has resulted in the updating of the PTHB Pandemic Framework for responding to new and emerging pandemics. We were informed that the lessons learned from the Storm Darragh debrief will be incorporated into future BCP plans and guidance.

Key Findings		Risk & Impact	Agreed Management Action
2	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.	Without appropriate testing, plans may be ineffective, and staff may not be adequately informed and practiced.	Agreed Action: 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.
			Expected Evidence of Implementation: Copies of annual tests, debriefs and post incident reports for all service area BCPs.
			Medium Priority
	Theme: Lessons Learnt	Control Operation	Target Implementation Date: 31 July 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.
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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.

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Risk Management & Assurance

Final Internal Audit Report

2024/25

Powys Teaching Health Board



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Appendix A 8

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTHB-2425-01

February - March 2025

April 2025

May 2025

Helen Bushell, Director of Corporate Governance

Ian Virgil, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit

Powell Bethan
08/05/2025 16:00:41

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Executive Summary

Purpose

The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risks and to also review the risk management arrangements in the People & Culture Directorate and the Mental Health & Learning Disability Service.

Overview

The Health Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board’s governance and system of internal controls. The Board is committed to having a risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements, meeting objectives and promoting its values.

At the time of our review the Health Board was undertaking substantial changes to its risk management framework. As well as continuing to develop the use of the Datix Cloud software to record and manage its key risks, the Health Board was revising its overall approach in the recognition that the Board Assurance Framework (BAF) is undergoing further development and also that there is too large a gap between the risks contained in the Corporate Risk Register and those that are managed at Directorate and Service level. The Health Board is therefore developing a sub-component of the BAF that will sit alongside a new Strategic Risk Register, which will replace the current Corporate Risk Register. An Organisational Risk Register is also to be introduced to sit in between the Strategic Risk Register and those at a Directorate level.

The key current concern is therefore development of the BAF, but as stated above this is currently being addressed. Notwithstanding this concern, the reporting of the current key risks through the Board and its sub-committees is working effectively. Given that the known areas of weakness are the subject of documented plans (i.e. the documentation of a BAF, and the introduction of both a Strategic and Organisational Risk Register), we have not raised findings in these areas, and we have concluded reasonable assurance overall. The only matter requiring management attention, over and above the detailed work already underway, is the need to ensure that Directorates and Services have a consistent and accurate approach to recording their risks. The implementation of the DatixCloudIQ system should largely address this but we recommend that this is supported by updated training and guidance.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

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	There is appropriate guidance in place which is up to date and accessible to all staff.	-	Reasonable
2	There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.	-	Substantial
3	There are appropriate processes in place for reviewing, monitoring and reporting of risks. Risks are escalated when appropriate.	1	Reasonable
4	There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.	-	Reasonable
5	The audit will identify the progress of implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (PHTB-2324-01).	-	Reasonable

Management Actions



High Priority



Medium Priority

Themes



■ Risk Management

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

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Findings & Agreed Action Plan

Objective 1: There is appropriate guidance in place which is up to date and accessible to all staff.

Reasonable

Overview / Summary of Observations

The Risk Management Framework has been updated and was approved by the Health Board in March 2025. Although the previous version of the Framework was overdue for review, it remained relevant to the existing arrangements for risk management. The Risk Management Toolkit will now also need to be updated to reflect the changes made in the Framework. The updated Toolkit is planned to be presented to the July 2025 meeting of the Audit, Risk and Assurance Committee for approval. There is therefore sufficient and current documentation available to managers and staff across the Health Board to provide appropriate guidance in the management of risk. We have allocated a rating of reasonable to this objective but not raised a specific finding as the Health Board has plans in place to update the Risk Management Toolkit.

Objective 2: There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.

Substantial

Overview / Summary of Observations

The Director of Corporate Governance is the nominated Director lead for risk management across the organisation. As the planned changes to the approach are implemented the Board will own the Strategic Risk Register and the Organisational Risk Register will be owned by the Executive Committee. Each Executive Director is responsible for identifying a 'Risk Champion' within their relevant directorate to attend the Risk and Assurance Group, a sub-group of the Executive Committee. The Risk and Assurance Group (RAG) provides the opportunity to collectively review Directorate Risk Registers, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate. The RAG has been in existence for some time but did not meet between November 2023 and July 2024. However, it now appears to be back on a quarterly meeting cycle, albeit that ensuring full attendance remains a challenge.

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Overview / Summary of Observations

There is evidence of appropriate review, management, and monitoring of risks at the Board and also with the Board sub-Committees regularly reviewing the risks allocated to them, supported by detailed information from the central risk team. There is also a procedure in place for the escalation of Directorate risks to the Corporate Risk Register, although to date very few risks appear to have been accepted for escalation, but the new procedures proposed for risk management, with the introduction of the Organisational Risk Register, may make this more likely in future. At a Directorate and Service level there is again evidence of appropriate review and updating of Risk Registers albeit that some contain inaccuracies and inconsistencies in their completion. It is hoped that a revised standard approach across the Health Board, populated within the Datix Cloud system, should help to address the issues noted.

Key Findings		Risk & Impact	Agreed Management Action
1	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.	Risks are not accurately recorded in terms of their overall priority and there may be confusion over whether controls are in place.	Agreed Action: 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.
	Theme: Risk Management	Medium Priority	Expected Evidence of Implementation: Updated guidance and training material.
		Control Operation	Officer: Deputy Board Secretary Target Implementation Date: November 2025

Overview / Summary of Observations

The Health Board has a BAF framework in place which was approved by the Board in May 2024, and is in the process of producing the strategic risk dashboard as a subcomponent of the BAF. This will be accompanied by a Strategic Risk Register drawn from the strategic priorities outlined in the Strategic Plan for 2025/26. The intention is for a populated Strategic Risk Register to be presented to the May 2025 Health Board meeting. The BAF dashboards will be developed alongside the Strategic Risk Register and will focus on the assurances in place for the strategic risks that have been identified. Whilst the Strategic Risk Register will be reviewed at all Board meetings, the BAF is expected to be reviewed on a twice-yearly basis. We have allocated a rating of reasonable for this objective as whilst there is a BAF framework in place, there is still a need to develop the risk dashboard as a subcomponent of the BAF. However, we acknowledge that plans are in place to complete this task and for that reason we have not raised a formal finding, but the ongoing action from the 2023/24 audit is noted within Appendix A.

Overview / Summary of Observations

Detail on the position with each of the recommendations from the 2023/24 report is provided in Appendix A. Progress has been made with all of the recommendations although four remain on-going at the current time.

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Appendix A

Ref	Recommendation	Management Response	Audit Update (March 2025)
1	The Risk Management Framework and Risk Management Toolkit should be reviewed in accordance with their stated version control requirements to ensure that their content is current, and in alignment with organisational strategic objectives.	The Risk Management Framework and Risk Management Toolkit will be revised as recommended. Deputy Board Secretary 30 September 2024	The Risk Management Framework has been updated and was signed off by the Board in March 2025. The Risk Management Toolkit will be updated in the coming months. On-going
2	Promotion of risk management should be undertaken to ensure that all Health Board staff are aware of their roles and responsibilities, and a rolling programme of risk management training introduced to maximise their understanding and application of the contents of the Risk Management Toolkit.	A programme of risk management training and awareness will be developed and roll out will commence by 30 October 2024. Deputy Board Secretary 31 October 2024	Training has been provided in-year but it is recognised that an effective programme of training and support will be essential for the effective implementation of the revised framework. Implementation will be supported by a suite of training, guidance and support which is currently under development by the Corporate Governance Team. This will include a revised Risk Management Toolkit, which will return to the Audit, Risk and Assurance Committee on 8 July 2025 for approval. On-going
3	Formal Processes should be established within the Medicines Management department, and Medical Directors Office to ensure regular review and formal reporting of their respective risk registers, and their collegiate risk issues as a whole.	Medicines Management/Pharmacy service leads to ensure that all Medicines Management/Pharmacy risks are reviewed on a monthly basis and that the risk register is updated as appropriate, initialled and dated. Head of Primary Care Medicines Management; Head of Community Services Medicines Management; Senior Pharmacist High-Cost Drugs/Formulary 30 June 2024 Risk register to be a quarterly standing agenda item on the senior pharmacist meeting agenda. Chief Pharmacist 30 June 2024	Review of the Medicines Management Risk Register demonstrates that this was last reviewed on the 30th January 2025. Subsequent to this date the Chief Pharmacist left the organisation on the 14th of February and currently the position has not been filled. Regular review of the register will recommence once a new Chief Pharmacist is in post. Complete Monthly meetings were in place between the Chief Pharmacist and Medical Director to review Medicines Management/Pharmacy Risk Register and will recommence when a new Chief Pharmacist is appointed. Risk is also discussed at Senior Pharmacists' meeting. Complete

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Appendix A

		Formal quarterly meeting between Medical Director and Chief Pharmacist in place to go through Medicines Management/Pharmacy Risk Register to ensure that risks are escalated to RAG as appropriate. Medical Director/Chief Pharmacist 31 August 2024	Risks scoring ≥ 12 escalated to the Risk and Assurance Group. This was evidenced by the submission of two risks for potential escalation to the Corporate Risk Register at the September 2024 meeting of the Executive Committee. This included the recommendation from the RAG on their consideration of these risks. Complete
4	All risks stated on the Women & Children risk register should be reviewed in accordance with a prescribed review timescale that is commensurate to the level of risk scoring. Risks should also be supported by a brief narrative to state action to be undertaken to mitigate each risk, a proposed timescale for completion if practicable, and an action progress update provided during each review undertaken.	Risk registers will be reviewed and updated within the monthly Women & Children Quality & Performance meeting, to ensure timely updates and escalation as required. Assistant Director, Women & Children 31 July 2024	The risk register live link is placed on the Women and Children Senior Leadership Team and Quality and Performance monthly meeting where each department produces a report which also highlights any risks for concerns. Complete
5	All Directorate/departmental risk management leads should be reminded that key risks that are scored 12 and above should be submitted to the RAG for discussion, with a further view for potential escalation onto the Corporate risk register.	Requests for directorate risks have been issued and incorporated onto the Risk and Assurance Group agenda for the scheduled meeting on the 18 July 2024 and will be a standing item thereafter. Director of Corporate Governance 30 June 2024	Review of the Risk & Assurance Group meeting notes suggest that this has been occurring but not on a consistent basis. However, the change in risk management arrangements, with the implementation of an Organisational Risk Register, is likely to make it easier for Directorate risks to be considered for escalation as appropriate and this is reinforced by the updated Risk Management Framework. On-going
6	Ongoing action should be taken to ensure that the BAF is populated as detailed within the covering paper presented to the May 2024 Board meeting. Furthermore, the BAF should then be subject to ongoing progress reporting to the Audit Risk & Assurance Committee and the Board.	The development of the BAF forms part of the scheduled work programme and forms part of the Board work programme for the Boards meeting on the 25 September 2024. Director of Corporate Governance 30 September 2024	Although work has been taken forward on the design of the BAF and how it will work in practice, it is still to be actually populated. The plan is for the Strategic Risk Register to be presented to the May Board meeting with the BAF then going to the July meeting. Ongoing

Appendix B

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.

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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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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.



Information Governance Follow-up Final Internal Audit Report

May 2025

Powys Teaching Health Board



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Health Board



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Review reference:	PTH-2425-17
Report status:	Final
Fieldwork commencement:	16 April 2025
Fieldwork completion:	22 April 2025
Draft report issued:	23 April 2025
Management response received:	30 April 2025
Final report issued:	01 May 2025
Auditors:	Ian Virgill, Head of Internal Audit
Executive sign-off:	Helen Bushell, Director of Corporate Governance / Board Secretary
Distribution:	Amanda Smart, Head of Information Governance, Records & Data Protection Officer
Committee:	Audit and Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose
The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the limited assurance Information Governance review (PTH-2324-09) that was reported as part of our 2023/24 work programme.

Overview of findings
Management have made good progress in addressing the recommendations, and implementing the management actions detailed in the previous Internal Audit Report. Of the six recommendations made, five have been closed and one is partially complete. An Information Governance (IG) and Records Management Activity Tracker has been constructed on a Power BI platform. However, implementation of the Tracker has been delayed, and the planned full needs assessment has therefore not been completed. Line management responsibilities have been assigned to the two Band 6s within the Information Governance team. Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) have now been identified across the Health Board and will also be acting as IG Leads for their areas. A training package outlining their roles and responsibilities has been developed and is being delivered. The new Information Asset Register (IAR) platform has been set-up and has been widely publicised to staff across the Health Board. Procedures and guidance are in place for the IAR, and the population of assets has begun. An Information Governance & Records Management Operational Group has been established to further promote and co-ordinate good practice across the Organisation. IG Performance Reports are now being submitted Quarterly to the Executive Committee and 6 monthly to the Audit, Risk & Assurance Committee. Due to the progress made on the recommendations, we have classified the follow-up audit as Substantial Assurance.

Follow-up Report Classification

		Trend
Substantial	Follow up: All high priority recommendations implemented with excellent progress on the medium priority recommendations.	

Progress Summary

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 IG Team Resources	High		Medium
2 IG Team Line Management	Medium		Closed
3 IAO and IAA Responsibilities	High		Closed
4 IG Leads / Champions	Medium		Closed
5 Information Asset Register	Medium		Closed
6 IG Reporting Arrangements	Medium		Closed

1. Introduction

- 1.1
- The follow-up review of Information Governance was completed in line with the 2024/25 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.
- 1.2
- This was a follow-up review of the original report that was issued in November 2023. This identified six issues and resulted in an overall assurance rating of 'Limited Assurance'.
- 1.3
- The Lead Executive Directors for this review are the Director of Corporate Governance / Board Secretary.

Audit Risks

- 1.4
- The potential risk considered in the original review was as follows:
 - Non-compliance with legislation.

2. Findings

- 2.1
- The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	1	1	-
Medium	4	4	-	-
Low	-	-	-	-
Total	6	5	1	-

- 2.2
- Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

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Appendix A: Management Action Plan

Previous Matter Arising 1: Information Governance Team Resources (Design)		
Original Recommendation 1.1	Original Priority	
The Health Board should ensure that a full assessment of needs and resources is undertaken to identify gaps and risk areas upon which capacity and resilience can be appropriately measured, including but not limited to the following: - all current and upcoming legislative duties, tasks, and strategic developments segregated into corresponding areas such as Records Management or IG; - approximate average time to resolve requests based on level of complexity (until a more suitable solution can be achieved with the Digital Transformation Team); - resource utilisation metrics e.g., total 'billable' hours / total available working hours x 100	High	
Original Agreed Management Action 1.1	Target Date	Responsible Officer
Accept: Work is being undertaken to identify and deploy a suitable digital solution that the IG team can use which will capture all information required to support a full needs analysis.	30/5/2024	Head of Information Governance, Records and DPO
Current findings		Residual Risk
The digital solution has been developed in the form of an Information Governance & Records Management Activity Tracker. The Tracker has been constructed on a Power BI platform and will allow for the recording of all activities undertaken by the Information Governance team and the time spent on these. A delay has occurred in the implementation of the Tracker, we were informed by the Head of Information Governance that this was due to a change in Exec portfolios and subsequent reprioritisation of workload in the Digital Transformation team, along with a temporary reduction in available resource within the Information Governance Team.		Potential risk of: Non-compliance with legislation.

As a result, the data is not yet available to allow for the full needs analysis to be completed. The current plan is for the Tracker to be fully implemented by the 1st July 2025.

Conclusion: The recommendation is partially complete.

New Proposed Management Action		Priority	
1.1	Following completion of the planned implementation of the Tracker, the full needs analysis will be undertaken to identify any gaps and risk areas.	Medium	
Management Response		Target Date	Responsible Officer
1.1	The Tracker will be fully implemented and in use by the Team by the 1 st July 2025.	1 st July 2025	Head of Information Governance
	Once implemented, this tool will provide insights to optimise team operations and ensure efficient resource allocation. It will take at least 6 months to gather enough data to support this work accurately, when a full needs analysis will then be undertaken by the Head of Information Governance and Director of Corporate Governance.	1 st March 2026	Head of Information Governance / Director of Corporate Governance

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

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

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



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Llandrindod Wells Phase 2

Final Internal Audit Report

2024/25

Powys Teaching Health Board



Reasonable Assurance

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Review Reference	PTHB-SSU-2425-27
Fieldwork	January -February 2025
Executive Sign Off	2 nd May 2025
Audit Committee	13 th May 2025
Executive Lead	Pete Hopgood, Executive Director of Finance, Capital & Support Services
Head of Internal Audit	Huw Richards

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Gwasanaethau Archwilio a Sicrwydd

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Executive Summary

Purpose

The overall objective of this audit was to evaluate the progression and delivery of the Llandrindod Wells Phase 2 project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Overview

The review noted that at the time of the audit fieldwork the project was on schedule to be delivered on time, and with no quality issues identified. The project benefited from good overall governance, with robust reporting channels and clear ongoing engagement with stakeholders ensuring they were informed of progress and key milestones/events, which was paramount given that the work was taking place in a live clinical setting. At the time of Audit fieldwork, the latest cost report indicated that the project would be delivered within budget.

We have concluded reasonable assurance on this area. We have identified two matters for reporting in our review:

- The Project risk register did not incorporate costs in line with the requirements of the PTHB Capital Procedures.
- KPIs were not completed in respect of the THB’s advisers or the Supply Chain Partner.
- Despite contractual obligations, a performance bond was not provided by the Supply Chain Partner.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Project Performance- achievement of the project’s key delivery objectives (time, cost, and quality).	-	Substantial
2	Governance - To obtain assurance that adequate governance arrangements exist including management ownership, defined roles and responsibilities, and clearly defined accountability & delegation arrangements.	-	Substantial
3	Project Management & Reporting - Assurance that appropriate recognised project management tools have been developed and are utilised to ensure effective oversight and delivery of the project. That appropriate project monitoring and reporting arrangements are demonstrated.	1	Reasonable
4	Contractual Appointments – assurance that the Supply Chain Partner and any advisers are appropriately appointed with standardised forms of contracts.	2,3	Reasonable
5	Financial Management – To confirm adequate cost control systems are operated, both internally and by the External Cost Adviser. Supply Chain Partner and Advisor payments are progressed in accordance with the contractual requirements and valuations are appropriately evaluated and approved. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.	1	Substantial

Management Actions



High Priority



Medium Priority

Themes



Risk Types

Financial Loss

Quality or Safety Issues

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Llandrindod Wells Phase 2 - At a Glance

A Programme Business Case was endorsed by Welsh Government for this phase of the project, with the initial scope incorporating infrastructure improvements to the envelope of the building, including roof and windows.

Phase 1 of the Reconfiguration scheme was completed in February 2020. Following its completion, discussions with Welsh Government (WG) colleagues focused on the investment required to establish the site as a key *Regional Rural Centre*, addressing backlog maintenance, estate compliance, and infrastructure issues.

In 2022, WG approved the Programme Business Case (PBC) for Phase 2 of the refurbishment project. Initially procured through the Scape framework, the original Supply Chain Partner (SCP) developed the design to RIBA Stage 4, finalised in October 2023. However, WG rejected the funding application, as the £2.77m cost for Building Envelope and External Improvements failed to demonstrate value for money.

To ensure competition and cost-effectiveness, PTHB's advisers proposed a competitive tender to Tier 2 Supply Chain Partners using the full RIBA Stage 4 design. Approved in June 2024, an Expression of Interest was issued via the Southwest Wales Regional Contractors Framework (SWWRFCF). Of seven Supply Chain Partners who expressed an interest, only one submitted a bid. After evaluation, the responding SCP was recommended for appointment.

In July 2024, PTHB secured £3m in WG Backlog Maintenance Funding to address the urgent compliance issues, including window replacement and roof repairs.

Agreement was received from WG, to use a proportion of the £3m backlog funding provided for extra work, to be undertaken by the SCP in addition to that contracted for the main works.

Further details on time and costs are provided within the Project Performance section.

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Findings & Agreed Action Plan

Objective 1: Project Performance

Substantial

Overview / Summary of Observations

Time

The WG funding letter dated 3rd July 2024, notes that the funding of £3m in respect of backlog maintenance relates to the period 01/04/24 -31/03/25, and that all funding must have been claimed in full by 31st March 2025. At the time of audit fieldwork, the SCP was working to Prog F issued 20/12/2024. The SCP progress report dated January 2025 noted the following in respect of days lost:

- Storm Bert caused a delay of 1 day on Sunday 23rd November 2024.
- A further 7 days have been lost to weather up to 7th January 2025 (affecting roof works).

However, this had not impacted the overall completion date which remained as 28/03/2025.

Cost

The main contract for the backlog maintenance work as part of phase 2 at Llandrindod consists of works agreed within the tender document at £1,325,827 with provisional sums agreed for Westdene totalling £309,400.

Llandrindod Main works	Wells	Cost as per FS1 (24 th August 2024) Main works	Cost as per FS5 (10 th January 2025) Main works	RISP X-RAY and SPA Road -additional work contracted and funded separately
Contract sum		£1,325,827	£1,325,827	
Provisional sums		£309,400	£309,400	
Main Contract PMI's		-£28,500	£27,886	
Consultant Fees		£217,841	£228,171	
Project Costs		£9,915	£17,806	
Contingency		£401,097	£281,252	
Additional Cost Allowance		£397,687	£219,439	
Main contract PMIs		-	£27,886	
Instructions		-	-	£451,004

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Vat excl recovery	£466,733	£513,977	
Total	£3,100,000	£2,951,644	£451,004

As per table above it can be seen that the cost for the main works which incorporates Llandrindod Wells and Westdene, as per (Cost report Fs1) was £3,100,000, and the latest cost report (Fs5 January 2025) as per column 3, estimated that this would be delivered within the budget envelope.

Additional funding has been secured from WG for RISP X-Ray and SPA Road, which are being delivered by PTHB, through additions to the Supply Chain Partner contract and the associated costings included within the cost reports and have been reproduced here for completeness.

Quality

The performance of the SCP in respect of the quality of the work was reviewed and reported on by virtue of the inspections carried out by the THB's Supervisor, with the reports provided for review/discussion at the Project Board Meeting. The Defect Notification Tracker as of December 2024 recorded - '*no defect notifications raised to date.*'

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Overview / Summary of Observations

The project operated under a clear governance structure, outlined within the Project Initiation Document and Project Board Terms of Reference. The Project Board was supported by an Operational Sub-Group and Client Progress Team, with regular meetings ensuring effective oversight.

Robust reporting channels facilitated communication with the Project Board and the Innovative Environments Group, which includes Executive members. Key roles were well-executed, with strong engagement from the Senior Responsible Officer (SRO), Project Director, and Senior Project Manager.

Powys Teaching Health Board (PTHB) follows established Capital Procedures, periodically reviewed and updated. The project organogram defined clear reporting lines, with escalation routes from the Project Director and SRO to the Finance and Performance Committee via the Innovative Environments Group.

The Llandrindod Wells Reconfiguration Board’s meeting minutes (July–December 2024) showed strong attendance, effective chairing, and meaningful discussions. A Stakeholder Group was formed with an approved Terms of Reference, ensuring broad representation and active engagement on key issues.

For future projects, PTHB may wish to reassess Stakeholder Group membership, given attendance patterns. While up to 30 members could attend, the highest recorded was 21, with 9 members attending only once in six meetings, highlighting the need to review participation criteria.

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Overview / Summary of Observations

A Project Initiation Document (PID) is in place for the scheme. The reviewed PID has been updated to reflect project progress and includes key elements, such as governance structure, roles and responsibilities, and project objectives.

The SCP provided the latest programme (Rev E.2, dated 15th November 2024), confirming a completion date of 31st March 2025, aligned with the contract. A December 2024 Project Highlight Report from the internal project team confirmed the project remained on schedule.

Fortnightly programmes, accompanied by design drawings, were shared with key stakeholders, outlining planned work and affected areas. The Project Board was kept informed of progress, with potential impacts on time, cost, and quality communicated through a suite of monthly reports, including:

- Project Management Dashboard Report (THB’s Advisers)
- Monthly Progress Report (SCP)
- Cost Reports.

The risk management process was outlined in the PID, with the risk register routinely reviewed at Project Board meetings.

Key Findings		Risk & Impact	Agreed Management Action
1	Risk Register PTHB Capital Procedures p22 state: <i>The Risk Register should list all the identified risks along with mitigating actions and the potential cost/programme implications associated with the risk.</i> 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.	Cost of risks not accounted for. Potential for contingency to be inadequate with increased likelihood of project overspend.	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.
		Medium Priority	Expected Evidence of Implementation: Updated risk register with appropriate costing calculations included.
	Theme: Risk Management	Control Operation	Officer: Associate Director of Capital, Estates and Property Date: 31/05/25

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Overview / Summary of Observations

Following an initially high-cost estimate for Phase 2 by the Supply Chain Partner from an earlier phase—rejected by WG—PTHB, with its advisers, issued an Invitation to Tender (ITT) for a Tier 2 SCP via the Southwest Wales Regional Contractors Framework (SWWRCF)..

Advice was obtained from NWSSP Procurement Services on the accessibility of the framework arrangements.

The contract used was NEC Option A (Priced Contract with Activity Schedule), incorporating delay damages of £861 per day for PTHB’s protection. On advice, PTHB opted for a Performance Bond over a Parent Company Guarantee to ensure project delivery.

Advisers were appointed via the NHS SBS Construction Consultancy Services 2 Framework under Lot 2 (Project Management) and Lot 4 (Quantity Surveyor).

All contract documents, including those for the SCP and advisers, were appropriately signed under seal per PTHB’s Scheme of Delegation.

Oracle financials was interrogated to identify payments made to the THB’s Advisers for the period August 2024 to January 2025, testing established that consultant fees had been applied appropriately and reimbursed as per agreed fees.

As noted, the contract was an NEC Option A which involves the THB’s SCP being reimbursed only for those activities undertaken in a given period. A review of the cost reports confirmed that these payments were in line with expectations.

Key Findings		Risk & Impact	Agreed Management Action
2	Key Performance Indicators The THB has appointed a supervisor to ensure the SCP delivered work to the required quality. The SWWRCF framework specifies that <i>'Project KPIs must be completed monthly and compiled quarterly by each region'</i> . 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 do not record/capture objective appraisals of appointed advisers’ performance. Any poor practice or service delivery quality considerations are not available to inform future contract awards.	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.
		Medium Priority	Expected Evidence of Implementation: Set of KPIs developed and utilised.
	Theme: Quality, Safety & Patient Experience	Control Design	Officer: Associate Director of Capital, Estates and Property Date: 31/05/25

3 Performance Bond 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 absence of financial reinsurance and recourse should the SCP fail to meet its obligations. Costs incurred for services not delivered.	The THB will ensure deduction/reimbursement of the cost associated with the provision of a performance bond.
Theme: Finance Management & Control	Control Design	Expected Evidence of Implementation: Confirmation that the THB has requested that the cost of the performance bond be excluded from the final account. Medium Priority Officer: Associate Director of Capital, Estates and Property Date: 31/05/25

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Overview / Summary of Observations

Monthly cost reports from the external cost adviser provided valuable insights into key cost performance areas and are a standing agenda item at Project Board meetings.

NWSSP SES representatives have attended Project Board Meetings, and monthly returns on overall capital expenditure, including Capital Resource Limit (CRL) performance, were submitted to WG. PTHB Capital Procedures and PID detail change control process and the control form to be utilised. A change management register is maintained and a review of a sample of changes found that these were supported by appropriate documentation.

Formal change control procedures were established, with a review of the change register, and testing confirming compliance with THB's procedures.

There was clear evidence of early consideration of adjacencies, ongoing stakeholder engagement, and the use of mitigating controls, including restricted working hours, dust suppression, and noise barriers.

As the works involve infrastructure, there were no forecast significant revenue implications for the project.

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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.

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

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.



Partnership Governance Framework Final Internal Audit Report (Advisory)

May 2025

Powys Teaching Health Board



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Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



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Review reference:	PTHB 2425-12
Report status:	Final Report
Fieldwork commencement:	14 April 2025
Fieldwork completion:	23 April 2025
Draft report issued:	25 April 2025
Management response received:	30 April 2025
Final report issued:	1 May 2025
Auditors:	Peter Stephenson, Principal Internal Auditor
Executive sign-off:	Helen Bushell, Director of Corporate Governance / Board Secretary Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Distribution:	Clare Lines, Assistant Director Partnership Development
Committee:	Audit, Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose

To establish and assess the current position and future plans towards development of a Partnership Governance Framework (the 'Framework').

Overview

The Partnership Governance Framework has only just been approved by the Executive Committee and will now start to be implemented. Therefore, our review was limited to the work done thus far on populating the framework and the plans for its operation. This appears to be reasonable, and the Health Board is approaching the implementation of the framework in stages with Phase One limited to the 14 Statutory Partnerships. As the framework is extended to cover "Partnerships by Choice" it will become increasingly important to ensure that the time and investment in maintaining the framework is justified by the value that it delivers. In particular, the Health Board needs to ensure that reporting on individual partnerships is proportionate to their importance to the Health Board, and also that current reporting mechanisms are not disrupted and/or duplicated.

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Report Classification

Assurance not applicable



Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	There is a clear plan and timeline in place for the development and delivery of the Framework.
2	All existing and planned partnerships and collaborations have been identified and documented to inform development of the Framework.
3	The partnerships and collaborations have been mapped against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes.
4	A partnership register has been developed with robust plans for ongoing review and maintenance.
5	The planned format and content of the Framework is appropriate to ensure effective ongoing governance and management of the Health Boards partnerships and collaborations.

Opportunities:		Audit Objective
1	Co-ordinated Partnership Reporting	3
2	Proportionate Investment of Resource	5

1. Introduction

- 1.1 Our advisory review of the Partnership Governance Framework was undertaken and completed in line with the 2024/25 Internal Audit Plan for the Powys Teaching Health Board (the 'Health Board').
- 1.2 Effective partnership working arrangements requires strong governance and performance management. There should be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population. Ongoing achievement of the Health Board's Health and Care Strategy is dependent on the development and maintenance of successful working relationships with key partners and stakeholders.
- 1.3 The development of a Partnership Governance Framework has been highlighted as a key action to mitigate the risk associated with partnership working. Presentation of the Framework is noted in the Planning, Partnerships and Population Health Committee 2024/25 work programme and is also noted for delivery to the May 2025 Board meeting.
- 1.4 The Executive Leads for this review are the Director of Corporate Governance / Board Secretary and the Executive Director of Planning, Performance & Commissioning.
- 1.5 The potential risk considered in this review is ineffective partnership working, including on service change/reconfiguration, resulting in poorer outcomes and experience for the citizens of Powys.

2. Detailed Audit Findings

Objective 1: There is a clear plan and timeline in place for the development and delivery of the Framework.

- 2.1 The Framework was taken to the Executive Committee meeting held on 2nd April 2025 for approval with the plan for it to become operational with immediate effect. The paper was jointly presented by Helen Bushell, Director of Corporate Governance, and Nicola Johnson, Executive Director of Planning Performance & Commissioning. The paper to the Executive Committee confirms that the development of the framework was a requirement of the 2024/25 Integrated Plan, and that for now 14 statutory partnerships and Joint Committees are covered by it. Regular reporting of the framework will be to the Planning, Partnerships and Population Health Committee, on a bi-annual basis, commencing in Quarter Two of the current financial year.
- 2.2 A full review of the impact of the Framework, and whether any changes are required, will be undertaken at the end of the first year of operation.

Conclusion:

- 2.3 The Framework has now been implemented following approval at the Executive Committee in April. Reporting against the framework will be bi-annual and will

be undertaken in Q2 and Q4 of the current financial year. A full review of the framework is likely to be covered by the Q4 report and it is anticipated that Phase Two of the framework, covering the inclusion of "Partnerships by Choice" will also have been completed by the end of the financial year.

Objective 2: All existing and planned partnerships and collaborations have been identified and documented to inform development of the Framework.

- 2.4 The framework is intended to act as a basis for understanding the Health Board's involvement in partnerships, for ensuring appropriate governance arrangements, and for identifying potential improvements in partnership working. For the time being the content is limited to statutory partnerships but going forward this will be expanded to include "Partnerships by Choice" (to be completed by 31 March 2026).
- 2.5 Population of the framework to date has been through targeting the Assistant Director network across the Health Board. Standing Orders and the Scheme of Delegation have been scrutinised to ensure that the operation of the identified Partnerships is both in accordance with these documents and any relevant national legislation. The Terms of Reference for each partnership have also been reviewed to assess whether the Health Board is adequately represented at each of the Partnerships.
- 2.6 The lead director or supporting officer/Partnership Co-ordinator was asked to provide additional information (if needed) and then to check the proposed entry in the framework. This has included colleagues outside the Health Board in relation to, for example, the Regional Partnership Board; the Public Service Board; the Mid Wales Joint Committee; the Joint Commissioning Committee; and the Area Planning Board.
- 2.7 The following are not included in the framework:
- NHS Contracts where the Health Board is the commissioner of other NHS bodies (NHS Long Term Agreements and NHS Service Level Agreements);
 - Individual programmes and projects;
 - Research and Development Partnerships;
 - Partnerships in relation to supplies, medicines and capital;
 - Advisory Arms-Length Bodies;
 - Executive Arms-Length Bodies;
 - Tribunal Arms-Length Bodies; and
 - Companies.

Conclusion:

- 2.8 The processes undertaken thus far should ensure the identification of all relevant partnerships and collaborations for inclusion on the framework.

However, if a partnership or collaboration has been missed, it can always be added so there is no real risk if one has been omitted in error.

Objective 3: The partnerships and collaborations have been mapped against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes.

2.9 The information recorded thus far for each of the 14 Statutory Partnerships is as follows:

- Formal name of the partnership and the usual acronym;
- Legislative basis of the partnership, where applicable;
- Current terms of reference;
- Major subgroups;
- Current chair of the partnership and the PTHB lead if different;
- Partnership budget and the PTHB contribution or share, where relevant;
- Key plans;
- Existing assurance arrangements;
- Summary of current reporting process and cycles; and
- Current key issues.

2.10 The framework states that assurance arrangements should include coverage of:

- Engagement and co-production;
- Progress against the agreed plan to achieve strategic objectives;
- Risk Management;
- Quality and safety;
- Information governance;
- Finance;
- Performance and Outcomes;
- Escalation arrangements; and
- Audit.

2.11 The Health Board is aware that it needs to ensure that reporting under the framework does not disrupt current reporting schedules, assuming they remain fit for purpose. For example, strategic change or relevant performance information from Regional Partnership Board and Public Services Board meetings would be channelled through the Executive Committee via either the Strategic Change Report or the Integrated Quality and Performance Framework. The highlight report to the Planning, Partnerships and Population Health Committee should not duplicate the information reported through either of these existing reports. **(Opportunity 1)**

- 2.12 Additionally partners such as the Joint Commissioning Committee (JCC) and NHS Wales Shared Services Partnership (NWSSP) produce their own highlight reports which are submitted to the Health Board after each of their Joint Committee meetings. We are advised that the biannual Partnership Governance Framework reports to the Planning, Partnerships and Population Health Committee will pick up on specific issues for Powys arising from either of these highlight reports, and therefore not duplicate the main report.

Conclusion:

- 2.13 As part of the information gathering exercise to populate the framework, existing governance and assurance arrangements have been documented. One of the objectives of having the framework in place is to work with partners to streamline activity across partnerships to prevent duplication and to ensure improved focus on the issues which will have the greatest positive impact on population and patient outcomes and experience and the efficient use of resources. As the framework is implemented and subsequently reported against, it is therefore anticipated that existing governance arrangements will be subject to ongoing review and revision, where considered appropriate.

Objective 4: A partnership register has been developed with robust plans for ongoing review and maintenance.

- 2.14 The Partnership Governance Framework is the Partnership Register. The framework includes a process for amending, adding or deleting partnerships but this is largely dependent on the information being supplied to those responsible for updating it. However, if a partnership is missed out, it can always be added later.
- 2.15 The framework states that the list of partnerships involving the Health Board should be updated annually. The Board should keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; address any specific requirements or directions made by the Welsh Ministers; and to ensure agreed terms and conditions for the partnership are in place.
- 2.16 When adding a new partnership, or amending the details of an existing one, the following will be considered:
- The Executive Committee will ensure that the PTHB Board is aware of the implications of any new or amended legislation;
 - The existing or nominated lead Executive Director will advise PTHB on the arrangements needed and, on its involvement, even where another agency is the lead for the partnership;
 - The Health Board will ensure appropriate engagement about the new or revised arrangements within the Health Board and with stakeholders;

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- There will be compliance with PTHB policy and procedures where PTHB employs/or is to employ staff to support the partnership;
- Consideration will be given as to whether amendments are needed to the Board's Scheme of Delegation;
- Revisions to the Terms of Reference of existing Partnerships may need to be approved;
- Resourcing or changes to the resourcing arrangements for partnerships need to be approved;
- Implications for other partnerships need to be understood;
- PTHB representation will be confirmed; and
- Reporting arrangements will be confirmed.

2.17 As previously stated, a full review of the impact of the Framework, and whether any changes are required, will be undertaken at the end of the first year of operation.

Conclusion:

2.18 The Partnership Governance Framework has been populated with details of statutory partnerships and will be further updated to include details of Partnerships by Choice by 31 March 2026. At this time it will also be subject to a full review to assess the progress made, and benefits accrued from its first year of operation and whether any changes are required to how it operates.

Objective 5: The planned format and content of the Framework is appropriate to ensure effective ongoing governance and management of the Health Boards partnerships and collaborations.

2.19 Reporting on each of the current 14 partnerships and collaborations recorded on the framework will be to the Planning, Partnership and Population Health Committee on a bi-annual basis with the first report due in Q2, 2025-26 and the second report due in Q4. The reports are likely to be in a tabular format using traffic-light reporting.

2.20 A potential issue for the biannual reporting is that the 14 partnerships included on the framework will have different reporting cycles and therefore the report to the Planning, Partnerships and Population Health Committee may be covering different reporting periods for each Committee. This issue will be exacerbated when Phase Two of the Framework is implemented, picking up "Partnerships by Choice". Whilst it would be politically difficult to introduce different tiers of partnerships depending on their importance to the Health Board, there is a need to ensure that the reporting is proportionate to the role of the particular Partnership with the Health Board.

2.21 The framework includes a Partnership Maturity Matrix. Completion of this will not be mandatory as there may already be existing matrices in place within specific partnerships, but ideally the expectation would be that each

partnership has some form of maturity matrix completed. The matrix uses the following levels:

- Never Event – Hostile or absence of partnership relationships;
- Level One - Predominantly single agency approach, with limited input from/involvement of partners. Limited communication. “Hot spots” of poor relationships;
- Level Two - Generally positive and effective engagement from all partners. Commitment to open and transparent communication. Shared commitment to success; and
- Level Three - Relationships characterised by openness, trust, integrity, and respect. Demonstrable commitment to partnership working. Regular and open communication. Regular opportunities for partnership reflection and development. Relationships and processes capable of resolution of difficult issues.

2.22 Whilst there may obviously be a desire to have as many partnerships at Level Three as possible, there also needs to be a cost/benefit analysis undertaken for those partnerships at the lower end of the scale to ensure that the investment in time, effort and resource to move a partnership to Level Three is justified by the benefits that should accrue. **(Opportunity 2)**

2.23 Work is also currently being undertaken with the Regional Partnership Board, which is chaired by the Health Board’s Chair, to implement the maturity matrix to assess the strength of partnership arrangements that it oversees.

Conclusion:

2.24 Whilst the planned arrangements for the framework seem sensible in terms of governance, format and content, the Framework has only just been approved. The course of the coming year will provide a better indication of how effective it has been in aiding the Health Board to ensure that partnership working is benefitting the health of the population that it serves.

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Appendix A: Opportunities for improvement and development

Finding 1: Co-ordinated Partnership Reporting	Residual Risk
Reporting against the framework is intended to be twice-yearly to the Planning, Partnerships and Population Health Committee. Most, if not all of the partnerships included in the framework, will already have formal reporting to the Health Board in place. For example, information about strategic change or relevant performance information from Regional Partnership Board and Public Services Board meetings would be channelled through the Executive Committee via either the Strategic Change Report or the Integrated Quality and Performance Framework. Additionally partners such as the Joint Commissioning Committee (JCC) and NHS Wales Shared Services Partnership (NWSSP) produce their own highlight reports which are submitted to the Health Board after each of their Joint Committee meetings. It is therefore important that the reports to the Planning, Partnerships and Population Health Committee do not delay, duplicate or contradict existing reporting mechanisms, provided that they are currently fit-for-purpose. Reporting to the Planning, Partnerships and Population Health Committee is likely to be made more complex as the individual partnerships will inevitably vary in their timing and frequency of meetings, resulting potentially in different reporting periods being presented to the Committee in the same report. This complexity is only likely to increase as the framework is extended to include Partnerships by Choice in addition to the existing Statutory Partnerships.	Reporting to the Planning, Partnerships and Population Health Committee may become too complex with the potential for both confusion and duplication and may therefore detract from delivering the benefits that the framework is intended to achieve.
Opportunity 1	Priority
We acknowledge that the Health Board intends a full review of the operation of the Framework at the end of the current financial year and ensuring that the biannual reports to the Planning, Partnerships and Population Health Committee are succinct, meaningful, and of value to the Health Board, should be a key consideration in this review.	N/A - Advisory Review

Management Response 1	Target Date	Responsible Officer
This advice is fully accepted. From the outset the Health Board will try to structure the high-level biannual reports to the Planning, Partnerships and Population Health Committee so the reports are succinct, meaningful and add value. It will then ensure this is a key consideration in the review at the end of the financial year.	31 st March 2026	Assistant Director Partnership Development

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Finding 2: Proportionate Investment of Resource		Residual Risk
The proposals for development of the Partnership Governance Framework include the completion of a maturity matrix, albeit that this will not be compulsory and if something similar is already in place, there would be no requirement for this to be replicated. The matrix includes levels of maturity that range from a hostile or no relationship with partners to one that is open and where there is a demonstrable commitment to working together. There is obviously a natural tendency to consider that all partnerships should be at the higher levels of maturity, but as the framework grows with the inclusion of Partnerships by Choice it is also important that the limited time and resource available to the Health Board is not over-invested in partnerships where the benefit to the Health Board does not justify the expense of seeking to boost the maturity levels of the partnership.		That the framework encourages an approach where all partnerships are viewed and treated the same when this may not always be justified from a cost/benefit analysis.
Opportunity 2		Priority
The Health Board should ensure that the investment in building and maintaining individual partnerships through the governance framework is proportionate to the benefits that could potentially accrue to the Health Board in meeting its strategic goals and serving the health needs of its local population.		N/A - Advisory Review
Management Response 2	Target Date	Responsible Officer
This is helpful advice. The Health Board recognises that the investment in building and maintaining individual partnerships through the governance framework needs to be proportionate to the benefits which could potentially accrue. In terms of the matrix development work is planned with the Regional Partnership Board, which is a key partnership for the PTHB. The broader issue will also be a consideration in the review of the first year of the operation of the Framework.	31st March 2026	Assistant Director Partnership Development



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

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Powys Teaching
Health Board

Agenda Item: 5.4

Audit, Risk and Assurance Committee		13 May 2025	
Subject:	Draft Head of Internal Audit Opinion & Annual Report 2024/2025		
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 draft Head of Internal Audit Opinion for 2024/25 and the draft Annual Report.			
RECOMMENDATION(S):			
The Audit, Risk & Assurance Committee are requested to:			
Consider and note the Draft Head of Internal Audit Opinion and Annual Report for 2024/25.			
Approve/Take Assurance		Discuss	Note
		Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
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	

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EXECUTIVE SUMMARY:

The draft HIA Opinion for 24/25 is that 'The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively'.

From the individual audits completed at the time of producing the draft Annual Report, the following final ratings have been provided:

- 7 Substantial Assurance
- 11 Reasonable Assurance
- 1 Limited Assurance.
- 1 Advisory

The Report also includes details of the 4 audits that have been removed from the plan during 2024/25, as reported to previous meetings of the Committee. These audits and the reason for their removal / deferment have been considered when compiling the draft HIA Opinion.

The draft Annual Report includes a number of highlighted areas where reference is made to audits that were work in progress (WiP) at the time of writing. These will be updated to reflect the position when the final HIA Opinion and Annual Report are produced.

The HIA Opinion will need to be reflected within the Health Board's Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the one Limited Assurance report issued so far during the year and the significance of the recommendations made.

BACKGROUND AND ASSESSMENT:

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

This is achieved through delivery of the annual audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2024/25 plan was formally approved by the Audit Committee at its March 24 meeting.

The draft Annual Report sets out the draft HIA Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

The report also details the outcome of audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for the Health Board.

NEXT STEPS:

The final Head of Internal Audit Opinion and Annual Report will be submitted to the Committee and Board in June 2025.

Head of Internal Audit Opinion & Annual Report 2024/25

Powys Teaching health Board



Reasonable Assurance

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Report status:	Draft
Draft report issued:	May 2025
Final report issued:	XX
Author:	Ian Virgill
Audit Committee:	May 2025

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1. Executive Summary

1.1 Purpose of this Report

Powys Teaching Health Board (the 'Health Board') Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards (PSIAS).

1.2 Head of Internal Audit Opinion 2024/25

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2024/25 is: **(To be confirmed pending completion of remaining audits)**

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

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the PSIAS.

The Internal Audit Plan for 2024/25 year, was presented to the Committee in March 2024. Changes to the plan have been made during the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, and the new NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we 'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the

requirements of the Public Sector Internal Audit Standards for 2024/25. We can state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2024/25

Substantial Assurance	• Integrated Performance Framework • Core Financial Systems • Board & Committee Structure / Effectiveness • Records Management • GMS Unified Contract Assurance Framework • Business Continuity Planning • Information Governance Follow-up
Reasonable Assurance	• Integrated Plan Development Process • Cleaning Standards • Staff Retention • Capital Systems • Energy Management • Patient Flow / Discharge Management • Additional Learning Needs Legislation • Community Cardiology • Medicines management (Pharmacy Stores) • Risk Management & Assurance • Llandrindod Wells Phase 2
Limited Assurance	• Deprivation of Liberties Safeguards (DoLS)
Unsatisfactory	•
Advisory/Non-Opinion	• Partnership Governance Framework

Assurance yet to be determined	• Quality & Safety Governance (Duty of Quality) • Contract Management • Cancer Services • Medical Devices Mattresses • Mental Health Care & Treatment Planning

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board’s risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the PSIAS, the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when

forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Powys Teaching health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2024/25 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control is set out below.

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there was **one** Limited audit in 2024/25) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2024/25, and reported to the Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors;

research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified the majority of reviews carried out during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, seven were allocated Substantial Assurance, eleven were allocated Reasonable Assurance, one was allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. One advisory report was also issued.

At the time of producing the draft Annual Report, five audits were still work in progress but had not been sufficiently progressed to reliably determine the assurance rating. It is anticipated that the majority of the work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area:

- **Board & Committee Structure / Effectiveness:** We identified that the Health Board has clear, defined Board and Committee governance and assurance structures that allow for effective and efficient decision-making and scrutiny on areas of accountability. Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks, and reporting is clear and concise. We concluded **substantial** assurance on this area:
- **Risk Management & Assurance:** At the time of our review the Health Board was undertaking substantial changes to its risk management framework. It was continuing to develop the use of the Datix Cloud software to record and manage its key risks and was revising its overall approach in the recognition that the Board Assurance Framework (BAF) required further development. As part of this the Health Board was developing a sub-component of the BAF that will sit alongside a new Strategic Risk Register, which will replace the current Corporate Risk Register. An Organisational Risk Register was also to be introduced to sit in between the Strategic Risk Register and those at a Directorate level. The reporting of the current key risks through the Board and its sub-committees was working effectively but we did note the need to ensure that Directorates and Services have a consistent and accurate approach to recording their risks. We concluded **reasonable** assurance on this area.

- Partnership Governance Framework:** At the time of our review, the Partnership Governance Framework had only just been approved and was starting to be implemented. Therefore, our review was limited to the work done on populating the framework and the plans for its operation. This appeared to be reasonable, but as the framework is extended to cover “Partnerships by Choice” it will become increasingly important to ensure that the time and investment in maintaining the framework is justified by the value that it delivers. In particular, the Health Board needs to ensure that reporting on individual partnerships is proportionate to their importance to the Health Board, and also that current reporting mechanisms are not disrupted and/or duplicated. This was an **advisory** review.

A review of the Annual Governance Statement highlighted that it was generally consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents. *– Still to be confirmed by review of the draft AGS to be submitted to the May AC.*

The planned audit of Policy Management was deferred to the 2025/26 plan as a new system for management of policies had been approved for implementation during 2024/25.

Strategic Planning, Performance Management & Reporting

We have undertaken three reviews in this area.

- Integrated Performance Framework:** We identified that the Health Board’s Framework is well designed and had been effectively implemented with strong governance and data validation processes in place. We also noted that the Framework was subject to effective reporting and review with evidence of actions being taken to address performance issues. We concluded **substantial** assurance on this area.
- Integrated Plan Development Process:** The Health Board had a robust process in place for developing the Integrated Plan that aligned with Welsh Government requirements and timescales and was supported by strong governance arrangements that provided effective oversight and scrutiny of the plan prior to submission to Welsh Government. However, the Health Board were unable to meet the statutory requirement to produce a financially balanced plan, meaning that the plan could not be approved by WG. We also noted that the Health Board had not identified schemes to fully meet its savings requirement at the point that the plan was submitted to WG at the end of March 24. We concluded **reasonable** assurance on this area.
- Business Continuity Planning:** The Health Board has appropriate operational business continuity plans and supporting processes in place, which cover all its critical operations. Sufficient training is available for operational staff to make them aware of business continuity plans and the actions required during an incident. Processes are in place for the testing of plans and ensuring lessons are learned, but we noted that some service area plans had not been tested in the last 12 months. We concluded **substantial** assurance on this area.

Financial Governance and Management

We have undertaken one review in this area.

- Core Financial Systems – Treasury Management:** The Health Board’s Standing Financial Instructions were in place and up to date, although Some updates were

outstanding with respect to the Financial Procedure Rules and review dates had not been defined. Robust processes were operating around cash forecasting, payments, receipts and reconciliations, with sufficient cash balances maintained and cash allocation requests appropriately made where required. We concluded **substantial** assurance on this area.

- The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The audit of Payroll received substantial assurance with Accounts Payable receiving Reasonable Assurance. The audit of PCS Pharmacy received substantial assurance.

Quality & Safety

We have undertaken three reviews in this area, two of which are work in progress, but are planned for inclusion within the 2024/25 opinion.

- **Deprivation of Liberties Safeguards (DoLS):** We reviewed the processes for DoLS applications to establish if they were managed in accordance with the DoLS code of practice, WG guidance and legislation. Whilst we noted that processes had improved recently, the position was not sustainable going forward due to a lack of clarity over the DoLS Supervisory Body role and issues around capacity and delays in key stages of the DoLS application process. We noted three high priority issues relating to the need to establish a sustainable approach for the future delivery of the DoLS Supervisory Body role, improve the process and timeliness for authorisation of DoLS applications and improve the case tracking and management information processes so that performance and delays against target dates in the DoLS process are identified, reported and addressed. We concluded **Limited** assurance on this area.
- **Quality & Safety Governance (WiP):** . We concluded **???** assurance on this area.
- **Medical Devices Mattresses (WiP):** . We concluded **???** assurance on this area.

Information Governance & Security

We have undertaken two reviews in this area:

- **Records Management:** The Health Board had appropriate policies, procedures and guidelines in place for records management. Acute health records were stored in environmentally controlled, secure locations with smoke detectors, but we did note a lack of fire suppression. The records were being transported and tracked appropriately with effective processes in place for archive and disposal. We concluded **substantial** assurance on this area.
- **Information Governance Follow-up:** Management had made good progress in addressing the recommendations, and implementing the management actions detailed in the previous Internal Audit Report. An Information Governance Activity Tracker had been constructed but implementation had been delayed. Information Asset Owners and Administrators had been identified across the Health Board and a new Information Asset Register platform had been set-up and the population of assets had begun. An Information Governance & Records Management Operational Group had also been established to further promote and co-ordinate good practice across the Organisation. We concluded **substantial** assurance on this area.

Operational Service and Functional Management

We have undertaken nine reviews in this area, two of which are work in progress but are planned for inclusion within the 2024/25 opinion. One is still in planning and unlikely to be included within the 2024/25 opinion:

- **GMS Unified Contract Assurance Framework:** The Health Board had undertaken significant work to ensure that the requirements of the Framework were complied with in delivering the 2023/24 cycle. An assessment of practice assurance was undertaken for all 16 GP practices in Powys and visits were then carried out at the 5 practices identified for further assessment. Outcome reports were provided to each practice with action plans agreed to address issues raised. We did however note that there was no procedure in place for determining the overall assurance rating for the visited practices. We concluded **substantial** assurance on this area.
- **Cleaning Standards:** We reviewed the processes and controls in place to ensure compliance with the cleaning standards in place within the Health Board. We found that processes are in place to ensure the effective management and supervision of cleaning standards, supported by a comprehensive cleaning standards procedure. We did identify three key matters relating to the need to clarify the line of reporting and escalation for cleaning standards, develop mechanisms for assuring compliance with cleaning standards in areas that are not directly cleaned by Health Board staff and finally review and clarify the arrangements for reporting performance against the cleaning standards. We concluded **reasonable** assurance on this area.
- **Patient Flow / Discharge Management:** Following our review, it was evident that a significant amount of work was being undertaken on discharge management both within the Health Board's community hospitals and for those Powys residents in beds in other Welsh Health Boards and English Trusts. However, we identified a number of issues around the adequacy and completeness of evidence to confirm that the requirements of the WG Hospital Discharge guidance and associated Discharge to Recover then Assess guidance are being fully and consistently complied with. We also noted that the HBs Community Hospital Discharge Policy and Procedures require updating to provide clear guidance for staff on the Red 2 Green process, so it is correctly applied in all cases. We concluded **reasonable** assurance on this area.
- **Additional Learning Needs Legislation (ALN):** The Health Board had a Standard Operating Procedure in place and had made progress with developing its systems for managing ALN requests and referrals. It was also working with partners to develop the wider strategies and plans. However, the collaborative governance arrangements required strengthening and a formal training programme was required for ALN operating within the Health Board. We also identified the need to improve the monitoring and scrutiny of the partnership's workplan and complete the introduction of data validation processes for the Health Board's case management system. We concluded **reasonable** assurance on this area.
- **Community Cardiology:** The Service was providing effective assessment and treatment to patients via clear pathways with appropriate discharge and onward referral where required. The Service also had robust systems for recording patient data and outcomes. However, we noted that there was an absence of a formal documented structure and adequate resource for the Service and also that there was a need to develop effective governance arrangements following the services move from the project phase into its fully operational status. We concluded **reasonable** assurance on this area.

- **Medicines Management (Pharmacy Stores):** Appropriate and up to date policies and procedures were in place for Pharmacy Stores covering the ordering, receipt, storage and distribution of vaccine stock which allow for vaccines stock to be managed correctly and safely. We did however note three issues around a lack of supporting documentation for the ordering, receipt and distribution of vaccine stock, inadequate and / or incomplete recording of information within the stock management spreadsheets and inadequate stock reconciliation procedures, including a lack of book to physical stock reconciliations. We concluded **reasonable** assurance on this area.
- **Contract Management (WiP):** . We concluded **???** assurance on this area.
- **Cancer Services (WIP):** We concluded **???** assurance on this area.
- **Mental Health Care & Treatment Planning (Planning):** . We concluded **???** assurance on this area.

The planned audit of Local Primary Mental Health Services was removed from the plan due to significant delay in agreeing to the scope of the audit which meant resource was no longer available to deliver.

The planned audit of Site Co-ordination was deferred to the 2025/26 plan due to a recent change in director responsibility for the area and on-going recruitment to the Head of Facilities post.

Workforce Management

We have undertaken one review in this area:

- **Staff Retention:** We identified that the Health Board was working to implement the National Nurse Retention Plan and also develop a local wider workforce retention plan. A number of initiatives had also commenced to encourage and improve the retention of staff and the Health Board was developing the process around exit questionnaires. However, the Health Board needed to set timeframes for those actions within the National Nurse Retention plan that had passed their original dates, and the local retention plan needed to be fully developed to ensure all actions are incorporated. Further work was also required to increase the rate of completion of exit questionnaires. We concluded **reasonable** assurance on this area.

Capital & Estates Management

We have undertaken three reviews in this area:

- **Capital Systems:** Capital and Estates had dedicated substantial time and effort to developing a structured control environment for their projects by implementing a capital toolkit designed to enhance project management and oversight. By establishing clear processes and standards, the department aimed to ensure consistency and quality across all projects. However, we did identify several significant matters including developing appropriate contract strategies for individual projects, standardising the level of detail in the procurement strategy for individual projects, establishing mechanisms to track and monitor areas for improvement identified in the annual procurement reports and reviewing the capital procedures to ensure document retention criteria is appropriate. We concluded **reasonable** assurance on this area.

- **Energy Management:** Appropriate governance arrangements were in place along with robust systems for data capture, validation and payments. The Health Board was also in the process of utilising re-fit monies of circa £4m to introduce or upgrade Building Management Systems (BMS). The move to the new NHS Wales energy contract in 2023 had encountered some issues, however, recognising the robust data processes operated at the THB, the impact of the national issues had not been as significant as seen elsewhere. We identified matters requiring management attention including enhancing energy issue reporting, maintaining appropriate attendance at the all-Wales Energy group meetings, conducting of site walk-arounds and consideration of additional energy risks for inclusion on the Estate's Risk Register. We concluded **reasonable** assurance on this area.
- **Llandrindod Wells Phase 2:** At the time of the audit fieldwork the project was on schedule to be delivered on time and within budget with no quality issues identified. The project benefited from good overall governance, with robust reporting channels and clear ongoing engagement with stakeholders ensuring they were informed of progress and key milestones/events. We did identify that the Project risk register did not incorporate costs, KPIs were not completed in respect of the Health Board's advisers or the Supply Chain Partner and despite contractual obligations, a performance bond was not provided by the Supply Chain Partner. We concluded **reasonable** assurance on this area.

The planned Estates Condition Follow-up was removed from the plan due to the funding constraints in addressing the underlying issues.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

From the specific Information Governance follow up audit undertaken in 2024/25, it was identified that progress had been made by management in implementing the agreed actions and we were therefore able to provide substantial assurance for the follow-up.

Through 2024/25, the Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to each meeting of the Committee.

We undertook work towards the end of the year to validate the stated position for a sample of recommendations. We were able to confirm the recorded position for all of the sampled recommendations and therefore provide the Committee with additional assurance around the accuracy of the tracker. *This work is on-going so will need to confirm this wording as it is completed.*

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2024/25 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2024/25.

2.9 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2024/25.

Our conformance statement for 2024/25 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2024/25 which will be reported formally in the Summer of 2025; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2024/25 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2024/25.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit Committee and Chair of the Trust.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;

- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Health board

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation’s audit programme, will cover activities relating to other health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the accounts payable process, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report.
PCS Pharmacy	Substantial	To provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to pharmacy contractors.
Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Recruitment Services	Substantial	To review the adequacy of systems and controls in place for Recruitment Services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. The overall Head of Internal Audit Opinion for NWSSP is **Reasonable Assurance**.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Financial Sustainability	Reasonable	To review the financial management arrangements in place to ensure the ongoing sustainability of services and project delivery, with a particular focus on sustainable funding requirements for projects (e.g. DPIF, WASPI).
Programme Management	Reasonable	To establish the effectiveness of the portfolio management model used by DHCW and the controls that are in place to ensure it operates across the range of active projects.
Mission One – National Data Resource	Reasonable	To provide assurance over the National Data Resource (NDR) Platform programme of work, including progress towards implementing local datastores, and reference, demographics and medicines data.
Mission One – Cloud Services	Substantial	To provide assurance over the programme of work to move live services from datacentres into the cloud.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation’s activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2025/26 operational audit plan.

The audit plan approved by the Committee in March 2024 contained 28 planned reviews. Changes have been made to the plan with 4 audits removed or deferred. All these changes have been reported to, and approved by, the Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	March 2024	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2024/25	A	79% 19/24	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	95% 18/19	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	G	84% 16/19	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management	G	100%	80%	v>20%	10%<v<20%	v<10%

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
response to issue of final report [10 working days]						

Key: v = percentage variance from target performance

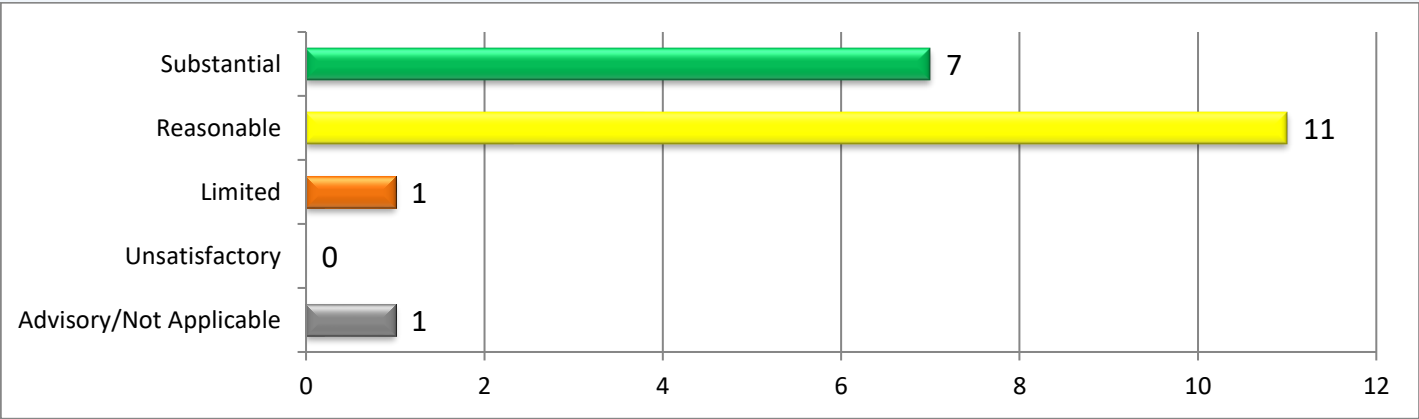
5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 25 (table currently showing 20 and will need to be updated following completion of work in progress) audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings



* Need to add in outcomes for the 5 audits that are still to be completed.

Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Integrated Performance Framework	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.
Core Financial Systems – Treasury Management	To evaluate and determine the adequacy of the systems and controls in place within the Health Board for Treasury Management.
Board & Committee Structure / Effectiveness	Evaluate the Health Board’s Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.
Records Management	Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.
GMS Unified Contract Assurance Framework	Review of the processes for managing the GSM Unified contract performance framework and monitoring and reporting performance.
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services.
Information Governance Follow-up	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 2023/24 Information Governance audit that reported ‘Limited’ assurance.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either

control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Integrated Plan Development Process	Review of the processes and assumptions used for developing the IMTP and Annual Plan, Including a focus on assessment of financial plans.
Cleaning Standards	Review of processes and controls in place to ensure compliance with national cleaning standards.
Staff Retention	Review and assessment of the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.
Capital Systems	A review of the arrangements in place for the selection and award of advisers and contractors at health board projects; to include the use of local, regional, and national framework arrangements, adequacy of contractual arrangements applied etc.
Energy Management	Determine the adequacy of and operational compliance with, the established systems for the management and control of energy consumption within the Health Board, will also take account of other supporting regulatory and procedural requirements.
Patient Flow / Discharge Management	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.
Additional Learning Needs Legislation	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).
Community Cardiology	Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.
Medicines Management (Pharmacy Stores)	Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing.
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.

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Review Title	Objective
Llandrindod Wells Phase 2	To assess the THB's processes, procedures and operational management of the delivery of the Llandrindod Wells redevelopment programme.

5.4 Limited Assurance (Amber)



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

Review Title	Objective
Deprivation of Liberties Safeguards (DoLS)	To review the controls and processes in place for the control, operation and reporting of the Deprivation of Liberty Safeguards (DoLS) as operated by the Health Board.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Partnership Governance Framework	To establish and assess the current position and future plans towards development of a Partnership Governance Framework.

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for removal / deferral
Policy Management	A new system for management of policies had been approved for implementation during 2024/25, so the audit was deferred to 2025/26 to provide assurance on the new system.
Local Primary Mental Health Services	Removed from the 24/25 plan due to significant delay in agreeing to the scope of the audit which meant resource was no longer available to deliver.
Site Co-ordination	Deferred 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.
Estates Condition Follow-up	Removed from the 24/25 plan, due to the funding constraints in addressing the underlying issues.

5.8 Work in progress

At the time of producing the draft Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. It is anticipated that the majority of this work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

Review Title	Objective
Quality & Safety Governance (Duty of Quality)	Review of the Health Board’s arrangements for quality monitoring and reporting through the Integrated Quality Report, as part of ensuring compliance with the Duty of Quality.
Contract Management	To assess whether the Health Board has appropriate contract management arrangements in place.
Cancer Tracking – Service Delivery	Review the effectiveness of the structures and processes in place to provide sustainable cancer services that deliver the suspected cancer pathway standards.
Medical Devices Mattresses	To review the processes and controls in place across the Health Board to ensure that mattresses are subject to appropriate checks and maintenance.
Mental Health Care & 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.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2024/25 plan.

Ian Virgill
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
April 2025

Powell Bethan
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Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing Orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2024/25.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit

	Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition, audit reports are followed up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management, it would be discussed and will be escalated to Board level for resolution.

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Appendix B

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.

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

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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.

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.



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



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

Date issued: May 2025

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

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

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

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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.

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Audit, Risk and Assurance Committee Update

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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](#).

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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 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
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.	Planning completed and Plan presented to Audit Committee. Draft Accounts received 2 May in line with agreed timetable. Final audit ongoing.	AGW sign off date is 27 June 2025

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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
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.	Blog and data tool published in April 2022	
		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).	Part 1 - Report drafting underway.	June 2025
		We also plan to review progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Part 2 – Report drafting underway	June 2025

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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 <u>tackling the planned care backlog</u>. 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.	Report in clearance	June 2025
Structured Assessment 2024 - 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 resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Issued in final	May 2025
Structured Assessment	Executive Director of Finance, Capital	This review will examine digital arrangements, with a particular focus on	In progress	TBC

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
2024 Deep Dive - review of investment in digital systems	& Support Services	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.		
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.	Project brief to be issued in May 2025	TBC
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	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of cancer services	To be confirmed	This work will follow on from the <u>review of national leadership arrangements for cancer services</u>. Whilst the exact focus of this work is to be determined, it is likely to consider: • 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.	Planning	To be confirmed
Follow Up - Review of Quality Governance Arrangements	To be confirmed	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.	Planning	To be confirmed

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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
<u>No time to lose: Lessons from our work under the Well-being of Future Generations Act</u>	April 2025
<u>The Biodiversity and Resilience of Ecosystems Duty</u>	March 2025

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update.

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
<u>Annual Plan 2025-26</u>	April 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.

Annual Audit Report 2024 – Powys Teaching Health Board

Audit year: 2023-24

Date issued: February 2025

Document reference: 4744A2025

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08/05/2025 16:00:41

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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.

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Summary report

About this report

- 1 This report summarises the findings from my 2024 audit work at Powys Teaching Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
 - examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
 - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
 - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
- 2 I report my overall findings under the following headings:
 - Audit of accounts
 - Arrangements for securing economy, efficiency, and effectiveness in the use of resources
- 3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.
- 4 We largely continued to work and engage remotely using technology, but with on-site audit work being undertaken where it was appropriate to do so..
- 5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.
- 6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI¹ auditing standards.
- 7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

¹ INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

- 8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2024 Audit Plan.
- 9 **Appendix 3** sets out the audit of accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.
- 10 The Chief Executive, Director of Finance, Capital and Support Services and Deputy Chief Executive, and the Director of Corporate Governance have agreed the factual accuracy of this report. We presented it to the Audit, Risk and Assurance Committee on 13 May 2025. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the [Audit Wales website](#) after the Board have considered it.
- 11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

- 12 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified 'true and fair' opinion.
- 13 However, in line with last year, the regularity opinion is qualified as the Health Board did not meet its revenue resource limit over the 3 years to 2023-24.
- 14 I also issued a substantive report explaining this qualification. The Health Board did not meet its first and second financial duties to operate within its revenue resource allocation over the three-year period ending 2023-24, and to have an approved three-year integrated medium-term plan.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

- 15 My programme of Performance Audit work has led me to draw the following conclusions:
- The Board and its committees are working well and there is an openness about the challenges the organisation faces and a commitment to secure the necessary improvements. The Health Board has been unable to deliver short- or medium-term plans that are supportable by Welsh Government, and on-going work is required to strengthen some key aspects of the Health Board's corporate governance arrangements.
- While the Health Board met its agreed deficit target for 2023-24, its recent track record of delivering against its overall savings targets is very 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 transformation changes required.

- The Health Board has addressed recommendations from my previous work on primary care relating to leadership and training and is progressing work to develop and strengthen Primary Care Clusters. However, it has struggled to shift resources from secondary to primary care, establish a financial baseline to understand the true cost of primary care and gain a comprehensive understanding of its primary care workforce.

16 These findings are considered further in the following sections.

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Detailed report

Audit of accounts

- 17
- Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation’s financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use (‘regularity’) of public monies.
- 18
- My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4, Appendix 3**.
- 19
- My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

- 20
- I gave an unqualified true and fair opinion but a qualified regularity opinion. In line with last year, the regularity opinion was qualified as the Health Board did not meet its revenue resource limit over the 3 years to 2023-24.
- 21
- The Draft Accounts were submitted to audit before the deadline, and the quality of the account was generally good. Supporting working papers were comprehensive and accurate, and we received excellent co-operation throughout the audit.
- 22
- I must report issues arising from my work to those charged with governance (the Audit, Risk and Assurance Committee) for consideration before I issue my audit opinion on the accounts. My Accounts Report was presented to the Audit, Risk and Assurance Committee on 9 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit, Risk and Assurance Committee

Issue	Auditors’ comments
Uncorrected misstatements	There were no misstatements identified that were left uncorrected in the audited accounts.
Corrected misstatements	There were initially misstatements in the accounts submitted for audit that were corrected by management, and we brought the more significant of these to the attention of the Audit, Risk and Assurance Committee in our report.

Issue	Auditors' comments
Other significant issues	There were no significant issues to report, in fact we noted improvements from the previous year in relation to accounting for payables and accruals.

23 I also completed my audit of the charitable funds accounts and issued an unqualified audit opinion on 31 January 2025.

Regularity of financial transactions

- 24 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work examines these powers and tests that there are no material elements of income or expenditure that the Health Board does not have the authority to receive or incur.
- 25 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.
- 26 The audit opinion in respect of the regularity of expenditure was qualified, because the Health Board breached its resource limit by spending £18.905 million over the amount that it was authorised to spend in the three-year period 2021-22 to 2023-24.
- 27 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the issue set out above, I issued a substantive report setting out the factual details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

28 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

assessing the extent to which the Health Board has implemented my 2019 recommendations on primary care, as well as the extent to which the Board and/or its committees consider matters relating to primary care and there is appropriate capacity and capability to deliver priorities;

- reviewing the effectiveness of the Health Board's cost savings arrangements; and
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically;

29 My conclusions based on this work are set out below.

Primary care follow-up review

- 30 My review examined the extent to which the Health Board has implemented my previous 2019 recommendations relating to primary care. I also assessed the extent to which the Board and/or its committees regularly consider matters relating to primary care, and whether the Health Board's central primary care services team has the appropriate capacity and capability.
- 31 My work found that the Health Board has made some progress to address my previous audit recommendations, but more action is needed.
- 32 The Health Board has addressed actions relating to leadership and training and is progressing work to develop and strengthen Primary Care Clusters. However, it has struggled to shift resources it invests in secondary care (both as a commissioner and provider) to primary care, establish a financial baseline to understand the true cost of primary care and gain a comprehensive understanding of its primary care workforce.
- 33 Primary care features in the Health Board's long-term strategy and corporate plan, and there are reasonable arrangements in place for monitoring delivery of primary care plans. But consideration of primary care, including performance reporting, at Board and committees needs strengthening, and primary care plans need to be clearer on outcome-based measures and the impact they are having on the experience of patients.
- 34 The Health Board has appropriate corporate arrangements in respect of oversight and lines of accountability for primary care. At the time of my work, I identified some risks associated with the interim arrangements for the Director of Primary Care role, however, since then the Health Board has appointed substantially to this role. My work also identified scope to take a more holistic approach to primary care by establishing an overarching management group that brings together all four of the primary care services, and the need to manage risks around capacity within the Primary Care Services Team including the need to have stronger succession planning arrangements within the team.

Review of cost savings arrangements

- 35 My review examined whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It considered the impact these arrangements had on the Health Board's 2023-24

year-end position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

- 36 My work found 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 very 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.
- 37 The Health Board has a good understanding of its cost drivers, and a clear process for identifying and selecting cost savings opportunities. Positively, of the savings the Health Board has delivered in recent years, the majority have been recurrent in nature. However, the Health Board's ability to deliver its overall savings targets has varied significantly. This varied track record, coupled with skills and capacity gaps in key areas, presents risks to achieving its 2024-25 savings targets.. This varied track record, coupled with skills and capacity gaps in key areas, presents risks to achieving its 2024-25 savings targets.
- 38 The Health Board has reasonably effective arrangements for monitoring and reporting on cost savings. However, opportunities exist to provide stronger assurances that key cost reduction plans are achieving their intended impact, to strengthen risk management arrangements, and to introduce a systematic approach for learning lessons from savings planning and delivery.

Structured assessment

- 39 My team examined the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.
- 40 At the time of my structured assessment work, the Health Board was subject to Targeted Intervention (Level 4) for finance, strategy and planning under the Welsh Government's escalation and intervention arrangements. The Health Board was in Routine Monitoring (Level 1) for all other domains.

Board transparency, effectiveness, and cohesion

- 41 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:
- Public transparency of Board business
 - Arrangements to support the conduct of Board business
 - Board and committee structure, business, meetings, and flows of assurance
 - Board commitment to hearing from staff, users, other stakeholders
 - Board skills, experiences, cohesiveness, and commitment to improvement

- 42 My work found that the Board is committed to conducting its business transparently and continuous improvement. The Board and its committees continue to operate well, and scrutiny has continued to strengthen but more assurance is required to ensure that committee workplans are aligned to key strategic priorities and their risks to delivery.
- 43 The Board and its committees demonstrate good levels of public transparency in the conduct of their business. Current arrangements could be further strengthened by clearer promotion of forthcoming committee meetings.
- 44 The Health Board has generally good arrangements for monitoring and updating its core internal control frameworks. Further work remains to strengthen its arrangements for probity and propriety.
- 45 The Board and its committees continue to operate well, and the quality of scrutiny from independent members has continued to improve. More work to further strength the Board Assurance Framework is needed to provide assurance that committees are aligned to key strategic priorities and their risks to delivery.
- 46 Whilst Board and committee papers are generally of a good standard, there are opportunities to secure further improvements. This includes ensuring key information is presented ahead of any detailed narrative to focus attention, being clear about what a committee is being asked to do in relation to agenda items and reducing the use of technical language and acronyms. The Board continues to hear from patients and staff and there remains scope to share learning from Board walkarounds.
- 47 The Board now has stable membership, following some significant changes and is committed to continuous improvement.

Corporate systems of assurance

- 48 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:
- overseeing strategic and corporate risks;
 - overseeing organisational performance;
 - overseeing the quality and safety of services; and
 - tracking recommendations.
- 49 My work found that the Health Board is continuing to develop its systems of assurance. There are robust arrangements for performance management, but more work is needed to develop the Board Assurance Framework, strengthen strategic and operational risk management arrangements, provide greater clarity on quality and safety priorities, and improve arrangements for closing recommendations.
- 50 The Health Board has developed the first phase of its Board Assurance Framework, but the Health Board still needs to identify all sources of assurance on the effectiveness of its arrangements to manage strategic risks and achieve its

organisational objectives. There is a need to strengthen the corporate risk registers and arrangements to escalate the highest operational scoring risks.

- 51 Revisions to the Health Board's performance management framework have helped strengthen oversight of organisational performance. The Health Board has generally effective arrangements for maintaining oversight of quality and safety and has continued to embed arrangements to oversee the Duties of Quality and Candour. However, while the Health Board's Integrated Quality and Performance Framework sets out measures to monitor quality and safety, it does not set out the Health Board's ambitions for the quality and safety of its services and how it will go about achieving them.
- 52 The Health Board's overall arrangements to monitor and track recommendations are generally effective, but more robust oversight and scrutiny is required to ensure actions taken adequately address recommendations before they are closed.

Corporate approach to planning

- 53 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:
- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
 - overseeing the delivery of corporate strategies and plans.
- 54 My work found that the Health Board continues to work towards delivering its long-term strategy 'A Healthy Caring Powys 2017-27' and is progressing work on its 'Better Together' transformation model although it continues to be unable to produce an Integrated Medium-Term Plan that is approvable by Welsh Government. Instead, it has developed an Integrated Plan 2024-29, with year one of the plan acting as its Annual Plan.
- 55 The Health Board's strategic objectives are also its well-being objectives, which were informed by appropriate evidence and engagement. However, well-being objectives should be reviewed annually to ensure they continue to be appropriate, and there is a lack of clarity as to how the Health Board intends to deliver its objectives and demonstrate their impact over the medium to longer-term.
- 56 The Health Board has generally effective arrangements for overseeing the delivery of year one of its Integrated Plan 2024-29. There is a need for the Health Board to ensure that its long-term strategy remains relevant and appropriate, and that progress is being made at sufficient pace to deliver intended impacts. Reporting of progress to deliver other plans, such as the Decarbonisation Action Plan and Digital Strategic Framework should be enhanced with information to show where delivery is off-track, associated mitigating actions, and revised delivery timescales.

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Corporate approach to managing financial resources

- 57 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:
- achieving its financial objectives;
 - overseeing financial planning;
 - overseeing financial management; and
 - overseeing financial performance.
- 58 My work found that while the Health Board's financial planning and management arrangements are generally effective, monitoring and reporting arrangements require strengthening to urgently establish control over the risks to its financial position. Ongoing financial challenges also means there is a need to monitor any associated performance and quality risks to service delivery.
- 59 The Health Board did not meet its financial objective to achieve breakeven in 2023-24, and it faces significant challenges in achieving its forecast year-end deficit position in 2024-25 and the control total deficit expected by the Welsh Government.
- 60 The Health Board has an effective approach to developing its financial plan in the short- to medium-term. However, ongoing financial challenges means there is a need to monitor financial risks and the impact of financial challenges on the performance and quality of services delivered.
- 61 While the Health Board continues to have generally effective arrangements for overseeing and scrutinising financial management, it urgently needs to control its costs. While financial reports provide sufficient information to enable effective scrutiny and challenge, they need to be clearer on the impact of actions taken to improve the Health Board's financial position.

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Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued since my last annual audit report.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2024
Opinion on the Financial Statements	July 2024
Charitable funds Accounts report and opinion	January 2025
Performance audit reports	
<u>Primary Care Follow Up Review</u>	July 2024
<u>Review of Cost Savings Arrangements</u>	December 2024
Structured Assessment 2024	May 2025
Other	
2024 Audit Plan	March 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the [Audit Wales website](#).

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Planned Care Services Recovery	May 2025
Urgent and Emergency Care – Arrangements for Managing Demand	June 2025
Urgent and emergency care: Flow out of Hospital – Powys Region	June 2025
Discharge Planning: Progress Update	June 2025
Review of Digital Transformation	September 2025

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Appendix 2

Audit fee

The 2024 Audit Plan set out the proposed audit fee of £321,168 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

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Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board’s 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: - test the appropriateness of journal entries and other adjustments made in preparing the financial statements; - review accounting estimates for bias; and - evaluate the rationale for any significant transactions outside the normal course of business.	Having undertaken the proposed audit work, we found no significant issues
There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10]. Powell Bethan 08/05/2025 16:00:41	The audit team will: - test the appropriateness of journal entries and other adjustments made in preparing the financial statements; - perform detailed testing on a sample of key transactions before and after the year end to ensure they are accounted for in the correct	Having undertaken the proposed audit work, we found no significant issues

Audit risk	Proposed audit response	Work done and outcome
	accounting period; and perform detailed testing on a sample of key year end balances to ensure they are appropriate and complete.	
There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a year-to-date deficit of £11.7 million and a forecast year-end deficit of £12.0 million which is in excess of the Minister's published control total. This, combined with the outturns for 2021-22 and 2022-23, predicts a three-year deficit of £18.8 million. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion]. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	We will focus our testing on areas of the financial statements which could contain reporting bias.	Our testing did not identify any reporting bias.
There have been historic errors in the Health Board's payables balances.	We will review the classification and accuracy of the balances and undertake post year end payments testing to ensure that transactions	It was pleasing to note that we found no errors in our sample testing of this area.

Audit risk	Proposed audit response	Work done and outcome
	have been accounted for in the correct year.	
A key source of estimation uncertainty relates to the provision for clinical negligence and personal injury claims. The subjective nature of these provisions and associated judgments give rise to increased risk.	My audit team will: - perform detailed testing on a sample of claims. - evaluate the reasonableness of key assumptions and judgments. - consider the work of Legal and Risk Services and the NHS Business Services Authority as a management expert.	We identified some inconsistencies between notes and some classification errors. All of which were amended by management.
There is a risk that the Health Board fails to disclose certain related party transactions and disclosures or discloses these transactions at the incorrect value.	We will review the completeness and accuracy of the disclosures.	Our testing did not identify any issues.
There have been historic errors in the Health Board's draft financial statements, when disclosing Senior Officers and Non-Executives Pay within the Remuneration Report.	We will review the completeness and accuracy of the disclosures	Our audit identified several errors within the Remuneration Report. All of which were amended by management.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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Structured Assessment 2024 – Powys Teaching Health Board

Audit year: 2024

Date issued: December 2024

Document reference: 4647A2024

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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.

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 structured assessment work at Powys Teaching Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.
- 2 Our 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe, and responsive services, and that public money is being spent wisely.
- 3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:
 - board transparency, cohesion, and effectiveness;
 - corporate systems of assurance;
 - corporate approach to planning; and
 - corporate approach to financial management.We have not reviewed the Health Board's operational arrangements as part of this work.
- 4 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:
 - model Standing Orders, Reservation and Delegation of Powers;
 - model Standing Financial Instructions;
 - relevant Welsh Government health circulars and guidance;
 - the Good Governance Guide for NHS Wales Boards (Second Edition); and
 - other relevant good practice guides
- 5 We undertook our work between September and December 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was

conducted in accordance with the auditing standards set by the International Organization of Supreme Audit Institutions.

- 6 Welsh Government has escalated the Health Board under the NHS Wales escalation and oversight framework. In November 2024, the Health Board was placed in Targeted Intervention (Level 4) for finance, strategy and planning due to the reduced confidence in the Health Board's financial position and its forecast deficit for 2024-25. Prior to this, the Health Board had been in Enhanced Monitoring (Level 3) since July 2023. The Health Board remains in Routine Monitoring (Level 1) for all other domains.
- 7 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

- 8 Overall, we found that **the Board and its committees are working well and there is an openness about the challenges the organisation faces and a commitment to secure the necessary improvements. The Health Board has been unable to deliver short- or medium-term plans that are supportable by Welsh Government, and on-going work is required to strengthen some key aspects of the Health Board's corporate governance arrangements.**
 - we considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We found that **the Board conducts its business transparently and is committed to continuous improvement. The Board and its committees continue to operate well, and scrutiny has continued to strengthen but more assurance is required to ensure that committee workplans are aligned to key strategic priorities and the risks to their delivery.**
 - we considered whether the Health Board has a sound approach to managing risks, performance, and the quality and safety of services. We found that **the Health Board is continuing to develop its systems of assurance with robust arrangements in place for performance management, more work is needed to develop the Board Assurance Framework, strengthen risk management arrangements, provide greater clarity on its quality and safety priorities, and improve arrangements for closing audit recommendations.**
 - we considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. We found that **the Health Board continues to progress work to deliver its long-term strategy and 'Better Together' transformation model although continues to be unable to produce a Welsh Government approved Integrated Medium-Term Plan. There is also a need to ensure**

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that the long-term strategy remains relevant and appropriate, and that progress is being made at sufficient pace to deliver intended impacts.

- we considered whether the Health Board has a sound corporate approach to managing its financial resources. We found that **while the Health Board’s financial planning and management arrangements are generally effective, monitoring and reporting arrangements require strengthening to urgently establish control over the risks to its financial position. Ongoing financial challenges also means there is a need to monitor any associated performance and quality risks to service delivery.**

Recommendations

9 **Exhibit 1** details the recommendations arising from our work. The Health Board’s response to our recommendations is summarised in **Appendix 3**. In addition, there remains work to do to ensure that recommendations from previous years are addressed in full (see **Appendix 2**)

Exhibit 1: 2024 recommendations

Recommendations	
R1	The Health Board should require staff with significant budget oversight and/or significant influence on commissioning arrangements to provide information on any relevant interests and include this information on the Register of Interests (paragraph 21).
R2	The Health Board should set out its ambitions for the quality and safety of its services and how it will go about achieving them (paragraph 66)
R3	The Health Board should strengthen recommendation tracking by ensuring information is provided to assure the Audit, Risk and Assurance Committee that actions taken have effectively addressed the recommendations (paragraph 74).

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Recommendations

R4 The Health Board should:

- 4.1. Ensure annual reviews of its well-being objectives are clearly communicated (**paragraph 86**); and
- 4.2. Ensure a review of its long-term strategy to confirm its continued appropriateness post pandemic, and, in light of the financial challenges is communicated and contributes to future strategy review plans (**paragraph 90**).

R5 As part of its core planning arrangements, the Health Board should clearly set out and monitor:

- 5.1. the actions it intends to take to deliver its well-being objectives over the lifespan of its long-term strategy (**paragraph 87**); and
- 5.2. strategic performance measures to accompany its well-being objectives that capture the long-term impact it is seeking to achieve (**paragraph 87**).

R6 The Health Board should strengthen reports setting out progress against wider corporate strategies and plans by clearly articulating where delivery is off-track, mitigating actions, and revised delivery timescales (**paragraph 92**).

R7 The Health Board should identify, monitor, and manage any immediate quality and performance risks that may arise because of the ongoing financial challenges (**paragraph 105**).

R8 The Health Board should provide greater assurances within finance reports on the impact of mitigating actions to address key financial risks (**paragraph 116**).

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Detailed report

Board transparency, effectiveness, and cohesion

- 10 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.
- 11 We found that **the Board is committed to conducting its business transparently and continuous improvement. The Board and its committees continue to operate well, and scrutiny has continued to strengthen but more assurance is required to ensure that committee structures and their workplans are aligned to key strategic priorities and their risks to delivery.**

Public transparency of Board business

- 12 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:
 - meetings that are accessible to the public;
 - papers being made publicly available in advance of meetings; and
 - business and decision-making being conducted transparently.
- 13 We found that **the Board and its committees demonstrate good levels of public transparency in the conduct of their business. Current arrangements could be strengthened further by clearer promotion of forthcoming committee meetings.**
- 14 The Board and its committees continue to operate meetings in public with most meetings held virtually. All Board meetings are livestreamed and access to meeting agendas and previous recordings are available via the Health Board's website which supports accessibility (see **Appendix 2 R1.1 2023**). Opportunities remain to promote committee meetings more explicitly on the Health Board's website and social media platforms in line with promotion of Board meetings. This would support increased transparency of business and encourage members of the public who wish to observe meetings to do so.
- 15 Board and committee agenda papers are made available to the public in advance of meetings, there are still instances where agenda items are added late (see **paragraph 34**). Unconfirmed minutes are now made available soon after meetings which promotes transparency of Board business (see **Appendix 2 R1.2 2023**).
- 16 Most Board business is conducted in open (in-public) sessions. Appropriate use is made of private sessions, with these reserved for confidential and sensitive matters only. The Board continues to provide a high-level overview of items discussed in private at the following public Board meeting to maintain transparency.
- 17 Our observations of Board and committee meetings found that they support good openness and transparency, particularly in relation to the challenges facing the organisation.

Arrangements to support the conduct of Board business

- 18 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of formal, up-to-date, and publicly available:
- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
 - Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
 - policies and procedures in place to promote and ensure probity and propriety.
- 19 We found that **the Health Board has generally good arrangements for monitoring and updating its core control frameworks. Further work remains to strengthen its arrangements for probity and propriety.**
- 20 The Scheme of Reservation, Delegation of Powers and Standing Orders were approved by Board in May 2024. Standing Financial Instructions are also up to date and available to the public on the Health Board's website.
- 21 The latest copy of the Declaration and Register of Interests was reported to the Audit, Risk and Assurance Committee (ARAC) for assurance in October 2024, and Board in November 2024. There is also an escalation process in place for Board Members who have not submitted declaration forms by the required date. Whilst no escalations were identified, this is a useful mechanism to ensure transparency and probity and propriety of decision making within the organisation. Despite the Register of Interests being embedded in the agenda bundle for the ARAC meeting, it continues to not be easily available on the Health Board's website (see **Appendix 2 R5a 2022**). As identified last year, the Health Board should expand the Register of Interests to include staff members with budget oversight and/or significant influence on commissioning arrangements (**Recommendation 1**).
- 22 Whilst there is a key policies page on the Health Board's website, the policies themselves continue to be unavailable to the public, although they are available on request (see **Appendix 2 R5a 2022**). The Health Board have acknowledged that they will not be looking to address this recommendation at this time.

Effectiveness of Board and committee meetings

- 23 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:
- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
 - Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well as being shaped on an ongoing basis by the Board Assurance Framework (BAF);

- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
 - committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.
- 24 We found that **the Board and its committees continue to operate well, and scrutiny has continued to strengthen. More work to further strength the Board Assurance Framework is needed to provide assurance that committees are aligned to key strategic priorities and their risks to delivery.**
- 25 The Health Board approved a BAF in May 2024 after being without one for several years (see **paragraphs 52 to 54**). The approved BAF contains the Health Board's assurance framework, and the corporate risk register is a component part of the framework. More work is needed to ensure risks are aligned to achieving strategic priorities and their associated controls and assurances. It is therefore difficult to conclude that the current committees are appropriately shaped by the BAF and aligned to the strategic priorities and their risks to delivery. The Health Board needs to at pace develop a more comprehensive BAF to gain and provide assurance that the current committee structure is appropriately aligned (see **Appendix 2 R3 2022**).
- 26 Despite the absence of a comprehensive BAF, committees appear to have appropriate work plans that collectively reflect the breadth of Board and committee business. However, until the risks to achieving strategic priorities are set out in full, the committees are not able to be certain that workplans provide comprehensive oversight of strategic risks. The committees' Terms of Reference were revised and received Board approval in May 2024. The changes included moving a few areas of business to a more appropriate committee and strengthening the purpose of some committees. For example:
- Information Governance has been moved from the Delivery and Performance (D&P) Committee to ARAC; and
 - the Planning, Partnerships and Population Health Committee (PPPHC) has increased its focus on population health.
- 27 The introduction of 'consent agendas' in committee meetings, which allows reports to be grouped and approved as a single agenda item, has created more time for focus and discussion on substantive items. Some committee chairs need to ensure that in each meeting they provide opportunity for consent agenda items to be moved into the main agenda for discussion if attendees feel this is necessary.
- 28 These changes should help make the workload of the D&P Committee more manageable, as the time available to manage the broad agendas for this committee has been challenging. The changes also mean that items included in committee work plans align better to their remits.
- 29 Despite the work to consider committee workplans, our Primary Care Follow Up Review in July 2024 identified opportunities to increase the visibility and

consideration of primary care at Board and committee level. During 2024, the Health Board escalated the status of mental health services in line with its internal escalation framework. Both the Board and the Patient Experience, Quality and Safety (PEQS) Committee routinely monitor progress against improvement plans.

- 30 The Chair and Director of Corporate Governance continue to encourage and support committee chairs to have greater ownership of their respective committee workplans and ensure appropriate scrutiny and challenge. The recent appointment of an independent member for finance has enhanced the quality of scrutiny on financial matters. Opportunities have been built into agendas to reflect how meetings went and provide feedback. Meetings are chaired well, and meeting etiquette is observed including polite but appropriate challenge and support.
- 31 Committee Chair Reports¹ continue to be provided to the Board to ensure appropriate flows of assurance. Some Chair Reports include a section to escalate areas of concern, and a standard template has been introduced to ensure consistency. Since our previous structured assessment, the Committee Chairs Forum has started to embed and is helping to coordinate committee business, reduce duplication of work across committees, and improve the quality of the committee chairs reports. The Committees provides routine updates to the Board through the Chairs' Report to Board providing a useful overview of forum discussions and associated actions (see **Appendix 2 R6a 2022**). There is opportunity to be clearer when referring business from one committee to another, what is expected to happen with the referral and whether there needs to be future update on the outcome of the referral.

Quality and timeliness of Board and committee papers

- 32 We considered whether the Board and committees receive timely, high-quality information that supports effective scrutiny, assurance, and decision making. We were specifically looking for evidence of clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.
- 33 We found that **whilst Board and committee papers are generally of a good standard, there are opportunities to secure further improvements.**
- 34 Board and committee information generally remains of a good standard and is constantly being reflected upon. Whilst a small number of agenda items are published later than the seven-day timeframe, this is largely due to the specific agenda information needing to be as timely as possible. This can limit the amount of time attendees and observers have to read and consider papers prior to meetings. The Health Board could consider whether adjusting the timing of Board and committee meetings would provide sufficient time to enable these papers to be

¹ Committee Chair Reports provide a summary to the Board of key matters considered and related decisions made by each committee since the previous Board meeting.

produced ahead of the paper deadline. Finance papers continue to be well received and regarded as clear and explanatory.

- 35 Independent members continue to provide ongoing challenge to support the continuous improvement of the quality of reports. This includes ensuring key information is presented ahead of any detailed narrative to focus attention and being clear about what the committee is being asked to do in relation to agenda items. We heard how too much technical language and use of acronyms may be a barrier to the public's understanding of committee papers. The Health Board needs to be mindful of the length of agendas and papers, especially for the D&P Committee for which agenda bundles can regularly be more than three hundred pages. This may hinder the depth of scrutiny and review which is undertaken in advance of meetings.
- 36 There also remains scope to be more explicit within committee papers as to how the sustainable development principle² is being considered and how staff present this in a meaningful way to underpin decision making.

Board commitment to hearing from patients/service users and staff

- 37 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.
- 38 We found that **the Board continues to hear from patients and staff, there remains scope to share learning from Board walkarounds.**
- 39 The Board has expanded its use of patient stories by including them on the PEQS Committee agenda. Patient stories are presented to Board and PEQS Committee both by service users attending in person and via videos. Stories now represent a broad spectrum of both positive and negative experiences (see **Appendix 2 R2 2023**). Whilst this is constructive, we have heard that the purpose of including patient stories is still unclear, and at the time of our review, a paper was being considered to help Board members maximise the impact of stories. Survey responses from the NHS Wales patient experience system (Civica) are routinely presented to PEQS Committee.
- 40 The Board and the Workforce and Culture Committee continue to receive staff stories. The Workforce and Culture Committee has also received routine updates on the Health Board's 'Great Place to Work' strategic priority, including staff retention, 'Speaking up Safely, and the Clinical Leadership Immersive Programme. The 2023 NHS Staff Survey results were also reported to the Workforce and

² The sustainable development principle means that the body must act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.

Culture Committee in June 2024. Despite a higher response than other health boards, the Health Board's response rate was low at 28%.

- 41 Board member walkarounds continue to take place and provide an opportunity for independent members to triangulate what they hear directly from staff with the information received in Board and committee meetings. Walkarounds are planned three to six months in advance, but there is an opportunity to integrate the roles of Independent Members and Executive Directors in the walkarounds (see **Appendix R3 3.1 2023**). At the time of our review however, a Board member visit was scheduled for mental health services, due to the challenges in this service area (see **paragraph 29**). We previously recommended that the Health Board should set out how the walkarounds operate and the mechanisms for reporting key themes and identifying learning. This has yet to be implemented (see **Appendix R3.2 2023**).

Board cohesiveness and commitment to continuous improvement

- 42 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:
- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
 - the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
 - a relevant programme of Board development, support, and training in place.
- 43 We found that **the Board now has stable membership, following some significant changes and is committed to continuous improvement.**
- 44 The Board has been through some significant changes in the past 12 months, but these have been managed well. Two new independent members have been appointed in 2024, with a further appointment to be made in early 2025. The Chair of the D&P Committee has temporarily chaired the ARAC until the new independent member for finance takes over the role in January 2025, after a handover period.
- 45 In addition, following the appointment of the substantive Chief Executive in February 2024, substantive appointments have also been made to the two executive director posts previously filled on an interim basis (see **Appendix 2 R10 2022**). Changes have been made across executive portfolios to align roles and responsibilities more appropriately with the Health Board's ambitions. This has resulted in substantive changes to the Director of Operations role which is now also responsible for primary care, alongside community and mental health. The Health Board will need to ensure that this role is appropriately supported given the challenges in these service areas.

- 46 During 2024, the Health Board has introduced committee effectiveness reviews for each of its committees. These were undertaken early in the year and the results shared with the Board and each committee with appended actions and timescales for completion (see **Appendix 2 R4 2023 and R9a 2022**). As discussed in **paragraph 30**, at the end of each committee meeting the Chair asks for feedback on how the meeting went (see **Appendix 2 R9b 2022**). Annual Reports for each committee were presented to the Board in May 2024 which included commentary on committee effectiveness and changes made as a result.
- 47 There continues to be an appropriate programme of board development, with sessions held each month which focus on four themes, developing the (Board) team, developing the organisation, engaging with external partners, and engaging with the organisation.

Corporate systems of assurance

- 48 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.
- 49 We found that **the Health Board is continuing to develop its systems of assurance. There are robust arrangements for performance management, but more work is needed to develop the Board Assurance Framework, strengthen strategic and operational risk management arrangements, provide greater clarity on its quality and safety priorities, and improve arrangements for closing recommendations.**

Corporate approach to overseeing strategic and corporate risks

- 50 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks to the delivery of strategic priorities / objectives and corporate risks. We were specifically looking for evidence of:
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
 - the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.
 - an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and
 - the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.

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- 51 We found that **the Health Board has developed the first phase of its Board Assurance Framework, but more work is needed to identify all sources of assurance on the effectiveness of its arrangements to manage strategic risks and achieve its organisational objectives. There is a need to strengthen the corporate risk registers and arrangements to escalate the highest operational scoring risks.**
- 52 We reported in 2021 and again in 2022 that the BAF had not been updated to reflect the priorities set out in the Health Board's long-term strategy and Integrated Medium-Term Plan (IMTP) and had not been presented to the Board since January 2020. A BAF was approved by Board in May 2024, it sets out the overarching framework of the Health Board's assurance mechanisms.
- 53 Whilst we recognise that component parts of the BAF, such as the Risk Management Framework are in place, there are opportunities to make clearer the impact each of the Health Board's strategic risks has against achieving its strategic priorities and the controls and sources of assurance. The Health Board does not identify strategic risks separately to corporate risks. As a result, there is a single register which contains both the complex, high level risks to delivering the strategy and the highest scoring operational risks. As part of the work needed to further develop the BAF, the Health Board should develop risk registers for strategic risks and corporate risks to ensure oversight is appropriate. Conventionally, we would expect the Board to own the BAF (containing the strategic risks), and the Corporate Risk Register (CRR) to be owned by the executive team. The Health Board should progress the work required on the BAF at pace and present this to Board for consideration as soon as practically possible (see **Appendix 2 R3 2022**).
- 54 The Health Board's Risk Management Framework was last updated and approved by the Board in November 2022 and reviewed by ARAC in November 2023. A risk management update was presented to ARAC in May 2024 and an updated framework was due to be presented to ARAC in October 2024, however, this has been postponed to January 2025 due to resource constraints. This creates an opportunity to align the further development of the BAF with the update to the Risk Management Framework. More positively, the Health Board's refreshed risk appetite was approved by the Board in May 2024 and is available on the Health Board's website.
- 55 The CRR template was updated in 2024, with the introduction of assurance ratings in a RAG format³. The CRR is presented to Board bimonthly, and committees have specific corporate risks allocated to them for assurance and review. This is helpfully mapped in the CRR cover paper and allocations are appropriate to the committee remits. Committee CRR reports are detailed and provide information to support scrutiny, but there are minor inconsistencies in their completeness. For example, some reports include the impacts of actions on the current risk score, and some do not.

³ Red, Amber and Green.

- 56 The Risk and Assurance Group has been meeting regularly and the CRR now goes to the group for review and consideration before it is presented to the Executive Committee for oversight. In June 2024, Internal Audit reported the findings of their review of operational risk management and assurance in three areas of the Health Board; Corporate Governance, the Women's and Children's Department and Medicines Management. The review received a reasonable assurance rating overall but noted that the Risk and Assurance Group had not reviewed either the Women's and Children's Department or Medicines Management risk registers for potential inclusion on the CRR. Whilst it is positive that the Risk and Assurance Group is in place, there remains work to do to ensure the corporate arrangements to review and escalate departmental risks onto the CRR are effective (see **Appendix 2 R4 2022**).
- 57 The Board's risk registers continue to be Excel spreadsheets. The Health Board recognise there are delays due to resourcing to migrating risks onto the updated Datix⁴ software module and this needs to happen at pace (see **Appendix 2 R5 2023**). This would allow the Health Board to hold all risks centrally, improve corporate oversight, and support greater consistency in the completeness of risk registers and escalation to the CRR.

Corporate approach to overseeing organisational performance

- 58 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:
- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
 - the Board and committees providing effective oversight and scrutiny of organisational performance.
- 59 We found that **revisions to the Health Board's performance management framework have helped strengthen oversight of organisational performance.**
- 60 The Health Board's Integrated Performance Framework was revised and updated and is now known as the Integrated Quality and Performance Framework (IQPF). It received approval from the Board in March 2024. This was in response to the requirement to embed the Duty of Quality⁵ which came into force in April 2023 and requires the Health Board to reflect on and develop the quality of services it provides. This three-year framework allows for an annual review.

⁴ DATIX is a system used by all NHS staff to report both incidents and risks.

⁵ The Duty of Quality was introduced under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and applies to NHS bodies in Wales.

- 61 The IQPF is comprehensive and sets out clear roles and responsibilities for performance management. It also sets out the oversight and accountability arrangements and the frequency and coverage of performance at specific meetings.
- 62 The Board and the D&P Committee receive the Integrated Quality and Performance Report (IQPR) at each meeting. The IQPR provides useful overviews of performance against both local and national targets, including trend and benchmarking data. Ministerial priority measures are also included in the report with compliance against the Health Board internal trajectory and the NHS performance framework clearly set out. The IQPR also includes measures and information on the performance of commissioned services, which is an area that the Health Board continues to try to influence and improve.
- 63 The IQPR cover report includes a 'by exception' section to provide focus on key achievements and challenges. This is a useful and accessible document which is well received by members. The Health Board should consider refining the cover report further by separating out achievements and challenge, rather than grouping them in a single narrative.

Corporate approach to overseeing the quality and safety of services

- 64 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:
- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework;
 - clear organisational structures and lines of accountability in place for clinical/quality governance; and
 - the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.
- 65 We found that **the Health Board has generally effective arrangements for maintaining oversight of quality and safety and has continued to embed arrangements to oversee the Duties of Quality and Candour. The Health Board's ambitions for quality and safety are unclear.**
- 66 The Health Board's IQPF (see **paragraph 60**) replaced its Clinical Quality Framework 2020-23 (see **Appendix 2 R6 2023**). While this sets out the measures to be used to monitor quality and safety, it does not set out the Health Board's ambitions for the quality and safety of its services and how it will go about achieving them (**Recommendation 2**).
- 67 Quarterly Integrated Quality Reports to PEQS Committee provide an update on the quality and safety agenda across the Health Board. The report includes information on 'Putting Things Right' and complaints, information on compliance with the Duty

of Candour (including the number of cases each quarter and trend data) and patient experience data. The report provides assurance to the committee that quality and safety is appropriately monitored with actions in place to continuously improve quality. However, not every area for improvement included in the report sets out supporting actions and where actions exist, these should be SMART⁶.

- 68 The Health Board continues to have appropriate arrangements to ensure compliance with the Duties of Quality and Candour. The Health Board's Duty of Quality webpage provides the Health and Care Standards and links to relevant websites such as Healthcare Inspectorate Wales and the Public Service Ombudsman for Wales.
- 69 The Health Board's Duty of Quality Report 2023-24 was presented to PEQS Committee in September 2024. The report recognises that as a first iteration since the requirement to produce annual quality reports came into being, it was 'light touch' but this was in line with Welsh Government expectations and the format and content will continue to develop in subsequent years.

Corporate approach to tracking recommendations

- 70 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations. We were specifically looking for evidence of appropriate and effective systems in place for tracking responses to audit and other review recommendations in a timely manner.
- 71 We found that **the Health Board has generally effective arrangements to monitor and track recommendations, but more robust oversight and scrutiny is required to ensure actions taken adequately address recommendations before they are closed.**
- 72 Since our previous structured assessment, the Health Board has continued to develop its arrangements for tracking internal and external recommendations, and a report is now presented to ARAC twice a year (see **Appendix 2 R7 2023**).
- 73 The recommendation tracker usefully includes a cover paper which provides a summary update of internal and external audit recommendations either completed since the last update, not due for implementation or overdue. A breakdown of progress made to date is included for each recommendation. The number of overdue recommendations has decreased over the last 12 months.
- 74 The Health Board, however, should strengthen its approach to closing recommendations. There is limited information provided in the recommendation tracker to give assurance that actions taken have adequately addressed recommendations, allowing them to be closed (**Recommendation 3**). For example, the recommendation tracker presented to ARAC in November 2024 indicated that there were just two recommendations from previous structured

⁶ Specific, Measurable, Achievable, Relevant and Time-based

assessment reports that remained open, whereas our fieldwork indicates that six recommendations require further work before they can be considered complete (see **Appendix 2**).

Corporate approach to planning

- 75 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.
- 76 We found that **the Health Board continues to progress work to deliver its long-term strategy and 'Better Together' transformation model although it continues to be unable to produce a Welsh Government approved Integrated Medium-Term Plan. There is also a need to ensure that the long-term strategy remains relevant and appropriate, and that progress is being made at sufficient pace to deliver intended impacts.**

Corporate approach to producing strategies and plans

- 77 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:
- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
 - appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
 - the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.
- 78 We found that **the Health Board continues to work towards delivering its long-term strategy and is progressing work on its 'Better Together' transformation model but continues to be unable to produce a Welsh Government approved Integrated Medium-Term Plan.**
- 79 The Health Board continues to work towards delivering its long-term strategy 'A Healthy Caring Powys 2017-27'. The strategy aims to reduce inequalities and focus on people with the greatest need, improve health and wellbeing and become a leader in integrated rural health and care. The Health Board has adopted a life-course approach to deliver its vision to ensure that its population 'starts well,' 'lives well' and 'ages well,' with focus on well-being, early help, and support, tackling chronic disease, and joined up care.

- 80 The Health Board's financial challenges over the last two years (see **paragraphs 97 to 100**) have meant that it has been unable to produce an IMTP which the Welsh Government can approve. Consequently, the Welsh Government required the Health Board to develop an annual plan instead. The Health Board has achieved this by developing a five-year Integrated Plan 2024-29, which is based on delivering the long-term strategy and objectives with year one setting out the required detailed annual plan.
- 81 The Health Board began developing its Integrated Plan 2024-29 in October 2023. It was informed by extensive engagement with staff, communities, and stakeholders. The Board met frequently using Board Development sessions and Board meetings to agree the strategic priorities and provide scrutiny on the development of the plan. The Integrated Plan 2024-29 was approved by Board and submitted to Welsh Government in March 2024. Internal Audit's review of the process to develop the Integrated Plan 2024-29 in September 2024 provided a reasonable assurance rating. At the time of writing, the Integrated Plan remained unapproved by Welsh Government due to the Health Board's financial position and forecast deficit for 2024-25.
- 82 The Integrated Plan 2024-29 clearly recognises the Health Board's challenges and sets out the progress it is making to develop a financially sustainable model for health and care – the 'Better Together' transformation model⁷. The Health Board has developed a three-phase approach, discover, design, and deliver, to advance the model, and has indicated that it is now progressing to the delivery phase which will focus on frailty and community services, planned care and diagnostic services, and mental health service transformation.
- 83 Aside from the Winter Resilience Plan 2023-24, no other strategies or plans were approved during the year.

Corporate approach to setting well-being objectives

- 84 We considered whether the Health Board has a sound corporate approach to setting its well-being objectives in accordance with the sustainable development principle⁸. We were specifically looking for evidence of:

⁷ 'Better Together – designing a sustainable approach for Powys' is the Health Board's transformation model. The model will be informed by the principles of the Well-being of Future Generations (Wales) Act (2015) and values-based healthcare, with the aim of transforming the services the Health Board provides, improving outcomes and, experience, and being financially sustainable. Values-based healthcare aims to achieve better outcomes for patients at reduced cost. This could be through, but not limited to elimination of harm, reducing over-treatment and procedures with limited clinical effectiveness, or adopting alternative or preventative approaches.

⁸ Under The Well-being of Future Generations (Wales) Act 2015, the Health Board is required to set and publish well-being objectives that are designed to maximise its

- appropriate arrangements in place for setting well-being objectives which are underpinned by the sustainable development principle;
- appropriate consideration given to how the organisation will ensure delivery of its well-being objectives; and
- appropriate arrangements in place to monitor progress and improve how the organisation applies the sustainable development principle.

85 We found that **the Health Board's strategic objectives are also its well-being objectives, which were informed by appropriate evidence and engagement. However, well-being objectives should be reviewed annually to ensure they continue to be appropriate, and there is a lack of clarity as to how the Health Board intends to deliver its objectives and demonstrate their impact over the medium to longer-term.**

86 A 'Healthy Caring Powys' 2017-27 sets out the Health Board's long-term objectives which are also its well-being objectives. The strategic / well-being objectives were shaped in line with the sustainable development principle and clearly aligned to the Health Board's vision and strategy (see **paragraph 79**). The objectives were also underpinned by engagement with Powys residents, the local authority and the third sector, and informed by the evidence underpinning the long-term strategy. However, there is a statutory requirement to review well-being objectives on an annual basis to ensure their continued appropriateness and this review should be clearly communicated (**Recommendation 4.1**).

87 There is also a lack of clarity of how the Health Board intends to deliver its well-being objectives over the lifespan of its strategy, and to measure their intended impact. The Integrated Plan 2024-29 clearly sets out priorities, timescales for delivery, and the intended outcomes and impact, but these are only in the short-term (**Recommendations 5.1 and 5.2**).

Corporate approach to overseeing the delivery of strategies and plans

88 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

contribution to achieving each of the well-being goals. Further information is available [here](#).

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- 89 We found that **the Health Board has generally effective arrangements for overseeing the delivery of year one of its Integrated Plan 2024-29. There is a need to ensure that the long-term strategy remains relevant and appropriate, and that progress is being made at sufficient pace to deliver intended impacts. Reporting of progress to deliver other plans should be enhanced with information to show where delivery is off-track, associated mitigating actions, and revised delivery timescales.**
- 90 The Health Board's long-term strategy is now at an important point, and given the strategy was set prior to the pandemic, it is necessary for the Health Board to assess and reflect whether the long-term strategy remains appropriate post-pandemic and in the context of the cost-of-living crisis (**Recommendation 4.2**). We understand a review of the strategy has taken place within the Regional Partnership Board, and the Health Board needs to ensure this is taken into account going forward and communicated.
- 91 Progress against the Integrated Plan 2024-29 is routinely reported to Board through quarterly Delivery Plan Updates. Overall, the report provides a good overview of progress against strategic objectives and sets out key deliverables, actions, and milestones (see **Appendix 2 R2 2022**). It also sets out Executive Director responsibilities for deliverables which enhances accountability.
- 92 During the year, the Board and committees received routine updates on the delivery of wider corporate strategies and plans such as the Decarbonisation Action Plan, Digital Strategic Framework, and Health and Safety Annual Report. While these provide information to demonstrate progress, they are in the main narrative and do not clearly articulate where delivery is off-track, associated mitigating actions, and revised delivery timescales (**Recommendation 6**).

Corporate approach to managing financial resources

- 93 We considered whether the Health Board has a sound corporate approach to managing its financial resources.
- 94 We found that **while the Health Board's financial planning and management arrangements are generally effective, monitoring and reporting arrangements require strengthening to urgently establish control over the risks to its financial position. Ongoing financial challenges also means there is a need to monitor any associated performance and quality risks to service delivery.**

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Financial objectives

- 95 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of the organisation:
- meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
 - being on course to meet its objectives and duties in 2024-25.
- 96 We found that **the Health Board did not meet its financial objective to achieve breakeven in 2023-24, and it faces significant challenges in achieving its forecast year-end deficit position in 2024-25 and the control total deficit expected by the Welsh Government**
- 97 The Health Board did not meet its financial objective to achieve breakeven for revenue for 2023-24. It instead reported achievement of its agreed control total deficit of £12 million, which was achieved with additional in-year financial support from Welsh Government. However, its underlying deficit deteriorated to £26.3 million meaning that the Health Board continues to be unable to meet its statutory financial duty to breakeven against its revenue resource limit over a three-year rolling period. The Health Board reported a small surplus of £25,000 against its capital resource limit.
- 98 The Health Board continues to be unable to submit a balanced financial plan for the three-year period 2024-27 and is working to an annual plan for 2024-25 which sets out a predicted deficit of £24.9 million. In May 2024, the Board agreed to revise its 2024-25 financial plan to achieve a £22.9 million deficit. The Welsh Government has set a deficit control total of £12 million for 2024-25.
- 99 Until November 2024, the Health Board was forecasting achievement of its planned year-end £22.9 million deficit. However, the Month 7 update to Board highlighted a £3.7 million year-to-date operational overspend with a significant risk that the position could deteriorate further by year-end, causing the Health Board to consider whether its financial forecast needed adjustment.
- 100 In December 2024, the Welsh Government announced a further £7.1 million funding allocation for the Health Board to support increasing demand, inflationary pressures, and commissioning costs. This should reduce the Health Board's planned deficit from £22.9 million to £15.8 million. As part of the conditions of the additional allocation, the Welsh Government expects the Health Board to deliver the deficit control total it set the Health Board (£12 million). The Welsh Government has indicated that any further deterioration of the financial positions would be unacceptable and unsupportable. The Health Board continues to forecast that it will remain within its capital resource limit of £12.6 million.

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Corporate approach to financial planning

- 101 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:
- clear and robust corporate financial planning arrangements in place;
 - the Board appropriately scrutinising financial plans prior to their approval;
 - sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
 - the Board appropriately scrutinising savings and cost improvement plans prior to their approval.
- 102 We found that **the Health Board has an effective approach to financial planning in the short- to medium-term. However, ongoing financial challenges means there is a need to monitor the impact of financial challenges on the performance and quality of services delivered.**
- 103 In 2023-24, the Health Board achieved its £12.1 million savings target because it recognised accountancy gains, which are non-recurrent in nature. Our [2024 Review of Cost Savings Arrangements](#) found that while the Health Board met its agreed deficit target for 2023-24, its track record of delivering against its overall savings targets is variable. Given the Health Board's current challenging financial position, it urgently needs to accelerate work on introducing a new, more financially sustainable service model and ensure it has the necessary skills and capacity to support the transformation required. We have made several recommendations within the report.
- 104 The Health Board has a clear process for developing its financial plan. Board members have scrutinised the development of the plan and the plan itself prior to submission to the Welsh Government.
- 105 The 2024-25 financial plan sets out several risks which the Health Board needs to manage. These include high levels of demand and capacity challenges across health and social care impacting on planning commitments, achieving the savings target, the impact of the 2024-25 pay award on staffing costs and continuing cost pressures. The Health Board will need to closely monitor financial risks and the impact of financial challenges on service delivery, performance, and quality **(Recommendation 7)**.
- 106 As at Month 7 2024-25, the Health Board was forecasting achievement of its £9.9 million savings target at year-end. However, there are risks associated with the capacity of teams to deliver the required savings. Performance against savings targets continues to be scrutinised by the D&P Committee and Board.

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Corporate approach to financial management

- 107 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:
- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
 - the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
 - effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
 - the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.
- 108 We found that **while the Health Board continues to have generally effective arrangements for overseeing and scrutinising financial management, it urgently needs to control its costs.**
- 109 The Health Board continues to have robust arrangements to ensure compliance with statutory instruments and to report breaches. As set out in **paragraph 20**, the Scheme of Delegation has been reviewed and approved by ARAC and the Board, and a review of Standing Financial Instructions is scheduled for early 2025. ARAC routinely reviews losses, special payments, single tender actions, and post payment verification reports.
- 110 An Internal Audit update in January 2024 set out themes and reflections from its work to the ARAC. The update highlighted that Internal Audit had completed 49 financial governance and management reviews at the Health Board between 2021-24, resulting in 67% and 33% given reasonable and substantial assurance ratings, respectively. The Health Board continues to have good counter-fraud arrangements. There is an agreed annual workplan and routine reports to ARAC showing delivery against the plan.
- 111 The Health Board continues to have a good understanding of its cost pressures which include continuing healthcare, commissioned activity, variable pay, inflationary cost pressures (including energy and prescribing costs), and the ongoing costs associated with responding to the legacy of the COVID-19 pandemic.
- 112 The Health Board has maintained enhanced reporting on expenditure at Board and committee levels and has established working groups, such as its Agency Spend Reduction Group, to contain expenditure. An Internal Audit review of the Agency Spend Reduction Group reported in April 2024 gave a reasonable assurance rating. The latest Finance report to Board (November 2024) continues to highlight significant adverse variances across pay budgets, as well as commissioning of healthcare services, continuing healthcare and NHS funded nursing care indicating

that the Health Board's actions are not achieving the desired impact. The Health Board issues accountability letters to Executive Directors which set out requirements to manage the Health Board's financial position.

- 113 The Health Board submitted good quality draft financial statements for external audit within the required timescales. Our audit identified no material misstatements but did identify some areas where corrections should be made. We issued an unqualified opinion in respect of the true and fairness of the accounts, but a qualified regulatory opinion due to the Health Board breaching its duty to deliver a breakeven position over the three-year rolling period 2021-24.

Board oversight of financial performance

- 114 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of the Board:

- receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- appropriately scrutinising the ongoing assessments of the organisation's financial position.

- 115 We found that **while financial reports provide sufficient information to enable effective scrutiny and challenge, they need to be clearer on the impact of action taken to improve the financial position.**

- 116 The Health Board has reasonably effective arrangements for reporting financial performance to the Board and D&P Committee. Finance reports are clear and provide sufficient information to enable scrutiny and challenge. Broadly similar reports are presented to both forums and there are opportunities, particularly at committee level, to undertake more in-depth scrutiny in line with their function and provide challenge in particular areas where performance is off track. Furthermore, whilst reports continue to highlight key financial risks to the financial position, there are opportunities to be clearer on the impact of mitigating actions
(Recommendation 8).

- 117 Our observations found that independent members are increasing their scrutiny and challenge on the Health Board's financial performance in Board and D&P Committee meetings. However, the current financial challenges at the Health Board will require the Board and D&P Committee to provide an appropriate level of scrutiny, and ongoing challenge on financial performance, delivery of savings, and managing risks.

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Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 2: audit methods

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit, Risk and Assurance Committee; • Delivery and Performance Committee; • Patient Experience, Quality and Safety Committee; • Planning, Partnerships and Population Health Committee; and • Workforce and Culture Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement;

Element of audit approach	Description
	• relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Chief Executive • Chair • Vice Chair • Director of Corporate Governance/Board Secretary; • Executive Director of Finance, Capital and Support Services and Deputy Chief Executive • Executive Director of Planning, Performance & Commissioning • Independent Member (Finance) • Chair of Audit, Risk and Assurance Committee • Chair of Delivery and Performance Committee

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Appendix 2

Progress made on previous year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Transparency of Board business R1 The Health Board should: 1.1. promote all Board meetings and other events, such as the Annual General Meeting, via the Health Board's social media channels and other communication mechanisms; and 1.2. make unconfirmed minutes available on the Health Board website soon after meetings to promote more timely transparency of Health Board business. (2023)	Complete – see paragraph 14 Complete – see paragraph 15
Board commitment to hearing from patients, service users and staff R2 The Health Board should introduce patient stories to the Patient Experience, Quality and Safety Committee to enable a broader spectrum of both positive and negative experiences to be heard. (2023)	Complete – see paragraph 39

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Recommendation	Description of progress
Board Walkarounds R3 The Health Board should strengthen its board walkaround arrangements by: 3.1. developing a forward programme which involves both Independent Members and Executive Directors and covers a broad range of Health Board services; and 3.2. develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes. (2023)	In progress – see paragraph 41 No action – see paragraph 41
Committee effectiveness R4 The Health Board should undertake its committee effectiveness reviews as soon as practically possible, to ensure continuous development in the way in which the committees operate. (2023)	Complete – see paragraph 46
Corporate approach to overseeing corporate risks. R5 The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module. (2023)	In progress – see paragraph 57
Corporate approach to overseeing the quality and safety of services. R6 The Health Board should ensure that the Patient Experience, Quality and Safety Committee has timely updates throughout the year on progress against the Clinical Quality Framework 2020-23 Implementation Plan. (2023)	Superseded – see paragraph 66
Corporate approach to tracking recommendations R7 The Health Board should ensure that the Audit, Risk and Assurance Committee regularly receives the recommendation tracker throughout the year. (2023)	Complete – see paragraph 72

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Recommendation	Description of progress
R2 Delivery reports for monitoring progress against the priorities and actions set out in the IMTP are largely narrative and lack a focus on measures and impact. The Health Board should revisit its delivery reports to ensure they are succinct, less narrative, and have an increased focus on measures and impact. (2022)	Complete – see paragraph 91
R3 The Health Board does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee workplans. The Health Board needs to update its Board Assurance Framework. (2022)	In progress – see paragraphs 25 and 53
R4 There is currently a disconnect between directorate risk registers and the Corporate Risk Register (CRR). The Health Board needs to review all high risks on directorate risk registers to ensure the relevant ones are escalated to the CRR, and that the Board is aware of wider risks that may materialise. (2022)	In progress – see paragraph 56
R5 Opportunities exist to improve public access to key Health Board documents. The Health Board should ensure that: a) policies and procedures, and the register of interest on the public website are accessible. (2022)	No action – see paragraphs 21 and 22 (The Health Board have acknowledged that they will not be looking to address this recommendation.)

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Recommendation	Description of progress
R6 There are no mechanisms for committee Chairs to meet formally outside of committee meetings to share concerns and good practice, and there are also no mechanisms in place to track issues and actions referred between committees. The Health Board should put in place a mechanism to enable: b) issues and actions referred between committees to be tracked and feedback provided when completed. (2022)	Complete – see paragraph 31
R9 Opportunities exist to improve self-reviews of Board and committee effectiveness. The Health Board should: a) ensure areas for improvement are captured and monitored via an action plan; and b) include a standing agenda item in all Board and committee meetings to allow for a review of the meeting. (2022)	Complete – see paragraph 46 Complete – see paragraph 46
R10 The Health Board is carrying several interim posts at a senior level which can cause instability for both services and staff. The Health Board should seek to appoint substantively to the interim posts within the Executive team as soon as practical to do so. (2022)	Complete – see paragraph 45

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Appendix 3

Management response to audit recommendations

Exhibit 4: Powys Teaching Health Board response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)

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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.

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.7

Audit Risk and Assurance Committee

13th May 2025

Subject:	Counter Fraud Update Report	
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital 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 the Counter Fraud Annual Report 2024/25 following which the Committee Chair will be asked to approve the annual self assessment return.		
Approve/Take Assurance	Discuss	Note
Y	Y	N

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 Counter Fraud Update Report updates the committee on key activity and developments in relation to the Counter Fraud Work Plan 2025/26.

The Counter Fraud Annual Report 2024/25 is appended to the Update Report. The Annual Report summarises the performance and counter fraud activity delivered in the Health Board throughout 2024/25.

The Annual Report incorporates the Health Board's self assessment return regarding compliance with Counter Fraud Standards which requires direct approval of the Committee Chair. Members are asked to review the Annual Report to support the Chair's approval.

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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	x			
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			
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			
Financial	x			
Corporate	x			
Operational	x			
Reputational	x			

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Item 5.7

Counter Fraud Update Report

13 May 2025

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1. INTRODUCTION

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.

2. BACKGROUND

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).

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below.

Strategic Area	Resource Allocated For FY 2025/26	Resource Used as of 29 April 2024
Strategic Governance	45	5
Inform and Involve	60	6
Prevent and Deter	103	12
Hold to Account	100	9
TOTAL	308	32

4. STRATEGIC GOVERNANCE

The Counter Fraud Annual Report 2024/25 is appended to this report for review. The Annual Report incorporates the Health Board's submission of compliance with NHS Counter Fraud Standards to NHS Counter Fraud Authority. The Committee's Chair has a direct sign off responsibility for this submission therefore the Annual Report presentation at this meeting allows for Committee Members to feed into that Chair approval.

5. INFORM AND INVOLVE

The Counter Fraud Team have issued revised literature for use in supporting counter fraud awareness within the Health Board. The Team have developed a tri-fold leaflet intended to replace an ageing information booklet. As well as stylistic updates to align to corporate branding the new leaflet contains core information around NHS

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fraud and signposts readers to other available means of learning and engaging with counter fraud.

6. PREVENT AND DETER

Work on the Health Board's matched data sets released by the National Fraud Initiative is underway. The first focus is on Payroll to Payroll matches which highlights dual employment between the Health Board and other public sector organisations. This follows identification of an allegation of dual working relating to a Health Board member of staff currently under investigation. This area of fraud risk has increased since the introduction of remote working opportunities following the Covid pandemic.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 2 to this report. A summary of basic investigation KPI data is presented at outset of the appendix.

Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.

The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.

A table of Closed Cases is also presented to review outcomes of investigations.

8. RECOMMENDATION

The Audit Committee is asked to **note** the Counter Fraud Progress Report.

Counter Fraud Annual Report 2024/25

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May 2025

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1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2024/25 was approved by the Audit Committee in March 2024 and identified a total resource of 308 days for the year. The Counter Fraud Team delivered 308 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £79,582.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2024/25 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high-risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. NHS Wales have adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority’s (NHS CFA) ‘NHS Counter Fraud Standards (Wales)’. At the conclusion of 2024/25 the Health Board is assessed as Green rated across all Standards with a Green overall rating. This is a reflection of the Health Board’s support to counter fraud activity and a realisation of previous years counter fraud work to drive compliance with Standards. The 2025/26 Counter Fraud Work Plan seeks to consolidate these ratings.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2025

The annual report must contain the declaration listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Provider Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2024/25 has been self-reviewed against the Functional Standard Requirements relating fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

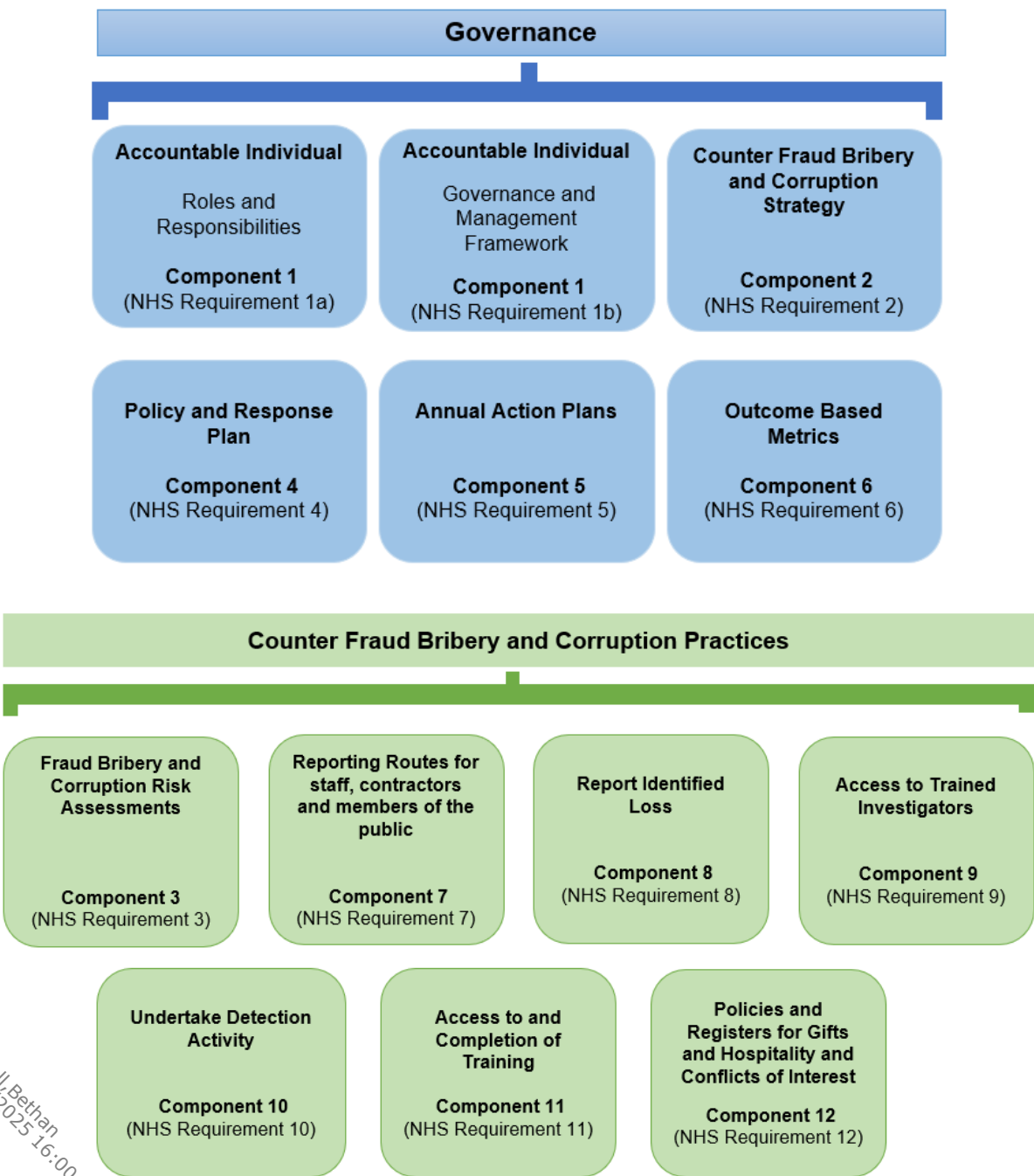
Organisation	Powys Teaching Health Board
Accountable Board Member Signature	Pete Hopgood
Date	

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4. Work carried out against the Functional Standard Requirements

In completing the annual report on the counter fraud, bribery and corruption work undertaken, the organisation should refer to the [Functional Standard Requirements](#) and the expected work needed to be compliant with each component.

The report should detail the work completed against each of the components relating to governance activities and counter fraud, bribery and corruption practices undertaken during the year, as set out below.



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Governance

This section of the annual report should outline how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 1 Accountable individual	NHS Requirement 1A	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in gaining assurance	GREEN	GREEN	NHSCFA proactive exercise reports have been presented to the Health Board's Audit Committee. A

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
		and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.			concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Director of Corporate Governance is nominated as the Organisation's Fraud Champion.
Component 2 Counter fraud bribery and corruption strategy Powell Bethan 08/05/2025 16:00:41	NHS Requirement 2	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFP&RP and work plan are agreed by Director of Finance

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 Policy and response plan	NHS Requirement 4	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy.
Component 5 Annual Action Plan	NHS Requirement 5	This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.

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Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 6 Outcome based metrics	NHS Requirement 6	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

Counter Fraud Bribery and Corruption Practices

This section of the annual report should outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

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Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 3 Fraud bribery and corruption risk assessment	NHS Requirement 3	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	AMBER	GREEN	work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments. Action plan to lift rating to Green from previous reporting period is complete with work undertaken to review existing risk assessments with risk owners and to utilise results of previous work to effectively demonstrate monitoring of risk with measurable outcomes which is reflected in the 2025/26 Counter Fraud Work Plan.

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Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 7 Reporting routes for staff, contractors and members of the public	NHS Requirement 7	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 10 new investigations in 2024/25. Surveys have been undertaken

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Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					in March 2024 to measure effectiveness.
Component 8 Report identified loss	NHS Requirement 8	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.
Component 9 Access to trained investigators	NHS Requirement 9	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional

Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
					development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2024/25 was 1.2 FTE.
Component 10 Undertake detection activity	NHS Requirement 10	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review process the Counter Fraud Team have registered 20 local proactive exercises on the case management system in 2024/25.

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Function Standard Component	NHS Requirement		2023 Rating	2024 Rating	Current Position
Component 11 Access to and completion of training	NHS Requirement 11	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations, inclusion on Corporate learning days for inductees and managers as well as e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts.
Component 12 Policies and registers for gifts and hospitality and Conflicts of Interest	NHS Requirement 12	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations.

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5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report details the total counter fraud resources used by the organisation.

Area of activity	Days used
Proactive work	202
Reactive work	106
Total days used	308

Appendix 2 – Counter Fraud Costs

This section of the annual report details the total costs of the counter fraud resources used by the organisation.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£52,193
Reactive costs	£27,389
Total costs	£79,582

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Appendix 3 – Nominations Overview

Role	Name of Nominated Person
Accountable Board Member	Pete Hopgood
Audit Committee Chair	Stephen Elliot
Counter Fraud Champion	Helen Bushell
Lead LCFS	Matthew Evans
Supporting LCFS	Louisa Steele

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Appendix 4 –Case Information Overview

This section of the annual report details case investigation activity recorded on the Clue case management system.

Case Information	Number
Cases carried forward from previous years	12
Cases Opened during the period	10
Cases Closed during period	16
Cases Ongoing	6

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Appendix 5 – CLUE Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

CLUE Information	Number
Investigations opened during the most recent financial year	10
Investigations closed during the most recent financial year	16
Investigations open as at 31/03/2025	6

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Appendix 6 – Fraud Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	7
Number of new FRAs recorded in line with the organisations risk management policy	7

Local Proactive Exercises	Number
Number of LPEs conducted during the year	20
Number of LPEs recorded on the NHS CFA Case management system as per component 8	20
Number of LPEs concluded during the year	20

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

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Appendix 7 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary applied and recorded during this financial year	0
Civil applied and recorded during this financial year	1
Criminal applied and recorded during this financial year	0
Total Sanctions	1

Redress Imposed	Total Amount £
Fraud identified	£0
Fraud Loss Identified	£0
Fraud Prevented	£0
Fraud Recovered	£0
Non-Fraud Loss	£120
Non-Fraud Recovery	£120

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NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.8

Audit Risk and Assurance Committee		Date of meeting: 13 May 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:			
The Audit Risk and Assurance Committee is asked to NOTE the analysis of Single Tender Waiver requests made between 1 April 2020 and 31 March 2025.			
RECOMMENDATION(S):			
The Committee is asked to:			
• NOTE there has been one Single Tender Waiver request made between 1 March 2025 and 31 March 2025. • Take ASSURANCE that the organisation has appropriate monitoring in place for single tender waivers.			
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.

DETAILED BACKGROUND AND ASSESSMENT:

During the Period 1st March to 31st March 2025 there has been no instances of Single Tender Waivers.

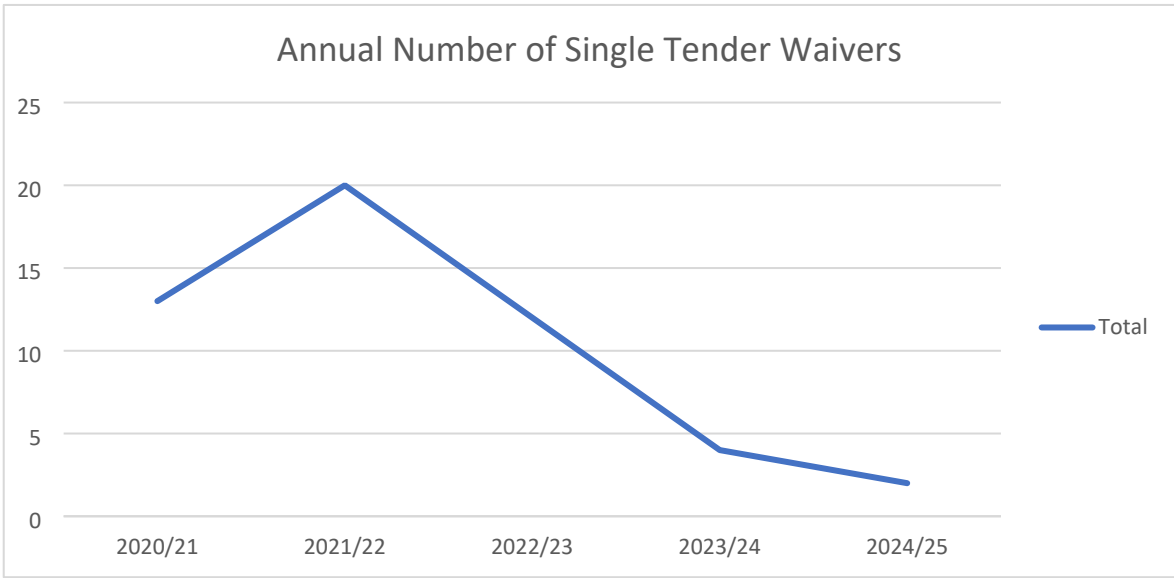
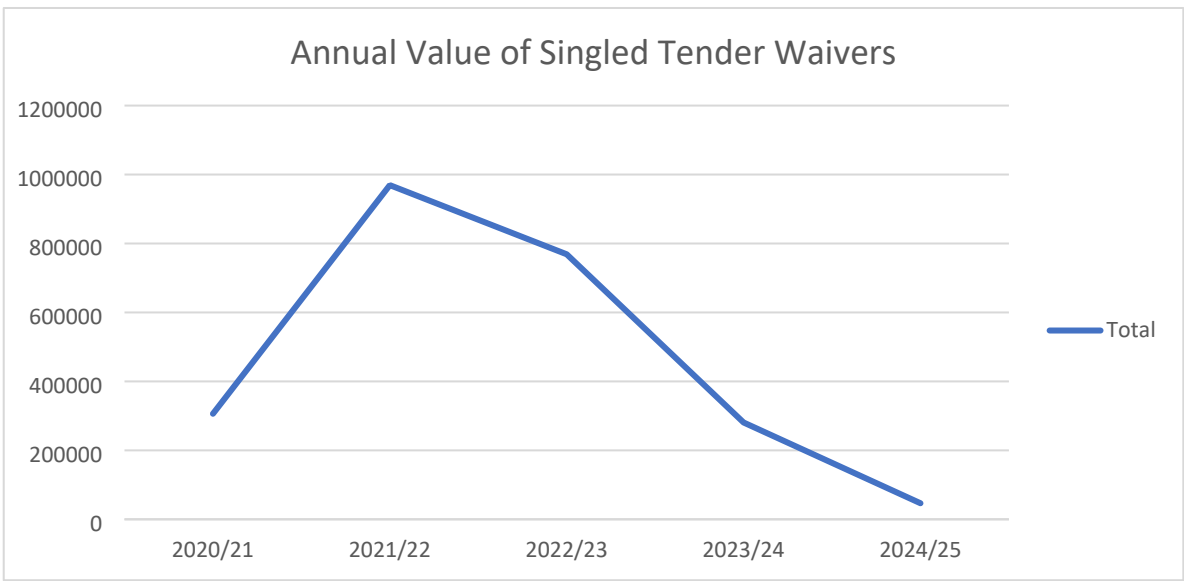
Periodically the Audit Risk and Assurance Committee receive a summary of STWs over a period of time, to identify trends and themes where there is a greater use of STWs in a particular area.

An analysis of approved Single Tender documents covering the period 1st April 2020 to 31st March 2025 has been undertaken by the Assistant Director of Finance.

The findings of this analysis are as follows:

Annual Value and Numbers of STWs

The trend can be seen that during 2020/21 the amounts per year were at a relatively low level until an increase in 2021/22. This peak increase in 2021/22 is mainly due to Health Care Provision related STWs for longer periods and larger values. Since this peak, the annual value and number of STWs has decreased over the following two years.

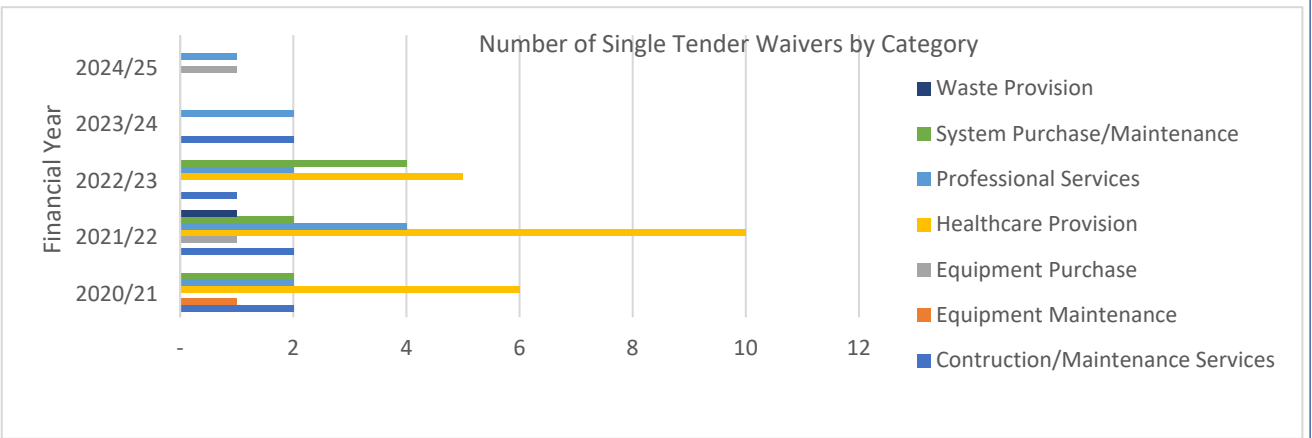
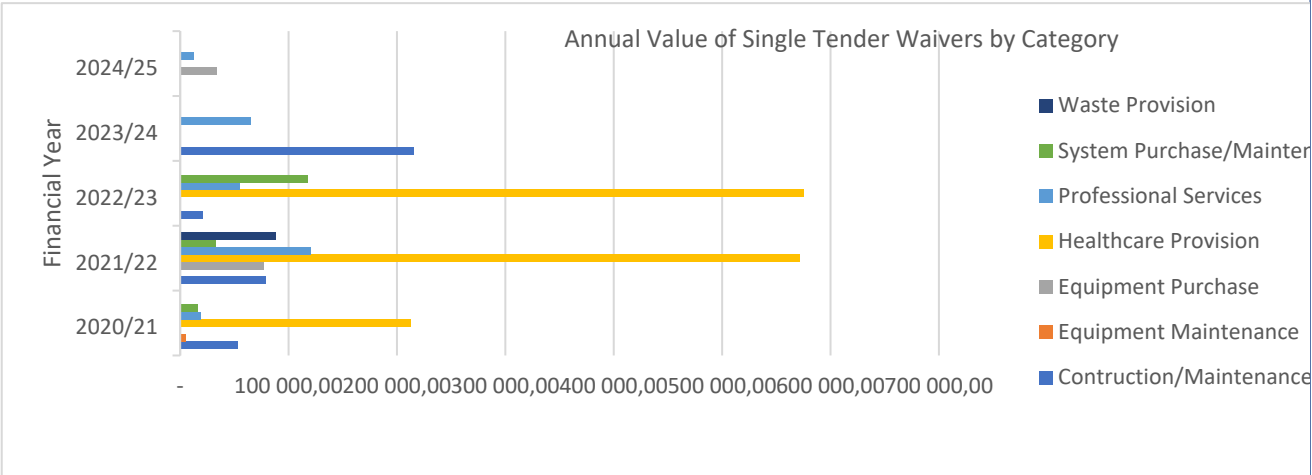


Category of Single Tender Waiver

The chart below shows that the majority of Single Tender Waiver usage relates to Healthcare provision but this has reduced since the peak period of 2021/22. The main reason for Healthcare Provision usage is due to augment NHS Capacity to undertake necessary services or treatments for the population of Powys.

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

The number of waivers by category chart is showing that on an annual basis the comparison of numbers per category can fluctuate but due to the low level of forms approved on an annual basis it is difficult to see any significant trends.



Numbers of Single Tender Waivers by Directorate

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

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Directorate									
Financial Years	Community Health Councils	Directorate of Medical Services	Directorate of Planning and Performance	Directorate of Primary Care, Community Services and Mental Health	Directorate of Workforce	Directorate of Finance, Estates and Support Services	Directorate of Nursing and Midwifery	Directorate of Therapies and Health Sciences and ICT	Grand Total
2020/21	1			9		2	1		13
2021/22			1	13	2	3		1	20
2022/23			1	3	4	1	1	2	12
2023/24					1	1	2		4
2024/25					2				2
Grand Total	1		2	3	29	4	8	1	51

NEXT STEPS:
None required as a result of this paper.

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT



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Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.9

Audit Risk and Assurance Committee		Date of Meeting: 13 May 2025	
Subject:	Annual Report for Losses and Special Payments 2024-25		
Approved and presented by:	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 RATIFY the Annual Report of Losses and Special Payments for the period 1st April 2024 to 31st March 2025.			
RECOMMENDATION(S):			
The Audit and Risk Assurance Committee is asked to:			
• RATIFY this Annual Report on Losses and Special payments covering the period 1st April 2024 to 31st March 2025.			
Approve/Take Assurance		Discuss	Note
Y		N	N

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	

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EXECUTIVE SUMMARY:

Losses and special payments are items that the Welsh Government would not have contemplated when it 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. Therefore, they are subject to special control procedures and are included within a separate note in the THB's annual accounts.

DETAILED BACKGROUND AND ASSESSMENT:

The following relate to payments made on behalf of cases for which Powys THB has 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 included below.

This report is for the period 1st April 2024 to 31st March 2025. The payments have been categorised as follows:

- Clinical negligence and personal injury
- Redress (Putting Things Right)
- General Medical Practice Indemnity (GMPI)
- Other Special Payments

Management Arrangements

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 Learning From Events Report (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.

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- 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 (and the former Experience, Quality and Safety 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 2024 to 31 March 2025, the THB made payments in respect of 12 cases totalling £172,448.43 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 received five reimbursements 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)	39	12	£172,448.43
Total	39	12	£172,448.43

There were no receipts from the Welsh Risk Pool in respect of Clinical Negligence and Personal Injury cases over £25,000 during 1st April 2024 to 31st March 2025.

Powys Teaching Health Board continues to hold a small claims portfolio. There are currently 13 cases which are inclusive of clinical negligence (8), and personal injury (5) claims with NWSSP Legal and Risk Services instructed to act on behalf of the Health Board.

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 2024 to 31st March 2025 are included in Appendix Aii.

	No. of payments/receipts	No. of cases	£
Redress Payments	15	6	£24,744.07
Total	15	6	£24,744.07
Redress Receipts	1	1	£5,913.00
Total	1	1	£5,913.00

There are currently 6 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 2024 to 31st March 2025 are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
GMPI Payments	14	5	£16,556.50
Total	14	5	£16,556.50

There are currently 7 open GMPI cases at variable stages of review/progression.

There have been no reimbursements from Welsh Risk Pool during 2024/25 in respect of GMPI.

Other Special Payments

Details of the payments are included in Appendix Aiv.

	No. of payments/receipts	No. of cases	£
Other Special Payments	5	5	£1376.07
Total	5	5	£1376.07

Conclusion

The Audit Committee is asked to RATIFY the above Annual report for 2024/25 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 – Av

NEXT STEPS:

None required as a result of this paper.

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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Appendix A1

Receipt Date	V
Nil receipts from Welsh Risk Pool	

Receipt Date	V
Nil receipts from Welsh Risk Pool	

Redress Losses And Special Payments for 2024-25 Financial Year					
1st April 2024 to 31st March 2025				Appendix Aii	
Payment Date	Redress Reference	WRP Reference	Nature of Payment	Amount	Amount by case
Apr-24	COM1048	RED7A7-0043/CD	Damages	£5,000.00	
May-24	COM1048	RED7A7-0043/CD	CRU	£913.00	
May-24	COM1048	RED7A7-0043/CD	Claimant Costs	£1,920.00	
					£7,833.00
Jun-24	RED67/INC7543	PTR/030/1851/JC	Defence	£35.90	
Oct-24	RED67/INC7543	PTR/030/1851/JC	Defence	£634.55	
Mar-25	RED67/INC7543	PTR/030/1851/JC	Defence	£2,334.81	
					£3,005.26
Jul-24	INC9358	PTR/030/1883/RR	Defence	£764.31	
Sep-24	INC9358	PTR/030/1883/RR	Defence	£104.70	
Mar-25	INC9358	PTR/030/1883/RR	Defence	£272.22	
					£1,141.23
Aug-24	Red69	PTR/030/1898/DS	Defence	£482.77	
Dec-24	Red69	PTR/030/1898/DS	Defence	£361.73	
					£844.50
Jan-25	RED73	RED-7A7-0057-EE	Defence	£282.69	
Feb-25	RED73	RED-7A7-0057-EE	Defence	£251.28	
Mar-25	RED73	RED-7A7-0057-EE	Defence	£136.11	
					£670.08
Jan-25	RED66	RED-7A7-0054-SJ	Damages	£11,250.00	
					£11,250.00
Total				£24,744.07	£24,744.07
Reimbursements from Welsh Risk Pool					
Receipt Date	WRP Reference	Redress Reference		Amount	Amount by case
Oct-24	COM1048	RED7A7-0043/CD		£5,913.00	
					£5,913.00
Total				£5,913.00	£5,913.00

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Appendix Aiii

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount by case
Apr-24	GPM/030/1650/CAP	Defence Costs	£1,050.00	
Jul-24	GPM/030/1650/CAP	Defence Costs	£2,364.00	
Jul-24	GPM/030/1650/CAP	Defence Costs	£1,155.00	
Sep-24	GPM/030/1650/CAP	Defence Costs	1,102.50	
				£5,671.50
Aug-24	GPM/030/1895/LKT	Defence Costs	£1,200.00	
Sep-24	GPM/030/1895/LKT	Defence Costs	£3,300.00	
Oct-24	GPM/030/1895/LKT	Defence Costs	£360.00	
Nov-24	GPM/030/1895/LKT	Defence Costs	£675.00	
Nov-24	GPM/030/1895/LKT	Defence Costs	£600.00	
				£6,135.00
Dec-24	GPM/030/1867/DT	Defence Costs	£1,440.00	
Jan-25	GPM/030/1867/DT	Defence Costs	£2,100.00	
				£3,540.00
Mar-25	GPM/030/1650/NB	Defence Costs	£122.50	
Mar-25	GPM/030/1650/NB	Defence Costs	£210.00	
				£332.50
Feb-25	GPM/030/1662/SL	Defence Costs	£877.50	
				£877.50
Total			£16,556.50	£16,556.50

Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Nil receipts to date			
		Total	£0.00

Appendix Aiv

Payment Date	Losses Reference	Nature of Reimbursement	Amount
Jul-24	256C4EG0001	Replacement personal hygiene item broken by staff member	£19.95
Jul-24	256C4EG0002	Glasses broken by Patient	£428.00
Sep-24	256C4EG0003	Loss of shoes in internal transit provided to THB for adaptation	£49.48
Dec-24	256C4EG0004	Replacement dentures lost on ward	£753.70
Mar-25	256C4EG0005	Replacement of mobile phone damaged by ward staff	£124.94
Total			£1,376.07

Audit Risk and Assurance Committee
Date: 13 May 2025
Agenda Item: 5.9

AUDIT, RISK AND ASSURANCE COMMITTEE

Date of Meeting:
13 MAY 2025

Subject :	Information Governance & Records Management Annual Report 2024-2025
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary
Prepared by:	Head of Information Governance, Records and Data Protection Officer
Other Committees and meetings considered at:	N/A

PURPOSE:

To provide assurance of the arrangements in place to support the health board's compliance with its statutory obligations in relation to legislation, national frameworks, Records management and good practice.

RECOMMENDATION(S):

The Committee are asked to:

- **RECEIVE** the annual report for 2024/25 taking **ASSURANCE** appropriate mechanisms are in place to monitor and record progress.
- **NOTE** the actions for continued development into 2025/26.
- **NOTE** the report will be provided to the Audit and Risk Assurance Committee in May 2025.

Assurance	Discussion	Information
✓	✓	x

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

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

	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	X
	2. Safe Care	X
	3. Effective Care	X
	4. Dignified Care	X
	5. Timely Care	X
	6. Individual Care	X
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The reporting period covers the annual position as well as Q4 reporting requirement (1 April 2024 to 31 March 2025). A breakdown of performance including statistics is in the detailed background and assessment section with a high-level overview below:

- 477 Freedom of Information (FOI) requests (down from 486 received last year). However, the requests received are increasingly more complex. There is an improvement in responses, from 86% to 89% but this is still below the ICO target of 90%. 2 requests during 2024-25 were considered under the Environmental Information Regulations (EIR) requests. The team also considered 6 internal reviews as part of the internal review process.
- Requests for Personal Information continue to increase with 814 requests received (716 requests in the previous year) as citizens increasingly exercise their right to access their personal information. Compliance at 98% has also increased from the previous year (95%) **however it is to be noted** requests **are** becoming more complex in nature.
- IG Mandatory E-Learning Training as of 31 March 2025 is 77.30%, which has distinctly lessened from the previous year score of 88.74%. This is now below the NHS Wales benchmark of 85%.
- The team delivered 27 bespoke training sessions to services. Sessions covered topics on Introduction to IG, Records Management Appraisal of Records, Subject Access Requests and Information Asset Register. This is a significant increase of 238% in comparison to sessions requested and delivered (8) in the previous year but shows a positive sign of service engagement.
- Datix Incidents (Breach Reporting) 172 IG related incidents were reported with 70 not reported within the UK GDPR regulatory 72 hours. All 70 were due to health board service delays in reporting. We received 2 IG related complaints, although one was an incident caused by another organisation.
- The National Intelligent Integrated Audit Solution (NIIAS) notifications have decreased slightly from 50 (2023-2024) down to 43.
- Records Management re-audited by Internal Audit. Previous no assurance was updated to substantial assurance.

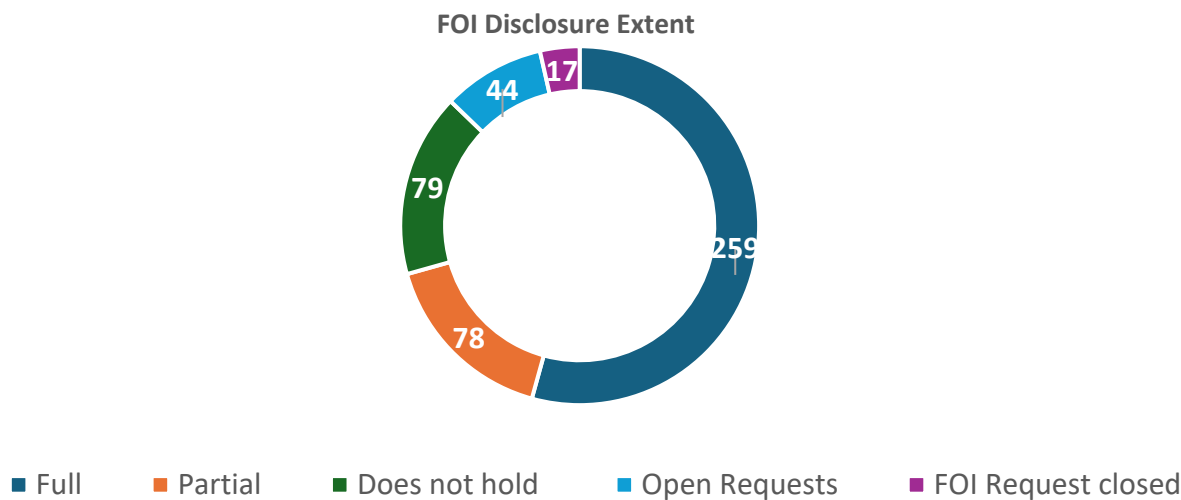
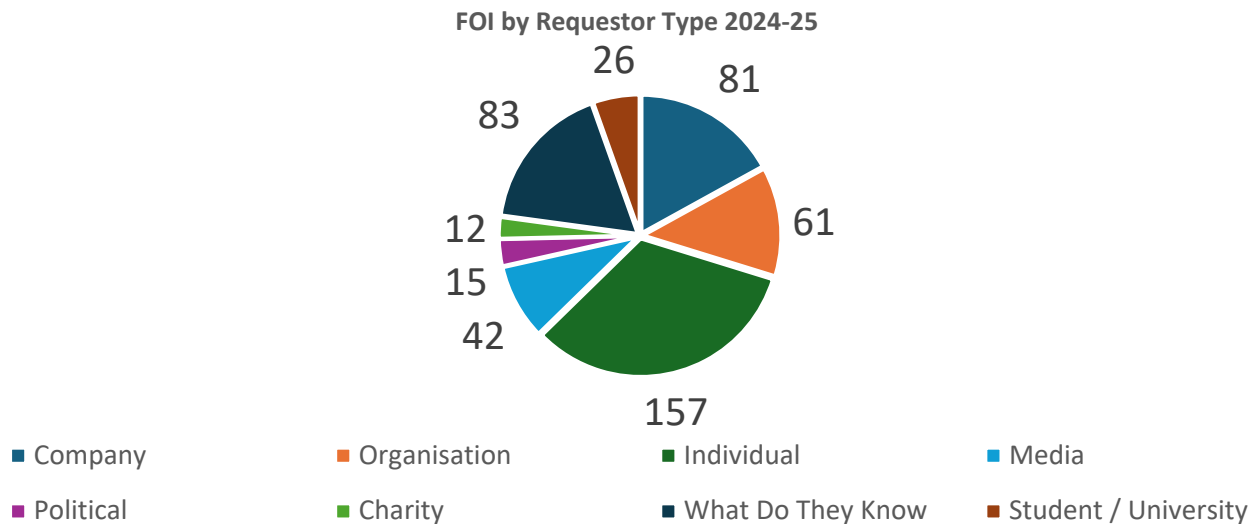
- Information Governance follow up by Internal Audit conducted April 2025. Previous limited assurance was updated to substantial assurance.
- NHS Wales Information Governance Toolkit Submission deadline for 2024/25 was submitted on time, a full out-come report and improvement plan will be submitted in June.
- The team developed 3 new policies & 3 new procedures. 4 existing procedures were reviewed. All have been made available on the Team's Intranet page and circulated to staff via an IG news item. The health board wide PTHB Team Focus includes all newly developed and reviewed policies and procedures in their briefing.
- The team have continued to review and update the service intranet pages to reflect the latest guidance, advice and news.
- The IG team reviewed and supported 42 Data Protection Impact Assessments (DPIAs) which include local and national programmes.
- The team reviewed and supported 19 contracts and information sharing agreements for both national and local programmes to ensure we meet our legislated obligations.
- The team support Research proposals and service evaluation requests ensuring that the proposals meet data protection and records management requirements. The team reviewed 24 proposals, which is an increase from 16 reviews undertaken last financial year.
- The new Information Asset Register platform was developed and deployed in Q2, to date there are currently 67 approved assets.

DETAILED BACKGROUND AND ASSESSMENT:

Compliance with Legal and Regulatory Framework:

Freedom of Information requests - The charts below illustrate the sources of requests received, and the response disclose extent made available to the requestor:

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Caveat: ‘Open Requests’ are responses that have not yet reached the 20-day deadline at the time of running report; therefore, we cannot record the extend of the disclosure.

The team have been proactively engaging with departments to update the FOI Publication Scheme to improve access to information and to lessen the pressure on services to provide information for similarly themed requests, and greater access to appropriate corporate information for the Public.

Requests for personal information:

Type of request by legislation and timeframe	Q1 2024-25			Q2 2024-25			Q3 2024-25			Q4 2024-25			Annual
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
SARs (UK GDPR/DPA 2018 – 30 days)	40	38	36	53	39	46	51	43	38	37	36	34	491
Rectification (UK GDPR/DPA 2018 – 30 days)	0	0	0	0	0	1	0	2	0	0	1	2	6
Erasure (UK GDPR/DPA 2018 – 30 days)	0	0	0	1	0	2	1	0	0	0	0	0	4

SARs Breached (UK GDPR/DPA – 30 days)	2	2	0	8	1	0	3	0	0	0	1	0	17
Deceased (AHRA) 40 days	3	2	2	1	0	3	1	0	1	0	1	2	16
AHRA Breaches (40 days)	0	0	0	0	0	0	0	0	0	0	1	0	0
Medical Examiner Service (72 hrs)	11	21	18	18	16	15	26	13	18	0	0	17	206
Medical Examiner Service (72 hrs) Breaches	0	0	1	0	1	0	1	1	0	16	17	0	4
3rd party DPA requests – no timescale	9	9	2	7	2	7	7	4	2	0	0	3	73
Other: Medical Reports etc	3	4	1	3	2	0	2	0	2	12	9	0	18
Total requests for all legislation	66	74	59	83	59	74	88	62	61	1	0	58	814
% Of compliance for all requests	97	97	98	90	97	100	95	98	100	10	98	100	98

The team continue to support services with compliance however the increasing number and complexity of requests is proving challenging. A News item was issued out Powys wide in Q3 to provide staff with clarity on what constitutes a Subject Access Request and a reminder that training is available upon request to those staff involved in the SAR process.

Datix Incidents (Breach Reporting)

All incidents with an information governance theme are investigated and risk scored by the team. Any scoring above the stated threshold is deemed reportable to the ICO. Below is a breakdown of IG related incidents for Q4 and the annual total for 2024-25:

	Q4 24-25	Total 2024-25
Number of PTHB IG Incidents reported	56	172
Number of IG incidents NOT reported within 72 hrs (inc non PTHB)	23	70
Non PTHB incidents	2	8
Number of incidents reported to the ICO	0	0

NHS Wales Mandatory e-Learning for IG, Records Management and Cyber security

Quarter 1 – 4 (April 24 – March 25) NHS Wales Mandatory e-Learning for IG, Records Management and Cyber Security – New starters

Mandatory IG Module Completion	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Compliance
Prior to joining	17	0	7	6	6%
Not completed	14	85	122	98	59%
Completed within 6 weeks	52	79	10	13	29%
Completed after 6 weeks	8	19	3	4	6%
Grand Total	91	183	142	121	41%

The table below shows a detailed breakdown of mandatory IG training compliance for each directorate as at 31 March 2025 (end 2024/25):

Directorate	Assignment Count	Required	Achieved	Compliance %
Bank Staff	1474	1474	884	59.97%
Chief Executive Office	19	19	16	84.21%
Community Care & Therapies	1095	1095	974	88.95%
Community Dental Service	72	72	66	91.67%
Corporate Governance	26	26	23	88.46%
ESR	27	27	24	88.89%
Estates & Works	53	53	44	83.02%
Finance Directorate	35	35	30	85.71%
Facilities & Support Services	200	200	146	73.00%
HCRW	78	78	67	85.90%
Medical Directorate	15	15	12	80.00%
Mental Health	486	486	410	84.36%
Medicines Management	39	39	37	94.87%
Nursing Directorate	32	32	25	78.13%
Public Health Directorate	87	87	79	90.80%
Planning Directorate	17	17	16	94.12
People & Culture Directorate	82	82	76	92.68%
Primary Care	20	20	18	90.00%
Therapies & Health Sciences Directorate	65	65	58	89.23%
Women & Children Directorate	211	211	190	90.05%
Grand Total	4133	4133	3195	77.30%

The team have been proactively targeting staff who are non-compliant and an additional process has been embedded to contact new starters who have not completed the training within the initial 6 weeks of employment.

Advice, Training and Assurance

Some of the key activities and achievements supporting the workforce and service areas are:

- Continued approach to assuring new and existing systems through the Digital Governance Board
- Developing Data Protection Impact Assessments
- Collaborating with services to establish data sharing agreements.
- Investigating IG related incidents and issuing IG Newsletters
- Providing tailored training sessions and updating intranet and webpages
- Providing advice and input as part of digital transformation projects both locally and nationally
- Participating in meetings and groups with national colleagues
- A targeted email campaign has continued through 2024-2025 to remind non-compliant staff to complete the mandatory IG, Records Management and Cyber ESR training.
- Established Information Governance & Records Management Operational Group - This has been established and the first meeting held. The team will continue to support the IAA/IAO in their roles along with enhancing data protection compliance,

promote best practices and ensuring adherence to relevant legislation and regulations.

Information Security Assurance

Digital Governance Board (DGB) has continued to meet and is a group of digital and clinical experts that approve the procurement of any local new or existing digital solution to ensure complies with relevant legislation and standards (UK GDPR and NIS Regulations) thus reducing the threat of PTHB being put at un-necessary risk, such as from a Cyber-attack, loss of data, incident/breach of patient's data, financial penalty from the ICO or NCSU.

The IG team has been involved in several high profile National and Local programmes and projects to ensure that the potential information risk to the health board is low and requirements align to data protection legislation and that we can continue to provide assurance to our key stake holders.

Risk Management Assurance

The Senior Information Risk Owner (SIRO) is responsible for overseeing information risks within the Health Board. The SIRO's role is supported by the IG Team who in turn work with system owners to populate the Health Board's Information Asset Register (IAR). This may also involve developing policies, procedures and business continuity plans as well as documenting their personal data information flows and conducting regular information risk assessments. The IG and Digital Transformation Team support services in achieving these objectives.

The SIRO and IG Team monitor and report IG related risks through the Risk and Assurance Committee. There are no IG or Records Management related risks currently residing on the Corporate Risk Register.

Data Protection Impact Assessments (DPIAs)

A Data Protection Impact Assessment (DPIA) is a risk assessment that is an essential part of health board accountability obligations when considering the use (processing) of patient, staff and corporate information. The team have continued to support and review DPIAs as and when they are required both on a local and national level. Work is being considered national to streamline and have an NHS Wales DPIA Template in the future.

Information Sharing Agreements and Contracts

Over the last 12 months, the team has continued to see a positive increase in the number of services voluntarily contacting the IG department for support with updating existing, or drafting new, information sharing agreements to support patient care with our external partners. This can include Information Sharing Protocols (ISPs), Data Disclosure Agreements (DDAs), and Data Sharing Agreements (DSAs). Alongside this, the team have also supported the review and development of contracts, Data Processing Agreements (DPAs) and Service Level Agreements (SLAs).

Research and Service Evaluations

The IG team review all proposals that are received by the Regional Innovation Co-ordination (RIC) Hub for Research and Development purposes, to ensure they meet our data protection obligations. There has been a steady increase in the number of proposals being reviewed and supported by IG each year as outlined by the table below.

Research & Service Evaluation Projects Reviewed and Supported by IG



Audit and Monitoring Assurance

The Health Board is required to undertake the NHS Wales Information Governance Toolkit for Health Boards and Trusts. All NHS Wales organisations must complete this annually to provide assurance that they are practising good data security, and that personal information is handled correctly. The 2024-2025 assessment has recently been completed with support from other health board services. The out-turn report and action plan will be available to the Board in June.

Internal Audit – Records Management

Internal Audit revisited Records Management in November 2024 with the final report awarding a substantial rating. Work is ongoing with the Associate Director of Capital, Estates and Property to address the one medium priority recommendation relating to the lack of fire suppression systems within records storage areas. Work is also progressing to ensure all records management storage areas are fit for purpose with an PRF submitted to the Capital Control Group to upgrade the current storage facilities at Bronllys O Ward.

Internal Audit – Information Governance

In April 2025, Internal Audit revisited the six recommendations made in 2023, with the final report awarding a substantial rating where previously it was limited. One action remains outstanding, regarding the deployment of the activity tracker which will support the full needs assessment of the service. The deadline to deploy the activity tracker is 1 July 2025, and supplementary deadline of March 2026 for the Head of Information Governance and Director of Corporate Governance to complete the needs analysis to fully complete this action.

National Intelligent Integrated Audit Solution (NIIAS)

Weekly reporting is undertaken by the IG Team to monitor potential inappropriate access of the member of staff's own clinical record or that of a family member (Home relation). The table below shows the figures for all notifications the team have investigated during 2024-25:

Potential incident (notification) type	Q1	Q2	Q3	Q4	Annual Total
Own Record – 1 st offence	4	0	3	4	11

Own Record - repeated	0	0	0	1	1
Home Relations (Family) Record - 1st offence	7	7	6	4	24
Home Relations (Family) Record - repeated	0	0	0	7	7
Both home relations and own record accessed	0	0	1	0	0
Notification for Non-PTHB member of staff	0	0	0	0	0
Total	11	7	10	16	43

The Team have proactively worked with services to ensure that the mandatory IG, Records Management and Cyber e-learning training has been completed may account for the reduction in NIIAS notifications being received as staff recognise their obligations in relation to personal data. When a notification has been investigated, the team are also now requesting that the mandatory e-learning IG training is redone (even if it is not due for renewal) by any members of staff who intentionally accessed their own record or that of a family member.

Information Assets

Since the deployment of the new Information Asset Register platform in Q2, a total of 67 information assets have been added with 11 information assets added in quarter 4. Work is ongoing to promote the Information Asset Register and to support services in identifying and registering their assets, with training deliverable upon request.

Records Storage Processes

- A new procedure and online request form was implemented in Q3 to take the management and co-ordination of requests for storage of archive records under the remit of the IG team. This process was introduced to streamline how archive paper records are managed across the health board and to ensure that designated facilities are fully utilised. To date the team have approved and co-ordinated 8 requests for the storage of archive records.
- Records Storage Security Checklist was developed and issued out to services for completion to risk assess the safety and security of physical records.
- Destruction of Programme Project commenced
- Work through CCG has started to refurbish and update existing storage facilities to be compliant with Records Management Standards

NEXT STEPS:

Work will continue in the following areas:

- Finalisation of the IG and Records Management Framework for PTHB
- Continue to progress the IG and Records Management workplans
- Monitor progress against the NHS Wales Information Governance Toolkit in readiness for 25/26 submission
- Continue to promote WASPI and Information Sharing across the Health Board.
- Continue to explore ways to improve IG and Records Management compliance performance across the organisation

- Continue to monitor IG related incidents, explore ways of working with service to reduce the number of incidents and improve reporting timescales
- Support Digital Transformation with the Connecting Care Programme
- Work collaboratively both internally and externally with key stakeholders
- Continued assurance reports to the Audit, Risk and Assurance Committee.

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IG Annual Report April 2025

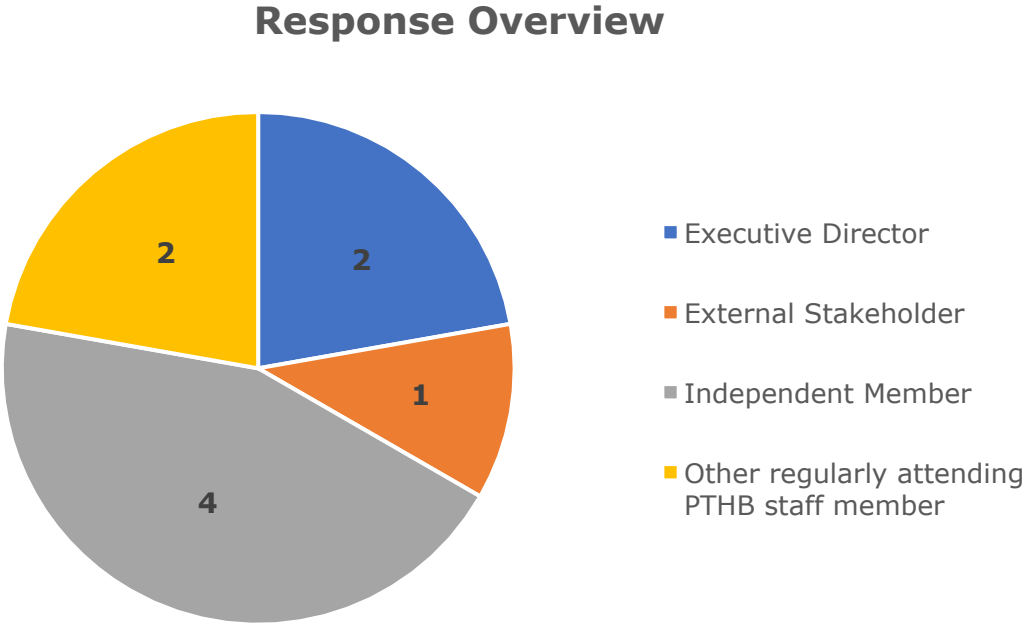
Audit, Risk and Assurance Committee
Date: 13 May 2025
Item: 5.10

Subject:	Committee Effectiveness – Audit Risk and Assurance Committee
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Author:	Deputy Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire and is provided to stimulate discussion within the Committee to support the identification of what works well, learning and actions for improvement.
Recommendations:	The Committee is asked to: • DISCUSS the summary of the Committee Effectiveness survey and any areas for action/improvement.
Executive Summary:	Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee’s understanding of its remit and oversight responsibility and a culture of continuous improvement. The approach for 2024/25 contained a questionnaire and then discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, (iii) assurance and remit and (iv) leadership and culture.

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Section 1 – Response Rate

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Total Responses Received: 9

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Section 2 – Composition and Establishment

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Section 2 - Composition and Establishment					
Question	Strongly Agree	Agree	Unsure	Disagree	Strongly disagree
The Committee understands its role:.	7 77.78%	2 22.22%	0	0	0
The Committee’s annual work plan and subsequent agendas enable it to effectively deliver the relevant areas of its Terms of Reference:	5 55.56%	4 44.44%	0	0	0
The Committee has the membership, authority and resources to perform its role effectively:	5 55.56%	3 33.33%	1 11.11%	0	0
The right people attend meetings of the Committee to enable it to fulfil its role effectively:	5 55.56%	4 44.44%	0	0	0
Committee members have the collective skills and experience required to fulfil the terms of reference and advise and assure the Board:	4 44.44%	5 55.56%	0	0	0

KEY THEMES:

- **Membership**

Comments:

- I think we could sometimes spend more time on some items, but this is not a major issue.
- Committee works well with good scrutiny and focus.
- Membership may require an additional IM given recent changes.
- Induction training for new members would be helpful.
- Regarding Q4 – I consider the Committee has struggled to maintain a quorum due to a low number of appointments to the committee and so do not consider the Committee has enough members on it. I do believe the committee has sufficient authority and resources (by which I mean access to officers) to undertake its role.
- Regarding Q6 – Because additional Committee Members are required it is hard to strongly agree that Committee Members do have the collective skills and experience required to fulfil the terms of reference.

Section 3 – Effective Functioning

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Overview of ratings – Effective Functioning

Section 3 - Effective Functioning					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge: .	4 44.44%	5 55.56%	0	0	0
Committee meetings are conducted professionally and managed effectively with issues getting the appropriate time and attention proportionate to their importance: .	4 44.44%	5 55.56%	0	0	0
Committee papers are of a reasonable length, good quality and provide the appropriate level of information to enable the Committee to fulfil its role: .	4 44.44%	5 55.56%	0	0	0
Papers are distributed in a timely manner, sufficient for members and attendees to adequately read, understand and scrutinise their content: .	3 33.33%	6 66.67%	0	0	0
There is good monitoring of matters arising and agreed actions to support the Committee in its role: .	5 55.56%	4 44.44%	0	0	0
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, escalated items, sharing of good practice) and shares feedb	5 55.56%	4 44.44%	0	0	0

Comments:

- Number of audits coming through can be challenging on times in relation to my time to review and scrutinise.

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Section 4 – Assurance and Remit

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Overview of ratings – Assurance

Section 4 - Assurance					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
The Committee receives advice and assurance on key issues which clearly sets out the analysis of the situation, key risks and what is required of the Committee to allow the Committee to discharge its	3 33.33%	6 66.67%	0	0	0
Information received is sufficiently balanced in terms of evidence (assurance) and professional opinion (reassurance):.	3 33.33%	5 55.56%	1 11.11%	0	0
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance: .	5 55.56%	4 44.44%	0	0	0
The Committee receives regular and sufficient evidence that the organisation is learning and improving:.	1 11.11%	6 66.67%	2 22.22%	0	0
The Committee receives the assurance (quantity, quality and timeliness) it needs to fulfil its role effectively:.	3 33.33%	5 55.56%	1 11.11%	0	0
The mechanism for providing onwards assurance to the Board is effective:.	5 55.56%	4 44.44%	0	0	0

Comments:

- Chair provides a summary to the board and members can also raise comments if required.

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Section 5 – Leadership and Culture

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Section 5 - Leadership and Culture					
Question	Strongly Agree	Agree	Sometimes/Unsure	Disagree	Strongly disagree
In meetings, contributions from members and other attendees are encouraged, open debate is welcomed, and all contributions are listened to and respected: .	8 88.89%	1 11.11%	0	0	0
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues: .	8 88.89%	1 11.11%	0	0	0
The Chair summarises discussions well, captures the main points that have been made and clarifies how the Committee will progress the item under discussion: .	5 55.56%	4 44.44%	0	0	0
Committee members routinely probe the facts, challenge assumptions and identify the advantages and disadvantages of proposals:	3 33.33%	6 66.67%	0	0	0

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Section 5 - Leadership and Culture					
Question	Strongly Agree	Agree	Sometimes/Unsure	Disagree	Strongly disagree
There is an effective relationship between Committee members and Executive colleagues: .	6 66.67%	3 33.33%	0	0	0
Matters considered by the Committee are improved/strengthened as a result of the Committees involvement and/or feedback: .	3 33.33%	5 55.56%	1 11.11%	0	0
The Committee is conducted in a manner consistent with the values of PTHB:	6 66.67%	3 33.33%	0	0	0
The Committee is conducted in a manner consistent with the principles of compassionate leadership: .	6 66.67%	3 33.33%	0	0	0

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Comments:

- Whilst questioning and scrutiny from IMs is generally appropriate, I feel there is room for this to be improved further and to ensure the focus is on the matters being reported as apposed to wider issues.

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Section 6 – General Comments

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In what areas do you think the Committee is doing well?
• Challenge and scrutiny
• All areas.
• It seeks assurance from the Executive teams through effective questioning and challenges and through the internal and external audit processes, therefore understanding the risks to effectively safeguard our patients and our staff.
• Well-rounded discussions and openness to ask questions.
• Meetings are well chaired and managed. There is a good relationship between IMs and Execs.
• Obtaining good assurance that controls are working efficiently and effectively through regular internal audit and Audit Wales updates, as well as counter-fraud updates.
• Coverage of the annual work programme. Management of agendas for individual meetings. Challenge of management in relation to key issues raised by auditors.
• In providing the governance requirements in relation to production of the annual accounts and associated areas which support good governance.

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In what areas do you think the Committee could improve and how?
• Supportive challenge
• Spend appropriate time re individual audits
• Seeking further assurance on financial controls and in year executive mechanisms relating to financial control.
• Strong progress being made – like the process of the deep dives to provide the executive team the opportunity to expand on the key actions being undertaken to address risks and provide the committee and board with assurance.
• Rotating of items as sometimes, if times constraints, things on agenda later do not have as much focus as earlier.
• I sometimes wonder if we as IMs receive more reassurance than true assurance. Sometimes feels the committee agenda is too busy with too many items to provide real scrutiny.
• Process for tracking progress of responding to audit recommendations could be improved.
• Could improve the level of scrutiny and challenge around long overdue audit recommendations. This could include strengthening the process for reporting and agreeing changes to the planned timescales for implementation of actions.
• When looking at internal audit reports give a greater balance of focus on those with lower assurance rather than spending too much time on those providing good assurance. Could be firmer in expectation that long standing audit recommendations and WHC's addressed.

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What training/other development activity would support the Committee in its role?
• Examples of really effective committee.
• Procurement re new PSR.
• Understanding of effective scrutiny in the type of questioning to draw out the key responses.
• None that I can suggest I think it works effectively. Possibly observe a peer audit committee for comparison.
• Perhaps a focus on how assurance can be gained.
• Training might be required if new members are added to Committee Membership. It is possible that all Committees need development in scrutiny as sometimes Committee Members are not firm enough in their expectations of good performance – but also might need confidence in their role. For Example, I do not recall any questions about the register of gifts and hospitality register where very little is registered – but perhaps members do not know the requirements in this area and so are not able to ask the right questions.
• Induction training for new members.

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What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?
• More insight and opportunity for comment on the planning of the audit cycle
• Areas are already included
• Changes to service models and impacts upon risks, assurance and effectiveness of resource allocation.
• Agenda should align to our risk register and strategic priorities.
• Interaction between PTHB and other bodies which support our work might be a good area to consider (e.g. JCC, DHCW, NWSSP)
• I think the current areas of focus are pretty much ok. Could look to ensure that future annual work programmes are effectively linked to HB's objectives and adequately reflect ongoing changes in the key risks to achievement of those objectives.

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Overall Summary

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- Scoring / ratings are strong across the survey with no negative scores
- Positive feedback regarding the management of the Committee and the prevalence of open and constructive discussions.
- Some specific areas to address:
 - Committee Membership and Quoracy
 - Focus of Committee time, e.g. on lower assurance audits, long overdue audit recommendations and WHCs, financial controls
 - Induction/training
 - Benchmarking for Committee effectiveness and 'what good looks like'

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Next Steps

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Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	13 May 2025
2. Receive feedback from the Committee, discuss any actions / improvements	13 May2025
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (8 July 2025)
4. Committee feedback and key actions will be incorporated into summary report with other Committees’ feedback and shared with the Board	By end May 2025
5. Committee forward plan for 2025/26 is in development and will form part of the Committee meeting (reviewed at each meeting)	Next Committee meeting (8 July 2025)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

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- Does the Committee collectively recognise the feedback?
- Are there any further reflections?
- Any areas of specific focus / priority to address?

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.12

Audit, Risk and Assurance Committee		Date of meeting: 13 May 2025	
Subject:	Audit, Risk and Assurance Committee Terms of Reference		
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary		
Prepared by:	Deputy Board Secretary		
Other Committees and meetings considered at:	Discussions taken place with Committee Chair and Lead Executive Director		
PURPOSE:			
The purpose of this paper is for the Committee to consider the Terms of Reference of the Audit, Risk and Assurance Committee in order to ensure that they remain fit for purpose.			
RECOMMENDATION(S):			
The Committee is asked to:			
• ENDORSE the proposed amendments to the Terms of Reference • IDENTIFY any further potential amendments • AGREE that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2025 for approval.			
Approve/Take Assurance		Discuss	Note
Y		Y	

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:			
1. Focus on Wellbeing		Commitment to good governance is a key element of Transforming in Partnership.	
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	Y		

EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis.

The existing Terms of Reference (May 2024) for the Audit, Risk and Assurance Committee are attached as Appendix A, and the proposed revised draft are attached as Appendix B.

Any suggested changes will need to be recommended to the Board for approval.

The Committee is asked to discuss the draft terms of reference and identify any further suggested amendments. The Chair of the Committee and Director of Corporate Governance will take forward any recommendations and/or final amendments to the Board in May 2025 to take effect into 2025/26.

It is suggested that the Committee considers **the following proposals**:

Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Assurance in regard to the performance management of digital and information management and technology (IM&T) systems is removed, to be transferred to the Committee (previously Delivery and Performance Committee). Increased clarity on the role of the Committee in relation to the oversight of the system of risk and assurance.
4 - Membership	Reworded to clarify membership comprises of a minimum of 3 members including the Chair and Vice Chair
5 - Committee meetings	The modern practice of holding meetings virtually has been reflected, including clarification in regard to arrangements for in-person meetings
6 – Relationship and accountabilities with the Board and it's Committees/Groups	Inclusion of a statement on embedding the Health Board's Values and Behaviours in alignment with the other Committees of the Board
Tidying up	The document has undergone general tidying up to ensure correct job titles etc. are reflected

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations to the Board in May 2025 to take effect into 2025/26.

APPENDICES

- a.** Audit, Risk and Assurance Committee Terms of Reference (Approved May 2024)
- b.** Audit, Risk and Assurance Committee Terms of Reference (Draft March 2025)



Audit, Risk and Assurance Committee

Terms of Reference & Operating Arrangements

May 2024

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Model Standing Orders, Reservation and Delegation of Powers for LHBs
Status: Approved
May 2024 (v1)

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1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to in this document as 'PTHB' or the 'health board') Standing Orders provides that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees"*.
- 1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.
- 1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

- 2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:
- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
 - advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
 - Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
 - Working with the other committees of the Board to provide assurance that governance and risk managements

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arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

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- a progress report from the Head of Internal Audit summarising:
 - ✓ work performed (and a comparison with work planned);
 - ✓ key issues emerging from the work of internal audit;
 - ✓ management response to audit recommendations;
 - ✓ changes to the agreed internal audit plan; and
 - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;
- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);
- management assurance reports;
- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
 - use of single tender waivers;
 - extensions of contracts;
 - writing off of losses; or
 - the making of special payments;
- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;

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- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- regular reporting on Information Governance arrangements to ensure compliance with statutory obligations in relation to data protection legislation, national frameworks and good practice,
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and

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provides appropriate assurance to the Board and the Accountable Officer through the Patient Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and
- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance

of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board’s procurement, budgetary and other requirements.

Access

- 3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.
- 3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.
- 3.9 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

- 4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Members of the Board x 3

The Committee may also co-opt additional independent ‘external’ members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

- 4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer

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- Executive Director of Finance. Capital and Support Services
- Board Secretary

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

4.9 The Board Secretary, on behalf of the Committee Chair, shall:

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- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.
- 5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

- 5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held no less than four times a year and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

- 5.4 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:
- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
 - meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
 - issue an annual programme of meetings (including timings and venues) and its annual programme of business;
 - publish agendas and papers on the Health Board's website in

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- advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

- 5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public 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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

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- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business (holding joint meetings where appropriate);
 - sharing of appropriate information; and
 - appropriate escalation of concerns.
- in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
 - bring to the Board's specific attention any significant matters under consideration by the Committee;
 - ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.
- 7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

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- 7.3 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.
- 7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum
 - Issue of Committee papers (some papers are confidential)

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

- 10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

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Audit, Risk and Assurance Committee

Terms of Reference & Operating Arrangements

Draft March 2025 ~~May 2024~~

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1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to in this document as 'PTHB' or the 'health board') Standing Orders provides that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees"*.
- 1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.
- 1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

- 2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:
- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
 - advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
 - Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
 - Working with the other committees of the Board to provide assurance that governance and risk managements

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arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

A report regarding the system of risk and assurance in operation within the Health Board, this may include:

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- any significant changes to the organisations framework for managing risk
- any significant changes to the organisations framework for managing board assurance
- progress updates in relation to the ongoing development and integration of risk and assurance systems and processes
- ~~a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;~~
- a progress report from the Head of Internal Audit summarising:
 - ✓ work performed (and a comparison with work planned);
 - ✓ key issues emerging from the work of internal audit;
 - ✓ management response to audit recommendations;
 - ✓ changes to the agreed internal audit plan; and
 - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;
- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);
- management assurance reports;
- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
 - use of single tender waivers;
 - extensions of contracts;
 - writing off of losses; or
 - the making of special payments;
- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;

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- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy and Board Assurance Framework;
- regular reporting on Information Governance arrangements to ensure compliance with statutory obligations in relation to data protection legislation, national frameworks and good practice,
- periodic reporting on Post Payment Verification Audits
- periodic reporting, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.
- assurance reporting regarding arrangements for the performance management of digital and information management and technology (IM&T) systems including:
 - the monitoring of digital related objectives and priorities as set out in the Board's Integrated Plan; and
 - the monitoring of the annual business plan for IM&T.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their

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effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Patient Experience, Quality & Safety Committee;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and
- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

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3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair

Independent Member of the Board

Vice Chair
Members

Independent Member of the Board
Independent Members of the Board x 3

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Executive Director of Finance, Capital and Support Services
- Director of Corporate Governance / Board Secretary

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

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- 4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.
- 4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

- 4.8 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:
- ~~4.9 The Board Secretary, on behalf of the Committee Chair, shall:~~
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.
- 5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

- 5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held no less than four times a year and in line with the Hhealth Board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

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Openness and Transparency

5.4 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public

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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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

Other meeting arrangements

5.6 Committee meetings will be held via virtual means unless otherwise specified.

Should a meeting be held in person this will be agreed in advance by the Chair and confirmed by Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated in advance by the Corporate Governance Team.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business (holding joint meetings where appropriate);
- sharing of appropriate information; and
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

~~6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.~~

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of ~~Committee minutes and~~ written assurance reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the ~~health~~ Health Bboard.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

- Issue of Committee papers (some papers are confidential)

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance / Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance / Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

- 10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

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Addysgu Powys
Powys Teaching
Health Board

Agenda item: 7.1

AUDIT, RISK & ASSURANCE COMMITTEE		Date of Meeting: 13 May 2025	
Subject:	Post Payment Verification (PPV) End of Year Report – 1st April 2024 to 31 st March 2025		
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services All Wales Post Payment Verification Manager		
Prepared by:	Amanda Legge - Post Payment Verification (PPV) Manager		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specifications and relevant legislation.			
RECOMMENDATION(S):			
The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving. The Audit, Risk & Assurance Committee is asked to: • RECEIVE the report and TAKE ASSURANCE that an appropriate mechanisms of reporting is in place.			
Approve/Take Assurance		Discuss	Note
Y		Y	Y

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

EXECUTIVE SUMMARY:

This paper highlights PPV progress and how practices have been performing over the current Post Payment Verification (PPV) cycle. It also compares the overall performance of the Health Board against the national PPV visits.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board Audit Committees, which should provide reasonable assurance that public monies are being appropriately claimed and that PPV continue to maintain an excellent level of PPV across all disciplines.

BACKGROUND

The following key points should be noted:

General Medical Services (GMS): in 2024-2025 we had 16 visits planned for Powys Teaching Health Board consisting of 6 routine and 9 revisits. By the 31st of March 2024, we had completed 100% of routine visits with 5 revisits remaining. The incompleteness of revisits was a national issue and is not specific to any individual Health Board. With revisits, we need to check 100% of the services that have been triggered, and they take a long time to finalise and unfortunately this year we are experiencing unexpected absence in the team in a disproportionate number.

In the first 2 months of the new financial year 2025/2026 we will be completing all outstanding visits that are overdue before we begin the new visit plan.

We have also been requested by Welsh Government to undertake the additional verification of Covid and RSV vaccines and will begin these checks for the visits due in 2025/2026.

General Ophthalmic Services (GOS): The visit plans for GOS 2024-2025 progressed well than the last few years based on us having the ability to carry out remote access on more contractors who have transferred to electronic patient records.

We do however have to carry out elements of physical visits too, as not all contractors are electronic.

This new financial year of 2024-2025 we completed 8 visits out of with 9 visits planned and have 1 more to complete and carry over into the new financial year of 2025/2026.

Moving forward into 2025/2026 we will also be verifying claims for an additional 2 services which are the WGOS 4 (Glaucoma and Medical Retina) and IPOS (Independent prescribing) 5 urgent claims.

General Pharmacy Services (GPS): In 2024/2025 NWSSP/PPV introduced a new service check following a successful pilot, which was the Collaborative Working Scheme. We now verify this service along with the Quality and Safety Scheme remotely. We have completed all 8 visits planned to pharmacy contractors.

Additional Services: We progressed well with our quarterly dispensing data checks and have introduced a robust service moving forward into the new financial year, which may result in future financial recoveries. The results will be added to our PPV reports once finalised.

Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this new year financial to align to the WGOS reform and the managing of clinical waste.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

NEXT STEPS:

Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.

We are also continue investigating other avenues for savings from the provision of Clinical Waste services and produce a 'non-collection' report to all our Health Boards.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting.

Audit Report - 1st April to 31st March 2025 = Po

To Note

Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change d
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recomr
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any c
Training/support is provided to practices after visit and throughout the year, whenever req

**PTHB 2023/2024 = 9 visits were com
of £8,362.4**

GMS recovery for PTHB 2024/2025	Visit Type	HB Annual Visits Due	No. In progress
	Routine	6	6
	Revisit	9	5
	TOTAL	15	11
PRACTICE	Routine or Revisit	Claim errors	% recovery
Practice 1	Revisit	152	23,75 %
Practice 2	Revisit	3	1,92 %
Practice 3	Revisit	Awaiting HB	
Practice 4	Routine	3	1,81 %
Practice 4	Revisit	37	40,22 %
Practice 5	Routine	122	51,69 %
Practice 5	Revisit	43	6,17 %
Practice 6	Routine	33	8,01 %
Practice 7	Routine	Awaiting Practic	
Practice 8	Routine	2	33,00 %
Practice 9	Routine	Awaiting Practic	
GOS	Visit Type	Annual Visits Planned	No. In progress
	Routine	9	8
	Revisit	0	0
	TOTAL	9	8

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access and physical visits are progre

PRACTICE	Routine or Revisit	Claim errors	% recovery
Practice 1	Routine	2	1,94 %
Practice 2	Routine	1	0,97 %
Practice 3	Routine	2	1,94 %
Practice 4	Routine	0	0,00 %

Practice 5	Routine	5	4,85 %
Practice 6	Routine	0	0,00 %
Practice 7	Routine	1	0,98 %
Practice 8	Routine	1	0,97 %

Summary of themes/findings/issues

Nothing to report at this stage

GPS			
	Visit Type	Annual Visits Planned	No. In progress
	Q&S Scheme / Collaborative Working Scheme	Routine	8
	TOTAL	8	

owys University Health Board

due to ad hoc visits or closures/mergers
mendations
oncerns that may arise
quested

ompleted with a total recovery
43

ALL WALES 2023/2024 = 205 visits
were completed with a recovery of
£216,810.03

No. Recoveries	Value of recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries Identified
171	£9 567,43	152	107	£76 694,74
235	£8 188,66	241	87	£105 902,78
406	£17 756,09	393	194	£182 597,52

Value of recovery
£1 870,67
£112,50

£155,05
£4 425,75
£7 952,89
£1 779,74
£1 330,61

£128,88

No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries Identified
	£636,95	126	103	£16 247,97
	0	5	1	£68,70
	£636,95	131	104	£16 316,67

essing well

Value of recovery
£82,18
£44,00
£127,36
£0,00

£305,21
£0,00
£53,00
£25,20

No. Recoveries	Value of recoveries	All Wales Value of Recoveries
0	£0,00	£0,00



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Cydwasaethau
Shared Services
Partnership

Primary Care Services Post Payment Verification April 2025

Situation

Between 2020-2023 Post Payment Verification (PPV) faced significant challenges associated with the COVID-19 pandemic and a new General Medical Services (GMS) Family Practitioner Payment System (FPPS).

The PPV service was initially reinstated towards the latter part of 2020 and through reinstatement at the end of 2020, to April 2022 we managed to complete a 3-year cycle of routine visits into a 2-year period. At this point, the revisits that were triggered in these periods were carried over in an attempt to complete them at the earliest opportunity.

As with all new systems there is a bedding in period, and with a new way for the contractors to submit evidence to support their claims posed more pressure for the PPV Team.

Moving forward into a new financial year, we have undertaken an analysis of the data to understand the position of our outstanding revisits remaining and to realign an achievable solution to provide the levels of assurance required.

Background

In 22-23 there were 261 visits on our GMS visit plan.

In 23-24 there were 297 visits on our GMS visit plan.

In 24-25 we had 393 GMS visits to undertake = 152 routine, and 241 revisits. On nearing the end of this financial year, we have 107 Routine visits, and 76 revisits finalised or in progress.

In 22-23 and 23-24 we undertook our routine visits which were triggering a higher-than-average number of revisits than we have seen in previous years. On closer inspection, it was noted that the data submitted by practices through the payment system was limited, resulting in a smaller pool of information available for sample verification.

Our normal process in creating a sample for a routine visit is 10% or 22 of the claims out of all the submissions, whichever is the greater. E.g. 100 claims we would check 22 as this is more than 10 and 250 claims, we would check 25.

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Assessment

We have recently reviewed the prompts for revisits along with looking at a plan moving into the next financial year. Due to a lower volume of claims submitted through the payment system, and the reduction of available evidence, we can give assurance that a large number of outlined visits would not have prompted a revisit in traditional circumstances.

There are approximately 40 routine visits to carry over into 25-26 which we will complete as a priority and then we will proceed with the new financial year's routine visits.

The revisits remaining that need to be undertaken, will be completed throughout the year and may include the routine visit as well. We refer to these as extended visits and has been an effective performance tool for us previously.

Alongside this, we are currently experiencing unexpected absence in the team, and we aim to adopt a practical approach going forward, focusing on what is realistically achievable while continuing to uphold a high standard of assurance.

Recommendation

Following the review of our practices, those that prompted revisits under unusual circumstances, specifically for claims verified at 19 and under in the financial years of 22-23 and 23-24, where the claim data and evidence provided by the practices affected the standard data samples available for PPV to be able to validate, we will recommend remove the need to revisit those practices, given the assurance we have in place.

We have also analysed the history of these practices to ensure there is no patterns to take into consideration in this provision of assurance, and we can confirm that we find nothing to raise concern with moving forward with the outlined plan.

Alongside this assurance, we have other trend data available to our team, and since October 2024, we have been verifying any duplicate claims in conjunction our visits, which is proving to be valuable in supporting assurance around practice claiming. We will continue to undertake this moving forward as additional assurance to our Health Boards, Committees and the service.

Powell Bethan
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Subject:	Welsh Health Circulars and Ministerial Directions Tracking Report (WHCs and MDs)
Approved and Presented by:	Director of Corporate Governance
Prepared by:	Corporate Governance Officer
Purpose:	The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the position relating to the implementation of Welsh Health Circulars and Ministerial Directions.
Recommendations:	The Audit, Risk and Assurance Committee is asked to: • RECEIVE the report; • Take ASSURANCE the organisation has a system in place to receive, monitor and implement Welsh Health Circulars and Ministerial Directions; and • NOTE that the position provided in this report will be included within the Health Board's Annual Report 2024/25.
Executive Summary:	Welsh Health Circulars are received from Welsh Government by the Corporate Governance Team, where they are logged and then distributed to the appropriate Executive Director for action. Please note that Welsh Health Circulars are reported on a calendar year. An overview of the position as of the 30 April 2025 is as follows: • For those WHCs received in 2022 there are <u>28 complete, 2 partially complete and 1 no progress.</u> • For those WHCs received in 2023 there are <u>37 complete and 2 partially complete.</u> • For those WHCs received in 2024 there are <u>42 complete, 10 partially complete and 2 not yet due.</u> • Of the 3 WHCs received in 2025 so far <u>1 is complete and 2 are partially complete</u> Tracking of Ministerial Directions commenced in 2022/23 following a request from Welsh Government, an overview of the position as of the 30 April 2025 is as follows • For those Ministerial Directions received in 2023 <u>all 20 are complete</u> • For those Ministerial Directions received in 2024 there are <u>22 complete and 4 partially complete</u> • Of the 5 Ministerial Directions received in 2025 so far <u>5 are complete.</u> Welsh Health Circulars and Ministerial Directions can be viewed here: Welsh Health Circulars and Ministerial Directions Appendix 1 - WHCs currently outstanding (not yet due, partially complete and no progress) and the progress made to action them Appendix 2 - WHCs completed since the last reporting period Appendix 3 - MD's currently outstanding (not yet due, partially complete and no progress) and the progress made to action them Appendix 4 - MDs completed since the last report

SUMMARY POSITION – Welsh Health Circulars and Ministerial Directions which remain outstanding with No Progress made.

Summary since the last report in: October 2024

The Table provides the committee with an overview of the WHCs and MDs that remain outstanding with no progress made. Updates will continue to be sought against these WHCs and reported to the Executive Committee and Audit, Risk and Assurance Committee.

Welsh Health Circulars – No Progress			
Status	Executive Lead	WHC/MD Ref	WHC
No Progress	Director of Nursing, Quality, Women and Family Health	WHC 2022-019	Non-Specialised Paediatric Orthopaedic Services

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Summary

The following table provides an overview of the progress made against the implementation of WHCs received since the last report (Audit, Risk and Assurance Committee, October 2024). The Corporate Governance team has undertaken an in-depth validation exercise to ensure accurate data is being reported and reflects the current position within the table below.

WHC’s progress position				
WHC Status	2022	2023	2024	2025
Not Yet Due	0	0	2	0
No Progress	1	0	0	0
Partially Complete	2	2	10	2
Completed since the last report	1	20	22	1

Actions being Taken:

- Lead Executives continue to give priority to the outstanding WHCs and MDs and provide further updates.
- Further updates will be provided to the Committee in the next report in October 2025.

Summary

The following table provides an overview of the progress made against the implementation of MDs received since the last report. (Audit, Risk and Assurance Committee, October 2024) The Corporate Governance has undertaken an in-depth validation exercise to ensure accurate data is being reported and reflects the current position within the table below.

MD's progress position				
MD Status	2022	2023	2024	2025
Not Yet Due	0	0	0	0
No Progress	0	0	2	0
Partially Complete	0	0	4	0
Completed since the last report	1	0	17	5

Actions being Taken:

- Lead Executives continue to give priority to the outstanding WHCs and MDs and provide further updates.
- Further updates will be provided to the Committee in the next report in October 2025.

The Corporate Governance Team will continue to track and distribute Welsh Health Circulars and Ministerial Directions to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported on a bi-annual basis. Following review by the Executive Committee this report will be presented to the Audit, Risk and Assurance Committee on 13 May 2025 and the reported position will be included within the Health Board's Annual Report for 2024/25.

The next update report will be presented to the Executive Committee in September 2025 for onwards reporting to the Audit, Risk and Assurance Committee in October.



Appendices:

The following appendices provide details extracts of the WHC Tracker:

- **Appendix 1** - WHCs currently outstanding (not yet due, partially complete and no progress) and the progress made to action them
- **Appendix 2** - WHCs completed since the last report (ARAC, October 2024)
- **Appendix 3** - MD's currently outstanding (not yet due, partially complete and no progress) and the progress made to action them
- **Appendix 4** - MDs completed since the last report (ARAC, October 2024)

Appendix 1 - WHCs currently outstanding (no

WHC No.	Name of WHC	Date Issued	Date received	Date Circulated (PTHB - Internal)
WHC 2022 - 019	Non Specialised Paediatric Orthopaedic Services	21.06.2022		
WHC 2022 - 006	Direct Paramedic referral to same day emergency care	21.04.2022		

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WHC 2022 - 022	Role of the Community Dental Service and Services for vulnerable people	22.08.2022		
WHC 2023 - 003	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	04.04.2023		

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WHC 2024 - 005	Private obesity surgery and the Welsh NHS	N/A		
WHC 2024 - 02	Standards for Competency Assurance of Non-Medical Prescribers in Wales	N/A		
WHC 2024 - 011 Powell Bethan 08/05/2025 16:00:41	Changes to dietary advice on feeding young children aged 1-5 years	N/A		

WHC 2024 - 012	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	N/A		
WHC 2024 - 016	Healthy Child Wales Programme: for school aged children	11.04.2024		
WHC 2024 - 024	Implementation the agreed approach to preventing Violence and Aggression towards NHS staff in Wales	17.04.2024		

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WHC 2024 - 035	Standardising the management of acute deterioration	17.09.2024	18.09.2024	18.09.2024
WHC 2024 - 040	Adopting a patient and family-initiated escalation approach		03.10.2024	07.10.2024
WHC 2024 - 042	Introduction of the 'Dictionary of medicines and devices	04.11.2024	05.11.2024	16.11.2024

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WHC 2024 - 030	Published Weight Management Medication Pathway	Unknown	05.11.2024	16.11.2024
WHC 2024 - 044	Mandatory E-Learning Module – Anti-Racism (Eng & Welsh PDF)	Unknown	03.11.2024	16.11.2024
WHC 2025 - 005	Climate Emergency Leadership day and adaption	12.03.2025	12.03.2025	

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WHC 2025 - 002	Timelines and responsibilities for Early Warning Scores (EWS)	04.03.2025	04.03.2025	28.02.2025
WHC 2024 015	People's Experience Framework and People's Experience Survey	02.04.2025	02.04.2025	02.04.2025
WHC 2023- 06	Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 - Expired 01.04.24	05.04.2023		

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ot yet due, partially complete and no progress)

Overarching Actions Required
To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales.
In order to reflect local service models, each health board will need to agree with WAST the mechanisms for enabling the 'clinician to clinician' discussion, which forms the basis of the acceptance of patients into SDEC services.

Powell Bethan
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Health boards should use their professional advisory structures to review and inform the provision of dental care by all local dental services including the CDS, primary care services provided by General Dental Services (GDS), Personal Dental Services (PDS) and Hospital Dental Services (HDS), and how these relate to local authority boundaries and primary care clusters. Specialists and Consultants in Dental Public Health will provide detailed and expert assistance in needs assessment and in collaboration with others, advice on service development.

The Community Dental Service should be regarded as an integrated dental service with a diverse and flexible role. It should not be regarded as a purely primary care-based service. A strong community dental service will provide all services needed for its local population and this can include both consultant, specialist, intermediate and routine general dental services. The Community Dental Service should be encouraged to work in collaboration with local hospital based dental services including oral and maxillofacial services. An effective CDS will require investment in both workforce and infrastructure, ensuring that the clinicians have access to modern equipment and robust IT systems. Poor infrastructure is seen as a barrier to recruitment and retention of staff.

This circular provides a clinical guideline for the investigation of moderate or severe early developmental impairment or intellectual disability (EDI/ID) in children. The guideline aims to outline a consistent Wales-wide approach to the identification, clinical assessment and investigation of children and young people who have moderate or severe EDI/ID.

Powell Bethan
08/05/2025 16:00:41

This Welsh Health Circular clarifies the roles and responsibilities of Welsh NHS providers for patients living in Wales who have undergone bariatric surgical procedures in the private sector. This is based on existing policy documents and clinical guidance. With respect to bariatric surgery, the NHS Wales Prior Approval Policy for specialist services states:

"If a patient has self-funded their own referral/treatment in the private sector, the Health Board cannot be expected to fund ongoing treatment in the private sector. To ensure equity, all such referrals will be declined, and the clinician advised to refer the patient to local or commissioned NHS services. If however there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and should be added to the appropriate waiting list accordingly."

All health boards, Velindre NHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust are required to implement the standards for competency assurance of non-medical prescribers within their organisation by 31 March 2026 at the latest.

- To support implementation, these organisations are required to develop an implementation plan with the support of HEIW by 30 September 2024.
- All health boards, Velindre NHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust should identify an appropriate senior manager within their organisation to be responsible for developing the implementation plan and whose details should be shared with HEIW by emailing Karen.Brambles@wales.nhs.uk by 28 March 2024.

I am writing to inform you of changes to Welsh Government dietary advice for young children aged 1 to 5 years following acceptance of recommendations made by the Scientific Advisory Committee on Nutrition (SACN) in its report on 'Feeding young children aged 1 to 5 years' . The role of SACN is to provide independent scientific advice on, and risk assessment of nutrition and related health to the 4 UK Governments. The report is based on an extensive and comprehensive review of the evidence base. It makes a number of dietary recommendations, some of which endorse existing advice, others represent a change in advice. These are summarised in the table below.

Bethan
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Acknowledging that different health boards/trusts will be at different stages of utilising and delivering career-spanning support, in January 2024, I agreed with Executive Directors of Nursing a phased approach to implementation of the policy position set out in the attached document. I expect this phased approach to be detailed by individual organisations in their own career spanning implementation plans reflecting your proposed schedule of adoption of the preceptorship standards and clinical supervision principles. I would be grateful to receive these by 1 July this year, and they can be sent to qualityandnursing@gov.wales. Long term, monitoring of the implementation of this career-spanning support will sit with the NHS Executive. However, until certain structures are fully realised following phase 2 of the NHS Executive's formation, my office will keep me informed.

The Healthy Child Wales Programme for school aged children is a new unified operating model for School Nursing Services which provides a programme of planned universal health contacts for all compulsory school aged children (aged 5 - 16 years) in Wales, regardless of setting. The operating model has been designed to create a consistent national approach to supporting children's health and well-being by School Nursing Services in Wales, whilst also providing flexibility to respond to identified local public health population needs. Given current variation across NHS Wales, a two-year implementation period has been agreed to give health boards the time to fully embed the new operating model into core service delivery. Our expectation is that health boards will begin implementation of the operating model from April 2024 and have fully implemented by March 2026. Progress will be monitored over the two-year implementation period with a formal review in April 2026. Oversight of the implementation will be undertaken through the Integrated Quality Planning Delivery (IQPD) meetings, pending any developments at NHS Executive level, with the introduction of a national Children's Health Clinical Network and in partnership with the national CNO/EDoNS leadership group. During the development of the nurse-led operating model, four key areas were identified as requiring further development work to enable health boards to implement the operating model consistently across NHS Wales. The issuing of this Welsh Health Circular to NHS Wales formally introduces Healthy Child Wales for school aged children in Wales.

Refresh Obligatory Responses to Violence in Healthcare Document including the requirements to implement and report upon violent incidents as set out in document.

Actions

1. provide the Anti-Violence Collaborative with contact details of the Board member with responsibility for anti-violence and aggression within your organisation.
2. ensure that your organisations have systems in place to carry out effective incident reporting as set out in section 2.1 of the Obligatory Responses to Violence in Healthcare (ORV)

Part 2: Guidance Document.

3. Ensure your organisation has assigned appropriate resource to the NHS Violence & Aggression Case Manager(s) role to enable them to play a proactive role, including:
 - Promoting incident reporting via Datix Cymru.
 - Support and guide victims through the criminal justice system and signpost them to well-being support available in the NHS.
 - Promote the ORV agreement within the organisation.
 - Provide reports and data to support awareness and prioritisation on Violence & Aggression matters.
 - Liaise with partners to the agreement in order to create effective local pathways of communication and understanding.
 - Provide a quarterly report to the AVC for review and reflection in collaboration with the CPS and Police.

The Obligatory Responses to Violence in Healthcare Document can be found here [Key Documents 2024 - NHS Wales Shared Services Partnership](#)

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Early Warning Scores (EWS) function to identify acute deterioration, to suggest a point at which care needs to be escalated and to define a response to escalation triggers. Current practice varies, with potential risks to patient safety. A standardised, national approach using evidence-based tools will ensure clarity, minimise risk and support improved patient outcomes. It has now been agreed, following a wide consultation process with a large number of stakeholders which tools should be used for respective areas across Wales:

1. NEWS2 (and subsequent updates) Should be used for the identification and escalation of acute deterioration in adults in Wales.
2. National PEWS (and subsequent updates) Should be used for children and young people in Wales.
3. NEWTT2 (and subsequent updates) Should be adopted for the identification and escalation of acute deterioration in neonates. A nationally agreed EWS for maternity will be finalised in October 2024. Organisations are expected to implement the use of the recommended EWS tools outlined above. The transition to the recommended EWS will require training for staff, and existing NHS England e-learning packages for NEWS2, National PEWS and NEWTT2 will be added to ESR for NHS Wales staff.

Adopting a Patient and family-initiated escalation approach Following extensive clinical engagement with stakeholders, the NHS Wales Executive has developed a patient and family-initiated escalation ("PFE") approach for hospital patients. The patient and family escalation approach in Wales will be named Call 4 Concern. This builds on pilots already undertaken across Wales but owes legacy to the Martha Mills' family and other families who have championed the importance of listening to families and patients. Following significant clinical engagement through a Task and Finish Group and reaching consensus on the PFE approach with senior NHS leaders and their representatives, the NHS Executive has agreed to support organisations in the development of individual implementation plans. The PFE approach and implementation plan will naturally be different for each organisation, dependant on the spectrum of their services. We expect organisations to work with the NHS Executive to develop their approach and ensure it enables patients, families and carers to escalate their concerns and provide a fresh pair of eyes to support them and the clinical team in a timely response to those concerns.

Welsh Government is formally mandating the use of the Dictionary of Medicines and Devices as a foundational interoperability standard in all NHS bodies in Wales.

Implementation Requirements

- NHS Local Health Boards, NHS Trusts, and NHS Special Health Authorities must ensure that where a digital system records medication and transfers that information to another system, the Dictionary of Medicines and Devices (dm+d) is used to identify that medication at the appropriate structural level.
- It is recognised that not every possible use of medicines data requires implementation of the full content of the Dictionary of Medicines and Devices (dm+d), and only those aspects that are relevant to the intended use of a system are required to be implemented. NHS Local Health Boards, NHS Trusts, and NHS Special Health Authorities must ensure that these requirements are appropriately identified when creating, procuring, or updating a digital system that records medication and transfers that information to another system.
- As the Dictionary of Medicines and Devices (dm+d) is updated on a weekly basis, it is the responsibility of each NHS Local Health Boards, NHS Trusts, and NHS Special Health Authorities to ensure that their digital systems can receive and appropriately process any valid dm+d codes that are relevant to the system.

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Purpose and Summary of Document: This is the Weight Management Medication Pathway addendum for the All Wales Weight Management Pathway. This guidance is to be used in conjunction with the All Wales Weight Management Pathway document and NICE guidance for weight management medications

The Anti-racist Wales Action Plan (ArWAP) outlines our vision for becoming an anti-racist nation by 2030. This includes ensuring that:

- Service Delivery: "Public sector providers are culturally aware and competent in delivering services to Black, Asian, and Minority Ethnic (BAME) people, recognizing the differences among ethnic minority groups."
- Workplace Equality: "All staff in public sector and funded bodies receive mandatory training on anti-racism."

An action in the health chapter of ArWAP commits to "Consistent, fit for purpose educational intervention offered to all staff, students and volunteers. Visible mandated education providing confidence to workforce that organisation is serious about anti-racist principles".

NHS Wales organisations have engaged in various interventions to embed an anti-racist approach including reverse mentoring, active bystander training and cultural competence training. However, a need was identified in social partnership to provide support to organisations by developing an e-learning module to provide a consistent foundation for awareness and skills development in anti-racism. The course is accessible via the Electronic Staff Record (ESR) system and Learning@Wales platforms and should take no more than 20 minutes to complete.

In line with "A healthier Wales (<https://www.gov.wales/sites/default/files/publications/2024-11/2024-plan-for-health-and-social-care.pdf>)" refreshed actions, NHS organisations must embed action on the climate emergency in decision-making and plans. As part of this work, organisations should build on their existing decarbonisation action plans to develop broader 'climate response plans' that cover both emission reduction and adaptation action. We recognise the additional support health and social care organisations may require to progress work on adaptation planning. The 'Climate adaptation strategy for Wales 2024 (<https://www.gov.wales/climate-adaptation-strategy-wales-2024>)' sets out the overarching strategy for adaptation planning, including for the health and social care sector (see section 5.7 and page 57). To support implementation of the strategy, a health and social care toolkit (<https://www.gov.wales/sites/default/files/publications/2024-10/health-and-social-care-climate-adaptation-toolkit.pdf>) has been published to help organisations identify the climate risks and opportunities most relevant to them and which should then inform work on plan development. Our expectation is for all organisations to have completed scoping, current and future risk assessment (sections 1 to 3 outlined in the Toolkit) and to have plans in place prioritising what short and longer term actions will be taken (sections 4 and 5) by 31 December 2025. The health and social care climate emergency national programme will continue to collaborate with you and provide guidance on this work as required

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Timelines and responsibilities for the implementation of Early Warning Scores (EWS) to identify acute deterioration. Implementation timelinesTo reduce variation and therefore improve patient safety, all NHS Wales organisations are expected to adhere to the following implementation deadlines:

- NEWS2: Implementation in all areas where NEWS or NEWS Cymru is currently used by 30 September 2025.
- PEWS: Full implementation in all acute paediatric services by 30 September 2025.
- NEWTT2: The Maternity and Neonatal Network have set out the expectation that NEWTT2 will have commenced by 31st March 2025 and will be fully implemented in acute settings by 30th September 2025.
- MEWS: The Maternity and Neonatal Network have set out the expectation that MEWS will have commenced by 31st March 2025 and will be fully implemented in acute settings by 30th September 2025.

With the aim of making the framework more inclusive and understandable, it has been renamed and refreshed as 'The People's Experience Framework'. This change follows extensive engagement with third-sector organisations, Llais, and NHS bodies. The updated language now recognises that people interact with NHS Wales services beyond the traditional definitions of "patient" or "service user".

The Act's Duties of Quality and Candour will support an ongoing system-wide approach to quality improvement within the NHS and further embed a culture of openness and transparency. The establishment of the Citizen Voice Body, to be known as Llais – your voice in health and social care, will empower the people of Wales to influence and shape their health and social care services. The Duty of Quality applies to all NHS bodies and Welsh Ministers, for health-related functions, with the dual aim of ensuring quality-driven decisions that improve the quality of health services and ensuring focus is maintained on improving outcomes for the people of Wales. The duty includes new Health and Care Quality Standards, replacing the Health and Care Standards of 2015. I am aware that organisations have commenced their internal preparations for this duty which will bring about significant sharing of quality outcome data with the public, as well as continuously improving services.

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Lead Executive	Expected Date of Completion	Status
Director of Nursing, Quality, Women and Family Health	01.04.2025	No Progress
Director of Primary Care, Community and Mental Health	Immediate	Partially Complete

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Director of Primary Care, Community and Mental Health	01.08.2024	Partially Complete
Director of Nursing, Quality, Women and Family Health	30.04.2023	Partially Complete

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Director of Primary Care, Community and Mental Health	N/A	Partially Complete
Medical Director (Chief Pharmacist responsible for implementing)	31.03.2026	Not Yet Due
Director of Nursing, Quality, Women and Family Health Powell Bethan 08/05/2025 16:00:41	01.04.2027	Not Yet Due

Director of Nursing, Quality, Women and Family Health	01.10.2025	Partially Complete
Director of Nursing, Quality, Women and Family Health	Immediate	Partially Complete
Executive Director of People and Culture	Immediate	Partially Complete

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Director of Nursing, Quality, Women and Family Health	n/a	Partially Complete
Executive Director of Nursing, Quality, Women and Family Health	N/A	Partially Complete
Director of Corporate Governance, Records & Data Protection • Information Governance. Amanda Smart and Vicky Cooper - contact for WHC updates	With Immediate Eff	Partially Complete

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Executive Director of Planning, Performance & Commissioning Executive Director of Primary, Community Care & Mental Health (Powys Living Well Service)	Immediately	Partially Complete
Executive Director People & Culture	des-25	Partially Complete
Executive Director of Finance and Capital and Support Services	07.03.2025	Partially Complete

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Quality and Safety		Partially Complete
Director of Nursing, Quality, Women and Family Health	apr-25	Partially Complete
Medical Director	01.04.2023	Partially Complete

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Comments

*Womens and Children moved to Nursing Directorate.

03/04/25 - No progress - Children's Services were only informed of this and the requirement for an update on 24/03/25

March 2025 update: Following actions have been taken since last update:

- Urgent and Emergency Care Clinical Transformation Lead appointed and 'in depth training needs analysis' of MIUs underway.
- 111p2 triage and assessment model in Mental Health, offering paramedics contact with MH professional for support with MH clients and pathways providing benefit to paramedic SDEC access.
- Review of clinical pathways in MIU planned.

04/10/2024 update: A Goal 3 (6 Goals Urgent & Emergency Care) objective, PTHB has confirmed with Welsh government and WAST that in the absence of Type 1 urgent care services, this action is not directly applicable to Powys. At the same time however, a number of actions have been taken including:

- To ensure that our Directory of Services is continually updated with NHS111 (including direct paramedic referral routes to community services)
- MIU opening details are kept updated directly with WAST
- Further transformation of our community urgent care offer is underway, commencing with the recruitment of an ENP transformation lead to review and develop our MIU offer
- An exploratory meeting is planned with Wye Valley NHS in the coming months, to explore how Powys might actively link into their SDEC service to augment our existing community urgent care offer.

17/02/2023 Emergency/acute care not commissioned within Powys. However, a range of actions being taken as defined in the Integrated Care ACTION Plan (ICAP), fully integrated with 6 Goals delivery and reviewed in monthly monitoring arrangements. Ongoing work with commissioned partners to ensure quality, safe and timely care in Emergency Departments – annual cycle, alongside daily engagement with operational flow

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March 2025 update: As above except Frailty Dental Nurse is currently at interview stage.

27/02/2025 update: The following actions have been completed:

- Salaried GDP roles in place at Senior and Dental officer grade
- Two Dental foundations in place
- Level 2 special care provision county wide including domiciliary service. Successfully recruited special care dentist subject to pre-employment check
- IV sedation training completed, - Level 2 oral surgery service in place with possible consultant support in future. Subject to RTT and not breaching. Early talks with WVT to source consultant support,- Inhalation sedation service expanded with upskilling of existing dental officer and training an additional therapist.
- Recruited one paediatric specialist for 3 sessions per month, - Endodontic service providing 2 full days per week at specialist level 3, Consultant in restorative dentistry(endodontics) JD approved by royal college and is currently going through TRAC process to be advertised shortly
- Frailty dental nurse has been approved by cluster process and is currently being advertised
- Urgent dental provision supported by CDS, - IT system upgraded and project is now complete for dental intra oral images and electronic notes. Using a cloud based solution
- Mobile dental service completed phase 1 and is now in location 2. Meeting has been arranged to discuss placement in a local high school that has been identified as high needs,- D2S PDS contract successfully re procured to support

04/10/2023 update: The following actions have been completed:

- Salaried GDP roles in place at Senior and Dental officer grade
- Two Dental foundations in place, - Level 2 special care provision county wide including domiciliary service
- IV sedation training completed with service start imminent
- Level 2 oral surgery service in place with possible consultant support in future. Subject to RTT and not breaching
- Inhalation sedation service expanded with upskilling of existing dental officer and training an additional therapist.
- Recruited one paediatric specialist for 3 sessions per month,- Endodontic service providing 2 full days per week at specialist level 3, - Unable to recruit specialist in special care, advert currently out, - Frailty dental nurse bid for cluster funds.- Urgent dental provision supported by CDS,- IT system upgraded and project is now complete for dental intra oral images and electronic notes. Using a cloud based solution, - Mobile dental service has started reacting to local population needs,- D2S PDS contract still in place to support the programme

17/02/2023 update: Recruited 1 WTE salaried GDP to provide routine GDS services, 0.6WTE vacancy for

03/04/25 - No progress - Children's services were only informed of this and the requirement for an update on 24/03/25

Guideline due to be reviewed 1/05/2025. WHC emailed to Claire Roche, Claire Madsen, and Kate Wright and cc'd to Pas, Hayley Thomas, Louise Turner and Marie Davies on 5/04/2023.

06.02.24 update; PTHB paediatric medical lead is a member of the network that have developed the guidance. The Guidance has been reviewed within W and C policies, procedures and guidance group and is in the process of having a cover front sheet completed to be approved and uploaded to PTHB intranet.

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March Update: To be updated by VBHC colleagues, as tracked via VBHC Programme Plan

September 2024 update: The Medical Directorate has no role in this program. Awaiting reply from colleagues in the Value Based Health Care Team (Planning Directorate)

Jan 2024 update: All Wales Outcomes (PROMs) Framework has five suppliers on it. BCUHB, CTMUHB, HDUHB and SBUHB have carried out a mini competition to select a preferred supplier from the five on the framework which they would then all use. PTHB, along with C&VUHB and Velindre NHS Trust had observer status to help inform what they do in relation to PROMs. PTHB colleagues including Transformation Programme Manager, Head of Data Infrastructure and Advanced Information Analyst continue to engage in the relevant National PROMs sub groups.

August 2023 update: - PTHB is continuing to work to implementing a PROMS solution that is aligned to the National Framework being enabled by DHCW. While a specific solution has not yet been selected, it will be aligned to the interoperability & integration standards for NHS Wales to ensure that Data is recorded in a consistent manner to create a true National picture of PROMS in NHS Wales. This data can be fed in DHCW and the National Data Resource programme which in turn will mean that National Dashboards can be created.

February 2023 update: Powys continues to participate in the small number of National Clinical Audits and Outcome reviews where it offers a relevant service. These are;

National Diabetes Foot Care Audit

All Wales Audiology Audit

Sentinel Stroke National Audit Programme

National Audit of Care at the End of Life

National Confidential Inquiry into Suicide and Safety in Mental Health

Maternal, Newborn and Infant clinical Outcome Review (MBRRACE)

CIVICA continues to be rolled out for PREMs collection in Powys.

09/11/22 Update: PTHB Executive Committee approved the use of EQ-5D-5L as the 'generic' organisational PROM, with condition specific PROMs 'layered' on top. A PROMs Implementation Task & Finish Group has been established to consider the options for the deployment of an organisational approach to PROMs for PTHB. This work will also align to the All Wales Outcome Framework being developed by the Welsh Value in Health Centre. The national group is also currently undertaking the 'quality' assessment of the tenders, then will move to financial analysis.

Oct 2022 Update: Action on going to develop PROM and PREM data within the Health Board and to ensure aligned to WHC requirements, also linking in with Value in Health to align to national approach re PROM and PREM.

WHC Received in August 2024. Unable to meet deadline. "28.08.2024 - karen.brambles@wales.nhs.uk (HEIW) notified that Jacqui Seaton, Chief Pharmacist would be responsible for the oversight of the development of the implementation plan prior to 28/03/24 deadline.

Susan Newport, Medicines Management Nurse, working in collaboration with HEIW. Implementation plan in place (in advance of the 30/09/24 deadline). Routine meetings in place with HEIW and health board leads to ensure a consistent approach to the implementation of the standards across Wales.

30/01/2025: As above"

09.04.25 these will be updated when the new Chief Pharmacist is in post in the next few weeks please, once we have a start date we will keep you updated when they start.

Exec Lead tbc - Operational Lead, David Farnsworth under the new Director of Community Services . Howard and KateWright will let us know Ownership following Exec Committee.

September 2024: Jacqui Seaton, Chief Pharmacist, produced a 7 minue briefing highlighting the concerns relating to medical gas cyclinder. Focus was on trianing requirements and incident reporting. Cascaded broadly across the health board.

https://nhs.wales365.sharepoint.com/sites/POW_comm_medicinesmanagement/SiteAssets/SitePages/Oxygen-Cylinders---Risk-of-death-if-used-incorrectly/7-Minute-briefing-Risk-of-death-due-to-incorrect-use-of-oxygen-cylinders-Sept-2024-FINAL.pdf?web=1

Training and incident reports are standing agenda items on the Medical Gases Governance Group - this meets quarterly
SBAR provided to execs on the training requirements - limited appetite to mandate medical gases training.

30/01/2025 - Restorative supervision is in place within Ditrstict nursing in PTHB. Time is being built into ward rosters for clinical supervision in readiness for the change with similar taking place in DN services. February 2025 - Preceptorship programme in place. Restorative Supervision - model being worked through with a plan to recruit and increase supervisors, use a train the trainer model to train supervisors while building a support network, this will enable the offer of restorative supervision to be operationalised later in the year. 01.04.25 Clinical lead identified, 'train the trainer' dates booked.
Feb 2025 - Action Plan in place to support implementation across 44 actions. PTHB currently RAG rated 27 Green, 10 Amber, 7 Red which include 3 against Workforce preparedness, 3 against the delivery of the full public health programme and 1 action against the availability of community drop in support for children educated other than at school. There assurance to be taken of progress to date. Gaps remain: Workforce - A named SCPHN for every school and Special School, this is a challenge currently to recruit trained (band 6) SCPHN's nurses due to Wales wide shortages. A local plan has been developed to recruit registered nurses with a "grow your own" model. It is anticipated that there may be a delay in the achievement of this requirement (due to available training places) until early 2027. The remaining red actions are on track. The delivery of a Public Health Programme for secondary schools at the moment is also red and the work stream are developing a Profiling Tool to support the delivery of this. And we have managed to progress the dedicated SCPHN school nurse for children educated other than school. This new JD is currently going through Job Evaluation and recruitment will be expedited within existing school nurse establishment. Digital E Consent progressing in PTHB and due to start in April HPV Immunisations programme following a successful local pilot - will in turn progress to an All Wales solution in the future. We are therefore confident that the areas featured red within our current action plan will be progressed to green within the implementation phase apart from the full number of SCPHN qualified staff though we will have made significant progress by September 2026 and anticipated green position on this final action by Spring 2027.
29.08.2024 - We have completed action 1 and actions 2 and 3 will be picked up by the next Health and Safety Group going forward, with it on the agenda for the next meeting. January 2025 - National guidance reissued and Prevention and Management of Violence and Aggression Officer provides professional support to services and reporting in to Health and Safety Group as part of business as usual activity.

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30/01/2025 NEWS 2 assessments are undertaken at ward level within the health board, there can be some variation in application.

A request for mandatory training for all staff has been submitted for ratification.

We are implementing an online Audit system in Spring of 2025 where we will be able to view compliance.

A review of local policy is required.

23/3/25 Adult: Review of the local Policy in underway and out to clinical teams for comments.

News 2 is in place on the inpatient ward and a program of Resus training and care of the deteriorating patient is in progress.

25/03/2025 WCH – This is in progress as per the national work.

01/04/25 HCSW Induction training reviewed, NEWS-2 scoring and Sepsis signs to be provided on reminder cards for all nursing staff, ESR module soon to be released

Exec Lead tbc - Operational Lead, David Farnsworth under the new Director of Community Services . Howard and KateWright will let us know Ownership following Exec Committee.

September 2024: Jacqui Seaton, Chief Pharmacist, produced a 7 minue briefing highlighting the concerns relating to medical gas cyclinder. Focus was on trianing requirements and incident reporting. Cascaded broadly across the health board.

https://nhswales365.sharepoint.com/sites/POW_comm_medicinesmanagement/SiteAssets/SitePages/Oxygen-Cylinders---Risk-of-death-if-used-incorrectly/7-Minute-briefing-Risk-of-death-due-to-incorrect-use-of-oxygen-cylinders-Sept-2024-FINAL.pdf?web=1

Training and incident reports are standing agenda items on the Medical Gases Governance Group - this meets quarterly

SBAR provided to execs on the training requirements - limited appetite to mandate medical gases training. David Farnsworth to ensure that all service managers ensure that all appropriate operational staff undertake

Jan 2025 - For Secondary Care PTHB will meet all of these requirements by procuring and implementing BetterMeds ePMA system.

BetterMeds was built on dm+d and uses dm+d natively, thus giving us no option but to comply with the above, this will be fully completed by Sept 2025.

Mar 25 - Update provided in Jan 25 is as stands and will be fully implemented as part of the eMPA Project.

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Expires in July 2025.

Jan 2025 update: Discussions currently ongoing to provide access to the NICE approved weight management medicines through the Powys Living Well, Weight Management Service. Discussions are involving community services, commissioning, medicines management, dietetics, PLWS. The health board does not currently have a pathway to provide access to the weight management drugs. The health board is in breach of its statutory requirement to implement NICE guidance.

Updated 05/03/2025: Pilot pathway now developed and proposed and awaiting Executive approval.

UPDATE (March 2025) following CG audit: Pilot pathway approved to be taken forward via Powys Living Well

January 2025 - E learning module developed but awaiting completion of national work on ESR to be able to assign the competency against individual staff.

April 2025 - Note progress and actions in relation to the environment and climate. Ongoing area of focus that is reported and monitored.

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28.02.25 - Email sent with the WHC 2025 002 Timeline and Responsibilities requesting updates in due course. 25/03/2025 Work continues on MEWS and NEWTT 2 in line with national work. In progress. 01.04.25 NEWS-2 scoring and Sepsis signs to be provided on reminder cards for all nursing staff, ESR module soon to be released
April 2025: The Quality and Safety Team will be rolling out the framework in the coming weeks, with a communication on their intranet page and a planned engagement roadshow during summer 2025.
May 2025: Almost complete, checking with Q&S colleagues to confirm

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WHC



WHC 2022 019 -
Non Specialised Paediatric



2022-006-Direct-p
aramedic-referral-to-sam

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WHC 2022 022 -
The Role of the Community



WHC 2023 003 -
Guideline for the Investig

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WHC_2024_005
English 2023 TEMPLATE (004)



WHC_2024_02 -
Standards for Competency As



WHC_2024_011 -
Changes to dietary advice

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WHC_2024_012 -
Preceptorship and CS WHC C



WHC 2024_016_
Healthy Child Wales Program



WHC 2023 039 -
PHD - Final - Welsh Health



WHC 2024 024 -
Implementation the agreed

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WHC 2024 035 -
Standardising the manage



WHC 2024 040 -
Adopting a patient and fam



WHC 2024-042 -
Introduction of the 'Dicti

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WHC 2024 030 -
Weight Management Medicati



WHC 2024 044 -
Mandatory E-Learning Modul



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WHC 2023 006 -
Commencement of the Health

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Appendix 2 - WHCs completed since the last

WHC No.	Name of WHC	Date Issued	Date received	Date Circulated (PTHB - Internal)
WHC 2022 - 005	Data Requirements for Value Based Health Care	24.03.2022		
WHC 2024 - 004	Assurance of aseptic preparation of medicines in NHS Wales	N/A		

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WHC 2024 - 006	National Clinical Guideline for Stroke, for the UK and Ireland	N/A		
WHC 2024 - 017	Implementation of the Non-pay Elements of the 2022-4 Collective Agreement	28.03.2024		
WHC 2024 - 013	Governance on interim appointments to Executive and Senior Positions	15.04.2024		
WHC 2024 - 022	Dispute Arbitration Process - Guidance for Disputed Debts (invoices and service agreements) within NHS Wales: 2024/25 - 2026/27	24.04.2025		
WHC 2024 - 026	2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	23.05.2024	unknown	unknown

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WHC 2024 - 029	Certification of Vision Impairment in Primary and Community Care	19.06.2024	unknown	unknown
WHC 2024 - 027	All Wales Critical Care Escalation Guidance for the Management of All Large Unplanned Increased in Demand	20.06.2024		
WHC 2024 - 31	Agency Workforce reduction programme and control framework 2024/2025	19/06/2024 circulated 26/06/2024 (due to non-receipt)		
WHC 2024 - 037	Winter Respiratory Vaccination 2024/25	02.08.2024	unknown	25.09.2024
WHC 2024 - 020	Welsh Health Circular NTF Exemption May 2024	Unknown	15.08.2024	30.08.2024

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WHC 2024 - 07	Guidelines for managing patients on the suspected cancer pathway. Guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target.	10.04.2024	15.08.2024	30.08.2024
WHC 2024 - 036	Oxygen Cylinders – Regulation 28 Report and Patient Safety Notice (PSN) 042 reminder	Unknown	28.08.2024	Unknown
WHC 2024 - 039	Pre-Transfusion Sample taking Compliance with the confirmatory sample rule		03.10.2024	07.10.2024

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WHC 2024 - 043	Pertussis Vaccine Offer for Healthcare Workers	Unknown	13.11.2024	16.11.2024
WHC 2024 - 045	Spotting Sepsis in Children Awareness Leaflet	Unknown	18.11.2024	29.11.2024
WHC 2024 - 046	Influenza (flu) Vaccination programme mop up 2024-2025	04.12.2024	04.12.2024	05.12.2024

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WHC 2024 - 021	Croeso i Gymru / Welcome to Wales: Policy Guidance Framework	Unknown	25.11.2024	25.11.2024
WHC 2024 - 047	Covid-19 spring vaccination programme 2025	18.12.2024	18.12.2024	18.12.2024

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WHC 2024 - 033	The Winter Respiratory Programme 2024/25	not known	not known	06.8.2024
WHC 2025 - 001	NHS Wales sustainability conference and awards	06.03.2025	06.03.2025	10.03.2025

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WHC 2024 - 006	National Clinical Guideline for Stroke, for the UK and Ireland	N/A		
WHC 2024 - 027	All Wales Critical Care Escalation Guidance for the Management of All Large Unplanned Increased in Demand	20.06.2024		
WHC 2024 - 037	Winter Respiratory Vaccination 2024/25	02.08.2024		
WHC 2024 - 020	Welsh Health Circular NTF Exemption May 2024	Unknown		

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WHC 2024 - 007	Guidelines for managing patients on the suspected cancer pathway. Guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target.	10.04.2024		
WHC 2024 - 036	Oxygen Cylinders – Regulation 28 Report and Patient Safety Notice (PSN) 042 reminder	Unknown		
WHC 2024 - 043	Pertussis Vaccine Offer for Healthcare Workers	Unknown		
WHC 2024 - 046 Powell Bethan 08/05/2025 16:00:41	Influenza (flu) Vaccination programme mop up 2024-2025	04.12.2024		

WHC 2024 - 047	Covid-19 spring vaccination programme 2025	18.12.2024		
WHC 2024 - 033	The Winter Respiratory Programme 2024/25	not known		
WHC 2024 - 001	Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests and Covid-19 treatments.	10.01.2024		
WHC 2023 - 018	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies	14.06.2023		

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WHC 2023 - 036	NHS Wales speaking up safely framework - Expired 30/10/2023	01.09.2023		
WHC 2023 -19	In support of prevention of suicide and self-harm	jun-23		
WHC 2023 - 11	Guidance on Self-Harm	apr-23		
WHC 2023 - 030	New 2023 National Safety Standards for Invasive Procedures (NatSSIPs2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034	11.08.2023		

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WHC 2023 - 032	Ammendments to Model Standing Orders and Model Standing Financial Instructions - NHS Wales - Expired March 2024			
WHC 2023 - 16	HPV immunisation programme update			
WHC 2023 - 15	COVID-19 vaccination observation periods/vacciantion following recovery from COVID-19	09.05.2023		
WHC 2023 - 07	Patient testing framework, updated guidance	30.03.2023		

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WHC 2023 - 04	COVID-19 spring booster vaccination programme 2023	08.03.2023		
WHC 2023 - 12	NHS Wales financial monitoring returns	26.04.2023		
WHC 2023 - 031	Healthcare associated infections and antimicrobial resistance improvement goals 2023 to 2024			
WHC 2023 - 17	Patient safety incident reporting management - Expired 12.05.23	12.05.2023		
WHC 2023 - 13	Health and Care Quality Standards 2023	02.05.2023		

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WHC 2023 - 08	Advice on tissue and cell donation	01.09.2023		
WHC 2024 - 07	Suspected cancer pathway: Guidelines	30.03.2023		
WHC 2023 -039	Independent Authorisation of Blood Component Transfusion (IABT)	01.11.2023		
WHC 2023 - 030	New 2023 National Safety Standards for Invasive Procedures (NatSSIPs2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034	11.08.2023		
WHC 2023 - 031	AMR & HCAI IMPROVEMENT GOALS FOR 2023-24	01.08.2023		
WHC 2023 - 039	Independent Authorisation of Blood Component Transfusion (IABT)	01.11.2023		

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WHC 2023 -046	All-Wales Control Framework for Flexible Workforce Capacity	13.12.2023		
WHC 2024 - 014	Introduction of the Office of National Statistics' (ONS) Register of Geographic Codes (RGCs) as a foundational standard for use across NHS Wales Bodies	30.04.2024		
WHC 2024 - 038	AMR & HCAI IMPROVEMENT GOALS FOR 2024-2025	2024		
WHC 2024 - 033	Letter to front line NHS staff re flu vaccine uptake - follow up to WHC(2024)033	20.12.2024		
WHC 2024 - 004 Powell Bethan 08/05/2025 16:00:41	Assurance of aseptic preparation of medicines in NHS Wales	N/A		

reporting period.

Overarching Actions Required
The basis of the WHC and subsequent processing of information is made in consideration of: ■ Section 1 of the National Health Service (Wales) Act 2006 which places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales, and in the prevention, diagnosis and treatment of illness. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty. ■ Pursuant to Section 3 of the National Health Service (Wales) Act 2006 the Welsh Ministers have a statutory duty to, inter alia, provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements, healthcare services and such other services or facilities as they require for the diagnosis and treatment of illness. ■ Pursuant to Section 12 of the National Health Service (Wales) Act 2006, the Welsh Ministers may direct a Local Health Board to exercise in relation to its area functions relating to the health service. Pursuant to the Local Health Board (Directed Functions) (Wales) Regulations 2009, the duty under Section 3 of the 2006 Act has been delegated to the Local Health Boards and are thus responsible for the provision of health services in Wales. ■ Pursuant to Section 18 of the National Health Service (Wales) Act 2006, the Welsh Ministers may by order establish NHS trusts to provide goods and services for the purposes of the health service. Pursuant to Section 19 of the National Health Service (Wales) Act 2006, the Welsh Ministers may give directions to an NHS trust about its exercise of any functions.
The guidance Assurance of aseptic preparation of medicines in NHS Wales (annex one) describes updated governance and regulatory arrangements for aseptic preparation of medicines by health boards and NHS trusts in Wales. The updated guidance takes account of changes to NHS organisational structures, policies and governance frameworks since DGM(97)5 was published in 1997, and the recommendations of the Department of Health and Social Care’s report Transforming NHS pharmacy aseptic services in England

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Stroke is the fourth leading cause of death in Wales and has a significant and life changing impact on those who survive; it is devastating for individuals, their families, and loved ones. This Welsh Health Circular provides a National Clinical Guideline for Stroke for the UK and Ireland. London: Intercollegiate Stroke Working Party; 2023 May 4. The full guideline is available at National Clinical Guideline for Stroke for the United Kingdom and Ireland. Published on 4 May 2023, this guideline is an initiative of the Intercollegiate Stroke Working Party. The 2023 edition is a partial update of the 2016 edition and was developed in collaboration with the Scottish Intercollegiate Guidelines Network (SIGN) and the National Clinical Programme for Stroke, Ireland and is endorsed for use in clinical practice by the Royal College of Physicians of London, SIGN and the Royal College of Physicians of Ireland.

In addition to the National Clinical Guideline for Stroke the NICE guideline [NG236] published in October 2023, provides updated recommendations for stroke rehabilitation in adults.

The requirements of this circular below provides the specifics of which aspects of each collective agreement non-pay element falls into each of parts 1-3. All implementation measures and reports should be agreed in partnership at the Local Partnership Forum. Reports must include a statement from the chair of the staff side that the content has been agreed. If there is no agreement, an explanatory statement as to why this is the case should be included.

Part 1 – Immediate assurance For each of points

- Review current implementation of the relevant aspect of the collective non-pay agreement.

Take any remedial implementation measures required.

This Welsh Health Circular supersedes the previous correspondence on this matter in respect of the appointment of interims. Recruitment and remuneration principles

5. Decisions relating to interim appointments must therefore:

- Employ robust corporate governance principles
- Demonstrate appropriate use of public money
- Demonstrate value for money

Interim arrangements for executive and senior posts must only be used in exceptional circumstances, where there is a clear rationale for not appointing substantively to the role. Where an interim ESP appointment can be justified – eg. for executive director posts – there must be approval from the relevant Welsh Government Head of Profession prior to an appointment being confirmed.

See paragraphs 8 to 40 of embedded document which outlines the principles of disputed debt management.

Develop robust plans that deliver against the priorities for 2024-25 set out in the NHS Planning Framework from within 2024/25 allocations. A clear expectation has been set that organisations will operate within core allocations. We know that, as in 2023/24, this financial year will present financial challenges, and it is essential that your monthly financial returns include a robust assessment of your forecast outturn and any risks to delivery, supported by high quality financial information which complies with the attached guidance. Within that context, some areas of improvement have been made to the Monitoring Returns submission templates. Organisations are also reminded that the extent detailed savings guidance on the

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Four changes have been made to the existing Certification of Vision Impairment Wales (CVIW) form to accommodate this: • The heading "To be completed by the Ophthalmologist (tick one)" changed to "To be completed by the Ophthalmologist/Optomestrist (tick one)", • Inclusion of tick boxes to indicate whether the practitioner is an ophthalmologist or optometrist, • Inclusion of tick boxes to indicate whether certification was performed within the hospital eye service, an optometry practice or a mobile setting • The label "Hospital address" changed to "Certifiers primary hospital/optometry practice address" The same CVIW 2024 form will be used for certification in primary and community care and in secondary care. The patient pathway for this service can be found in the relevant clinical manuals

5. Health boards and NHS Trusts, as appropriate, are expected to work with other health boards, NHS Trusts in England and the National Strategic Clinical Network for Critical Care, Trauma and Emergency Medicine to ensure their arrangements for critical care escalation meet the requirements of this guidance.

6. Health boards and NHS Trusts, as appropriate, should assure themselves they have plans in place to manage unplanned or sustained increases in demand for adult, children, and neonatal critical care.

7. Health boards must ensure they have a robust plan for the resuscitation or stabilisation of critically ill children and the provision of ongoing paediatric critical care whilst awaiting the arrival of specialised transport services or when a PICU bed is unavailable for a prolonged period

- Enhance quality and safety of patient experience by delivering more care by our own workforce who are employed in and familiar with our organisations and processes.
- Transparent, consistent, and equitable application of existing agreed national terms and conditions, ensuring we pay our employed workforce for their contractual and any additional hours worked at the appropriate contractual or agreed national rate.
- Transparent, consistent, and equitable application of national terms and conditions in pay and reward for those people who work flexibly through the NHS Staff Bank.
- Better value for money for NHS resources – reducing the additional costs associated with avoidable deployment of agency workforce into the NHS at premium rates (covering all professional groups).
- Avoid inter-organisation competition for people leading to increase in costs for the NHS with no extra

NHS organisations are expected to ensure plans for the WRVP are underpinned by the principles of the National Immunisation Framework. In particular, health board operational plans should clearly derive from the approaches set out in their vaccination equity strategies and incorporate targeted actions to reduce inequity in a measurable way. In commissioning services, health boards should be assured that (where appropriate) primary care contractors have robust mechanisms for call/recall as well as communicating eligibility and the benefits of vaccination. Working with Public Health Wales, health boards should ensure communication and engagement resources are suitable for primary care settings and made available in a timely way.

Exemptions to the requirement to implement recommendations.

Exemptions for the NHS to make a new medicine or intervention routinely available within the two months allowed for in directions. The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New Medicines into the National Health Service in Wales Directions 2009 as amended (the principal directions), provide for a health board or NHS trust to notify the Welsh Government's Chief Medical Officer of situations in which it is unable to meet the two month implementation and for this period to be extended to a maximum total three month implementation period.

It was envisaged this flexibility would be used in a limited way and only where a health board or NHS trust had local extenuating circumstances warranting an extension.

The amendment directions exempt health boards and NHS trusts from the requirement to

Updated guidance (April 2024): Guidelines for managing patients on the suspected cancer pathway. Version 6.5. This WHC provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target. This updated guidance (April 2024):

- Clarifies reporting responsibilities for incidental findings,
- Provides further clarity on procedures that qualify as first definitive treatment (FDT)
- Addresses accessibility issues

The main actions in PSN041 are as set out below: -

Actions in PSN041:

1. To identify if oxygen cylinders are used in your organisation, even if only in emergencies.
2. To bring this notice to the attention of all those with a leadership role in ensuring clinical staff understand how to operate oxygen cylinders safely.
3. To consider if immediate local action is needed and ensure that an action plan is underway to reduce the risk of incorrect use of oxygen cylinders.
4. To communicate the key messages in this notice and your local action plan to all relevant staff.

As a direct consequence of the Regulation 28 report and following discussions with NWSSP-SES we would expect the following actions to also be taken.

- Ensure medical gas groups include these actions on their agenda and report progress;
- Ensure medical gas training is mandated for all NHS staff using or handling medical gases (not just cylinders); and
- Ensure staff complete the BOC free online training in the operation of Oxygen CD cylinders.

In light of the above concerns, I ask that all health boards and trusts ensure they are complying with their policies and procedures in relation to pre-transfusion sample taking, to ensure that risk assessments, policies and procedures are being reviewed, updated, and appropriately applied. Failure to do so could result in significant harm to patients and even death. As you can see from the example above, practitioners who do not comply with this aspect of the policy can be subject to regulatory action. I also ask that you assure yourselves that all staff (including supplementary staff and managers) are familiar with these policies and procedures.

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Following the recent increase of incidents of pertussis and to help protect the most vulnerable, I would like to remind NHS Wales colleagues of the need to ensure that the occupational offer of pertussis vaccine to HCWs remains an active one. In particular, HCWs who work with the following cohorts should be offered an occupational pertussis vaccination, if they have not had one in the past five years:

- HCWs with regular and close clinical contact with women in the last month of pregnancy and severely ill young infants. This includes:
 - o clinical staff who work in areas where pregnant women are likely to attend in their last month of pregnancy (for example midwifery, obstetrics and maternity settings)
 - o neonatal and paediatric intensive care staff who are likely to have close and or prolonged clinical contact with severely ill young infants
- HCWs with regular clinical contact with young unimmunised infants in hospital or community settings. Examples include:
 - o general paediatric staff
 - o paediatric cardiology staff
 - o paediatric surgical staff
 - o paediatric emergency medicine
 - o health visitor staff
- HCWs with intermittent clinical contact with young unimmunised infants in the community. This includes HCWs in general practice.

This leaflet providing information to parents and care providers of children to help them spot the signs and symptoms of sepsis. To ensure that this leaflet is fully communicated a link to the printable version of the leaflet is provided for you to use during your consultation process.

The leaflet provides a symptoms checker and reminds everyone to be 'Sepsis Savvy'.

Clinicians will need to follow the Association of Medical Royal Colleges'

Statement_on_the_initial_antimicrobial_treatment_of_sepsis_V2_1022.pdf

The link to the Sepsis Awareness leaflet can be found on the Welsh Government website:

(<https://www.gov.wales/sepsis-trusts-spotting-unwell-child>) and from NHS 111. Primary care providers, community pharmacies, and community nursing teams can issue this leaflet to parents and care providers to help them look for the signs and symptoms of sepsis.

As no additional supply of adult flu vaccine has been procured by the Welsh Government this year, health boards should make the necessary arrangements to use surplus stock held in Primary Care¹ and in their own organization, to support this mop-up exercise. Supply for the children's flu vaccination programme (LAIV) should be ordered in the normal way via Immform.

Although it is something that we hope to enable in the near future, I am aware the timely write-back of vaccinations recorded in the Welsh Immunisation System (WIS) to GP systems will not be possible for this mop-up exercise. Instead, a weekly summary of administered vaccinations will be provided by health boards to the registered GPs of vaccinated individuals, for the purposes of updating the patient record using an appropriate code. I recognise this will require administrative work within practices. That work is, of course, very similar to that already required when recording flu vaccinations given in Community Pharmacy. There will, however, be a clinical record of the vaccination having been administered in WIS & CYPRIS. Health boards and General Practice are asked to work in partnership to manage this additional administration, which for individual practices is not expected to be significant. Due to multiple data systems in use to record influenza vaccinations, every effort should be made to check an individual's previous vaccination history prior to vaccine administration. This will reduce the risk of an individual being double vaccinated.

Our policy guidance framework, Croeso i Gymru / Welcome to Wales, has been developed collaboratively to promote a uniform and equitable approach to information provision. The framework outlines overarching themes that define the minimum essential information that must be provided to IENs. These themes include:

- General background on the health board/trust, working in Wales, and the local area
- Pastoral and social support
- Organisational induction
- OSCE preparation
- Broader policy context the information specified under these themes represents the minimum standard that

should be readily available. However, NHS organisations are encouraged to include additional relevant details. All organisations must also provide specific information related to Wales-wide policies, strategies, and guidance.

To facilitate the consistent delivery of this information, the Pastoral App (NHS Wales International Recruitment) has been centrally funded for three years. This App enables IENs to access crucial information, which can be easily managed and updated by each respective organisation.

Health boards are expected to continue to maximise vaccine uptake, minimise vaccine waste, retain their focus on reaching the most vulnerable, and understand and address inequity by ensuring access for all eligible people.

With this in mind, we expect:

1. All those eligible for a spring vaccination to receive an invite for vaccination.
2. Health boards should make every effort to maximise uptake across all cohorts ensuring:
 - i. uptake levels are maintained or improved for those over 75 years of age and those resident in a care home for older adults, and that every effort is made to achieve 75% uptake for these cohorts.
 - ii. all possible interventions which could improve uptake for the immunosuppressed cohort are explored and acted on, including removing any barriers to vaccination.
 - iii. the gap is reduced between uptake rates in the least and most deprived areas of the health board.

When planning for improved uptake of vaccination Local Health Boards should draw on experience of successful initiatives from across Wales that have demonstrated impact and seek to incorporate lessons learnt. We encourage the use of existing vaccination forums to facilitate the sharing of information on good practice to support this planning round. The primary aim of the COVID-19 vaccination programme is the prevention of severe COVID-19 disease (hospitalisation and mortality). Eligible Cohorts The JCVI advise that a COVID-19 vaccination should be offered to:

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 6 months and over who are immunosuppressed (as defined in tables 3 or 4 in the COVID-19 chapter of the Green Book) This vaccination should be offered around 6 months after the last vaccine dose, although operational flexibility around the timing of the spring dose in relation to the last vaccine dose is considered appropriate (with a minimum interval of three months between doses). More information on operational flexibility will be provided in the COVID-19 chapter of the Green Book.

This letter is aimed at health professionals who are responsible for commissioning and delivering the COVID-19 vaccination programme in Wales. We encourage you to share this guidance with all those involved in delivering the programme in your area.

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The NHS Wales sustainability conference and awards 2025 The NHS Wales sustainability conference and awards has been established to promote the principles of sustainable healthcare and support the incorporation of sustainable practices into clinical care. Further to the success of the inaugural event in 2024, the second NHS Wales sustainability conference and awards has been arranged to take place on 20th June 2025 at Swansea Arena. Deadline for awards entries

The deadline for NHS organisations to submit entries against Wales Sustainability Awards categories has been extended to 21 March 2025. This will enable staff who are both passionate about the climate agenda, but also impacted by winter pressures more time to enter, and provide the opportunity to further raise the profile of sustainability throughout the NHS

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Exemptions to the requirement to implement recommendations. Exemptions for the NHS to make a new medicine or intervention routinely available within the two months allowed for in directions. The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New Medicines into the National Health Service in Wales Directions 2009 as amended (the principal directions), provide for a health board or NHS trust to notify the Welsh Government's Chief Medical Officer of situations in which it is unable to meet the two month implementation and for this period to be extended to a maximum total three month implementation period. It was envisaged this flexibility would be used in a limited way and only where a health board or NHS trust had local extenuating circumstances warranting an extension. The amendment directions exempt health boards and NHS trusts from the requirement to implement a NICE or AWMMSG recommendation within two months where:

- NICE extends the implementation period as confirmed in the Final Appraisal Determination;
- AWMMSG has recommended the implementation period is extended; or
- The Welsh Ministers make a determination to extend the implementation period. There are no other situations in which health boards and NHS Trusts are exempted from the requirement to implement NICE or AWMMSG recommendations as required by the principal directions. The amendments come into effect on 1 May 2024.

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NWSSP-SES we would expect the following actions to also be taken.

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Priorities for the WRVP 2024/25. NHS organisations are expected to ensure plans for the WRVP are underpinned by the principles of the National Immunisation Framework. In particular, health board operational plans should clearly derive from the approaches set out in their vaccination equity strategies and incorporate targeted actions to reduce inequity in a measurable way. In commissioning services, health boards should be assured that (where appropriate) primary care contractors have robust mechanisms for call/recall as well as communicating eligibility and the benefits of vaccination. Working with Public Health Wales, health boards should ensure communication and engagement resources are suitable for primary care settings and made available in a timely way. Flu - As set out in WHC/2023/047 there will be a phased start to this year's flu programme. Starting in September, 2 and 3 year olds and school aged children/young people should be vaccinated as quickly as possible. Health boards have previously been asked to develop plans to reach 75% uptake for these groups by the end of 25/26 season. There is an expectation that those plans will be further developed this year and the actions identified which will help realise this ambition.

Testing will continue where clinically indicated in secondary care settings. There will be no change to the way Health Boards order their lateral flow tests for clinical use. These should continue to be ordered through NWSSP via the Oracle ordering system. Guidance on respiratory viruses including Covid-19 for staff in health, social care and special schools can be found here. Current advice and guidance on Covid-19 testing and Covid-19 antiviral treatment on Welsh Government's web pages will be updated from 1 February to reflect the changes detailed within this circular.

Notifying NHS Wales bodies of the requirement to adopt HL7 FHIR as a foundational standard for interoperability and advise of the need for compliance from May 2023

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It is essential to enable NHS Wales staff to speak up about issues with confidence knowing their concerns will be taken seriously, heard fairly and that they will not face personal repercussions for raising concerns.

The purpose of this circular is to ensure that all GPs in Wales and all Local Health Boards in Wales are aware of and consider:

- The General Medical Council's (GMC) guidelines on sharing information and the consensus statement which has been agreed by the Department of Health, Royal Colleges and other partners.
- The guidance on when and how to deal with disclosures of patient information can be found in the following link General Medical Council Confidentiality: good practice in handling patient information within which guidance is outlined to assist with Disclosures for the protection of patients and others "All patients have the right to a confidential medical service. Challenging situations can however arise when confidentiality rights must be balanced against duties to protect and promote the health and welfare of patients who may be unable to protect themselves." (Section 50). In addition, the Department of Health (and others) have produced a consensus statement (which applies to adults) designed to promote greater sharing of information within the context of the relevant law, and to clarify that this is a matter of professional judgement for an individual practitioner providing care to an individual person. The principles of the Statement are supported in Wales:

The purpose of this circular is to ensure that all GPs in Wales and all Local Health Boards in Wales are aware of and consider:

- The National Institute for Health and Care Excellence (NICE) guidance on Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE The guidance covers assessment, management and preventing recurrence for children, young people and adults who have self-harmed. It includes those with a mental health problem, neurodevelopment disorder or learning disability and applies to all sectors that work with people who have self-harmed. The guidance includes recommendations on:
- Information and support
- Consent and confidentiality
- Safeguarding
- Involving family members and carers
- Psychosocial assessment and care by mental health professionals
- Risk assessment tools and scales
- Assessment and care by healthcare professionals and social care practitioners
- Assessment and care by professionals and from other sectors
- Admission to and discharge from hospital
- Initial aftercare after an episode of self-harm
- Interventions for self-harm
- Supporting people to be safe after self-harm

NatSSIPs2 have been developed in collaboration across the four UK nations and replace the 2015 NatSSIPs introduced in Patient Safety Notice PSN034. The NHS Wales Executive will not be issuing a new Patient Safety Notice since the actions required in PSN034 are equally applicable to NatSSIPs2.

Powell Bethan
08/05/2025 16:00:41

The Welsh Government has reviewed and revised the following model documents: • Model Standing Orders and Model Standing Financial Instructions – Local Health Boards. • Model Standing Orders and Model Standing Financial Instructions – NHS Trusts. • Model Standing Orders and Model Standing Financial Instructions – the Welsh Health Specialised Services Committee (WHSSC), which form Schedule 4.1 of the Local Health Board Model Standing Orders. • Model Standing Orders – the Emergency Ambulance Services Committee (EASC), which form Schedule 4.2 of the Local Health Board Model Standing Orders [Note: Model Standing Financial Instructions have not yet been issued to EASC]; and • Model Standing Orders and Model Standing Financial Instructions – Health Education and Improvement Wales. • Model Standing Orders and Model Standing Financial Instructions – Digital Health and Care Wales Special Health Authority

Change to the vaccine schedule: As previously advised, a move to a one-dose schedule for the HPV vaccination programme has been recommended by the Joint Committee on Vaccination and Immunisation (JCVI) for the routine adolescent programme and gay, bisexual and other men who have sex with men, vaccine will continue to be used for the HPV programme. The eligibility and schedule of the programme is:

- a one-dose schedule for the routine adolescent programme* and GBMSM programme for those vaccinated before their 25th birthday
- a two-dose schedule from the age of 25 in the GBMSM programme where vaccination is commenced on or after the individual's 25th birthday
- a three-dose schedule for individuals who are immunosuppressed and those known to be HIV-positive

With the COVID-19 spring booster vaccination programme well underway, and the Joint Committee on Vaccination and Immunisation (JCVI) statement outlining the COVID-19 vaccination of infants aged 6 months to 4 years in clinical risk groups announced on the 6 April, I would like to remind colleagues of the guidance on post-vaccination observation periods, both for those receiving a booster and those receiving a primary dose of a COVID-19 vaccine. Firstly, adults and children with a history of allergy should continue to be managed in accordance with the advice set out Chapter 14a of the Green Book. For adults and children without a history of allergy (as described in the Green Book), the universal requirement for a 15-minute observation period is currently suspended on the recommendation of the UK Chief Medical Officers and with the agreement of the Commission on Human Medicines. However, in accordance with the guidance set out in Welsh Health Circular 2023/09, the following groups should continue to receive a 15-minute post-vaccination observation period. • Individuals registered as learning disabled receiving a COVID-19 vaccine for the first time. • Adults and children lacking capacity receiving a COVID-19 vaccine brand for the first time. The guidance on observation periods is kept under constant review. Any changes will be communicated to colleagues immediately. I would also like to take this opportunity to clarify that it is no longer necessary to defer vaccination for adults or children after recovery from a recent episode of compatible symptoms, whether or not the patient has been tested for COVID-19.

The Welsh Government's Framework for COVID-19 testing for hospital patients in Wales was first published in March 2021. In light of widespread vaccination and changing public health conditions we continually review the framework in the context of the current public health conditions. Advice is provided by Public Health Wales and the Testing Clinical Advisory and Prioritisation Group on reviewing the arrangements. This provides a further update following a review of arrangements for testing over spring and summer 2023. Update to Framework Within this current context and expert advice received the framework has been updated for spring/summer (April-September) with a focus primarily on testing to diagnose individuals who are eligible for antiviral therapy against SARS-CoV-2 or influenza and when clinically indicated. Active surveillance programmes will continue and the strategy will be reviewed if a SARS-CoV-2 variant spreads and causes significant health impact.

The JCVI has recommended, as a precautionary strategy, a booster vaccine dose in the spring for: ■ adults aged 75 years and over; ■ residents in a care home for older adults, and ■ individuals aged 5 years and over who are immunosuppressed (as defined in table 3 or 4 in the Green Book)

We have returned to routine expectations in that, organisations are expected to plan and operate within core allocations notified at the start of the financial year. We know that this financial year will present significant financial challenges, and it is essential that your monthly financial returns include a robust assessment of your forecast outturn and any risks to delivery, supported by high quality financial information which complies with the attached guidance. I remind you that this information should form a key part of the financial governance of your Board, and the timeliness and quality of the information provided should reflect that.

Wales remains committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action Plan 2019-2024 and addendum published in May 2022. Work is underway on a 4-nations basis to develop the next 5-year National Action Plan from 2024, but for 2023-24 the focus needs to be on continuing to work towards the goals of the current 5-year National Action Plan. In Wales the aim is to combat antimicrobial resistance through lowering the burden of infections, improving treatments and optimising our use of antimicrobials in humans.

We would like to draw your attention to the new national policy on patient safety incident reporting and management. This has been developed by the former NHS Wales Delivery Unit (now part of the NHS Wales Executive) through a series of consultation workshops held in late 2022 and fulfils action 4 of the Quality and Safety Framework: learning and improving. As a result of feedback provided during consultation the new policy merges Welsh Government policy and Delivery Unit implementation guidance. It replaces the interim Welsh Government Patient Safety Incidents policy of May 2021 and the Delivery Unit implementation guidance of June 2021. The policy sets out several key changes, for example the establishment of a system to thematically analyse incident data has been superseded by plans to undertake thematic analysis at a national level using the Once for Wales Concerns Management System. Incident reporting and shared learning go hand in hand to help improve the quality and safety of patient care, one of the aspirations of A Healthier Wales. This updated policy empowers organisations to take ownership and accountability for incident reporting and management and sets out clear expectations for patient safety incident reporting across NHS Wales. We expect NHS organisations to ratify this revised national policy through their internal governance processes during Q1 2023/24. The updated policy and supporting documents can be accessed through at the following link and should be used with immediate effect.

The health and care quality standards in the duty will now replace the 2015 health and care standards issued under WHC (2015) 015. The introduction of the duty of quality provides an opportunity to directly align the standards not only with the duty but with wider quality management practice in health. The revised health and care quality standards are designed to simplify the requirements and be flexible with the wide remit of the duty of quality. These new standards set out the high-level standards that people in Wales can expect when accessing health services. They comprise six domains of quality (safe, timely, effective, efficient, equitable and person centred) supported by six quality enablers (leadership, workforce, culture, information, learning, improvement & research and whole systems approach). Detailed information on the domains and enablers can be found in section 6 of the duty of quality guidance.

Health boards and trusts are asked to ensure implementation of the recommendations outlined in the FAIR III report for any living or deceased tissue or cell donations. These include activities such as bone donation during hip replacement surgery. Colleagues are also asked, where required, that additional communications be made available within pre-donation information for donors and families.

Within this current context and expert advice received the framework has been updated for spring/summer (April-September) with a focus primarily on testing to diagnose individuals who are eligible for antiviral therapy against SARS-CoV-2 or influenza and when clinically indicated. Active surveillance programmes will continue and the strategy will be reviewed if a SARS-CoV-2 variant spreads and causes significant health impact. The framework sets out the testing approach under the following testing purposes: • Test to diagnose - to support NHS clinical care – diagnosing those who are infected so that clinical judgments can be made to ensure the best care. • Test to safeguard - to protect our NHS and social care services and individuals who are our most vulnerable. Updated guidance for the health and social care sector will emphasise the importance of rigorous compliance with infection, prevention and control procedures. This includes monitoring and reporting of outbreaks, good hygiene practices, social distancing and the appropriate use of personal protection equipment (PPE). Health staff should continue to wear facemasks (type IIR) when working in respiratory care pathways and when clinically caring for suspected/confirmed COVID-19 and Flu patients.

The All-Wales Policy for Independent Authorisation of Blood Transfusion (IABT) describes the process for selection, education, approval, and support of Health Care Professionals (HCPs) undertaking this role within Wales. For standardisation and safety reasons the only recognised route to practice is through acquisition of an agreed, accredited programme of education and assessment. HCPs undertaking the IABT role will have completed a specific Higher Education Institution (HEI) accredited programme of education and assessment, commissioned by Health Education and Improvement Wales (HEIW).

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This Circular focuses on the actions required to deliver a clear control framework for deployment of flexible workforce capacity. This control framework will be implemented within NHS organisations and coordinated on an all-Wales basis to drive best practice, provide transparency and fairness for our workforce, avoid inter organisation competition which unnecessarily inflates cost pressures across Wales and avoid unintended consequences for individual organisations.

Whilst our headline focus is on reducing avoidable agency expenditure, the control framework will be applied to both agency and variable pay expenditure to aid transparency as costs move from the agency to variable pay categories. This will ensure that we realise the potential efficiencies rather than simply transfer costs.

Welsh Government recognises the need to implement a standardised coding structure for geographic data. The Office of National Statistics implemented a coding and naming policy on 1st January 2011 in the form of its Register of Geographic Codes. This register consists of a simple nine-character alpha-numeric coding structure at its centre. The Register of Geographic Codes, coding structure and policy are designed so that codes cannot be re-used or changed solely because of a name change. The Welsh Government is formally mandating the use of the Register of Geographic Codes across NHS Wales bodies for coding geographic data in all IT and digital systems / services.

Antimicrobial Resistance (AMR) & Healthcare Associated Infections (HCAI) Improvement Goals 2024/25 As part of the UK 20-year vision to confront and address antimicrobial resistance (AMR), Wales alongside the other three UK nations, is committed to developing a series of five-year national action plans to prioritise actions and direct resources in areas of highest risk. The UK's second five-year national action plan setting out ambitions and actions for the next five years (2024-2029) was published on 8 May 2024. This Welsh Health Circular sets out the improvement goals for 2024/25 reflecting on the data from the previous year and the new targets set out in the new AMR national action plan. Healthcare associated infections (HCAIs) remain a key patient safety issue that result in a significant burden of disease and financial cost to the NHS in Wales and across the care sector. Whilst some progress was made in 2023-24 in reducing the incidence of a number of HCAIs in some areas, we remain a significant way off achieving the majority of the improvement goals and achieving the UK AMR vision.

As dedicated frontline NHS staff in Wales, we are aware of your enduring efforts and hard work all year round to protect the health and well-being of your patients which are truly appreciated. As winter is here and we are now seeing the inevitable additional pressures on the NHS, it is more important than ever to safeguard yourself, your colleagues, and your patients by taking up the offer of a seasonal flu vaccination. We are now more than two months into the Winter Respiratory Vaccination Programme and it is disappointing that the number of frontline staff who have come forward for vaccination is lower than in previous years. This is a trend we urgently need to address.

The guidance Assurance of aseptic preparation of medicines in NHS Wales (annex one) describes updated governance and regulatory arrangements for aseptic preparation of medicines by health boards and NHS trusts in Wales. The updated guidance takes account of changes to NHS organisational structures, policies and governance frameworks since DGM(97)5 was published in 1997, and the recommendations of the Department of Health and Social Care's report Transforming NHS pharmacy aseptic services in England

Bethan
08/05/2025 16:00:41

Lead Executive	Expected Date of Completion	Status
Director of Finance and IT, Medical Director and Director of Primary Care, Community and Mental Health	31.03.2025	Complete
Medical Director	Immediate	Complete

Powell Bethan
08/05/2025 16:00:41

Director of Therapies	N/A	Complete
Director of People and Culture	jan-25	Complete
Chief Executive	Immediate	Complete
Director of Finance, Capital and Support Services	apr-27	Complete
Director of Finance, Capital and Support Services		Complete

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08/05/2025 16:00:41

Director of Primary Care, Community and Mental Health		Complete
Director of Planning, Performance and Commissioning	Immediate	Closed
Executive Director of Finance and Capital and Support Services	N/A	Complete
Director of Public Health	jan-25	Complete
Medical Director (Chief Pharmacist responsible for implementing)	01-mai-24	Complete

Powell Bethan
08/05/2025 16:00:41

Medical Director/Director Primary Care, Community & Mental Health/Director of Planning & Performance	immediately	Complete
Medical Director	30-sep-24	Complete
Executive Director of Primary Care	31 September 2026	Complete

Powell Bethan
08/05/2025 16:00:41

Director of Public Health/Director of People and Culture	N/A	Complete
Medical Director	Immediately	Complete
Head of Service: Public Health Programs and Projects (Sarah Barnes) / Director of Public Health/ Chief Pharmacist	Immediately	Complete

Powell, Bethan
08/05/2025 16:00:41

Director of People and Culture/Director of Primary Care	immediately	Complete
Director of Public Health, Sarah Barnes leading on updates	immediately	Complete

Powell Bethan
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Director of Public Health/ medical Director	immediately	Complete
Executive Director of Finance and Capital and Support Services	10.03.2025	Complete

Powell Bethan
08/05/2025 16:00:41

Director of Therapies	N/A	Complete
Director of Planning, Performance and Commissioning	Immediate	Closed
Director of Public Health	jan-25	Complete
Medical Director (Chief Pharmacist responsible for implementing)	01-mai-24	Complete

Powell Bethan
08/05/2025 16:00:41

Medical Director/Director Primary Care, Community & Mental Health/Director of Planning & Performance	immediately	Complete
Medical Director	30-sep-24	Complete
Director of Public Health/Director of People and Culture	N/A	Complete
Head of Service: Public Health Programs and Projects (Sarah Barnes) / Director of Public Health/ Chief Pharmacist	Immediately	Complete

Director of Public Health, Sarah Barnes leading on updates	immediately	Complete
Director of Public Health/ medical Director	immediately	Complete
Director of Public Health	N/A	Complete
Director of Allied Health Professions, Health Sciences and Digital	jun-26	Complete

Powell Bethan
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Director of People and Culture	30.10.2023	Complete
Director of Primary, Community Care and Mental Health Services		Complete
Director of Primary, Community Care and Mental Health	Immediate	Complete
Director of Primary, Community Care and Mental Health Services	Immediate	Complete

Powell Bethan
08/05/2025 16:00:41

Directors of Corporate Governance/Board	31.03.2024	Complete
Director of Public Health		Complete
Director of Public Health	Immediate	Complete
Director of Public Health	Immediate	Complete

Powell Bethan
08/05/2025 16:00:41

Director of Public Health		Complete
Director of Finance, Capital & Support Services	apr-24	Complete
Director of Nursing, Quality, Women and Family Health	Immediate	Complete
Director of Nursing, Quality, Women and Family Health	12.05.2023	Complete
Director of Nursing, Quality, Women and Family Health	2028	Complete

Powell Bethan
08/05/2025 16:00:41

Medical Director	18.09.2023	Closed
Medical Director	jun-23	Complete
Medical Director	01.10.2026	Complete
Director of Finance, Capital & Support Services/ Medical Director	Immediate	Complete
Director Primary Care, Community and Mental Health	31.03.2024	Complete
Medical Director	01.10.2026	Complete

Powell Bethan
08/05/2025 16:00:41

Medical Director	05.01.2024	Complete
Director of Finance and IT; Director of Information Governance	imediately	Complete
Director of Nursing, quality, Women and Family Health	2025	Complete
Medical Director/Director of Public Health/Director of Allied Health Professions, Health Sciences and Digital	Immediate	Complete
Medical Director	Immediate	Complete
Powell Bethan 08/05/2025 16:00:41		

Comments

08.04.25 - This has been implemented. It will continue to be an iterative process as improvements are made and areas of service delivery are focussed upon as part of local and All Wales programmes

03.09.2024 - PTHB is progressing two areas in relation to PROMs for Powys patients:

1) Links have been made with neighbouring organisations which treat Powys patients to request PROMs data is provided. For the other Welsh health boards and Velindre UNT, this data will eventually flow through the NDR, and in the interim, the hope is that data can be provided from providers directly to PTHB. One of the main English NHS Trusts which treats Powys patients is working to provide PROMs data and links are being made with the other main English providers to obtain this.

2) From a provider perspective PTHB is continuing to work towards implementing a PROMS solution that is aligned to the national direction. PTHB initiated a PROMs Task and Finish group which compiled a list of options to consider for an organisational PROMs solution and an update paper and recommendations were presented to the VBHC Programme Board which confirmed that work should commence on a business case to identify funding for procurement via the national outcomes (PROMs) framework. The development of Business Case for PROMs & PREMs Organisational solution for PTHB has been currently paused due to other organisational priority work.

Jan 2024 - All Wales Outcomes (PROMs) Framework has five suppliers on it. BCUHB, CTMUHB, HDUHB and SBUHB have carried out a mini competition to select a preferred supplier from the five on the framework which they would then all use. PTHB, along with C&VUHB and Velindre NHS Trust had observer status to help inform what they do in relation to PROMs. PTHB colleagues including Transformation Programme Manager, Head of Data Infrastructure and Advanced Information Analyst continue to engage in the relevant National PROMs sub groups.

August 2023 - PTHB is continuing to work to implementing a PROMS solution that is aligned to the National Framework being enabled by DHCW. While a specific solution has not yet been selected, it will be aligned to the interoperability & integration standards for NHS Wales to ensure that Data is recorded in a consistent manner to create a true National picture of PROMS in NHS Wales. This data can be fed in DHCW and the National Data Resource programme which in turn will mean that National Dashboards can be created.

February 2023 Powys continues to participate in the small number of National Clinical Audits and Outcome reviews where it offers a relevant service. These are; National Diabetes Foot Care Audit, All Wales Audiology Audit, Sentinel Stroke National Audit Programme, National Audit of Care at the End of Life, National Confidential Inquiry into Suicide and Safety in Mental Health

Maternal, Newborn and Infant clinical Outcome Review (MBRRACE) CIVICA continues to be rolled out for PREMs collection in Powys.

On 09/11/22 PTHB Executive Committee approved the use of EQ-5D-5L as the 'generic' organisational PROM, with condition specific PROMs 'layered' on top. A PROMs Implementation Task & Finish Group has been established to consider the options for the deployment of an organisational approach to PROMs for PTHB. This work will also align to the All Wales Outcome Framework being developed by the Welsh Value in Health Centre.

The principles and processes described in this guidance apply to all aseptic preparation of medicinal products in NHS pharmacy aseptic facilities in Wales, other than those products manufactured under an MHRA authorisation. The guidance therefore applies to all NHS pharmacy aseptic facilities undertaking preparation of sterile medicinal products under the Section 10 exemption.

PTHB does not have any aseptic facilities where aseptic products are prepared under the Section 10 exemption. This WHC is therefore not relevant to PTHB.

Powell Bethan
08/05/2025 16:00:41

Feb 2025 - Stroke Steering Group will be taking this forwardSeptember 2024. As Stroke care in Powys is entirely about Post-Stroke rehabilitation rather than acute Stroke care this WHC is the remit of the Therapies Directorate.

29.08.2024 - All initial actions have been completed and further updates will go through LPF, Executive and reported to Welsh Government in accordance with the timelines included.

This can be closed out as we ensured the requirements of the WHC were embedded within our standard operating arrangements for senior appointments and decisions for interim, secondment and substantive appointments go to our RaTS Committee.

April 2025 - Implemented and followed when needed.

April 2025 - Implemented and followed re Monthly Monitoring Return as submitted

Powell Bethan
08/05/2025 16:00:41

06/03/25 Update:

Planned Care continues to provide this certification via ophthalmologists. CVI certification is also available in community optometry in line with current WG specification. It is anticipated that WG guidance develop will be continually developed enabling further CVI in the community.

UPDATE (March 2025) following CG audit: Updated in March no further update needed.

Jan 2025 - Planing Performance and Comissionin doe not provide Acute care. Doe not apply. TB closed.

29.08.2024 - Wrongly allocated to People and Culture Exec Lead. It belongs to Finance. AMENDED and update requested.

08.04.25 - Clearly this has lots of workforce actions as detailed but the response to the agency reduction action is taken via Operational groups as relevant and the Variable Pay group provides some oversight. This is an ongoing iterative process and regularly reported in Finance and Workforce reports so complete and ongoing across a number of portfolio areas.

06.02.2025 WRVP delivery has been successful with collaboration between GPs, community pharmacies and the Health Board Vaccination Service.
Working with primary care contractors the Health Board has ensured that all patients have been called for COVID/Flu and signposted to community pharmacies to help use up any remaining flu vaccination stock. RSV delivery is underway in GP Practices and the Vaccination service and conversations between GP and the Health Board are ongoing to try to encourage more practices to sign up to offer RSV vaccine to their registered population.
23.08.2024 - Plans and discussions with GPs are ongoing on RSV delivery.

WHC Received in August 2024. Unable to meet deadline.

Jan

09.04.25 these will be updated when the new Chief Pharmasisit is in post in the next few weeks please, once we have a start date we will keep you updated when they start.

Powell Bethan
08/05/2025 16:00:41

Jan 2025 - Noting context of PTHB with in reach service provision, small teams, diagnostics/OP only no treatment pathways with MDT taking place outside PTHB. Powys Provider USC pathways are managed in accordance with the updated WHC guidance, enhanced tracking in place for PTHB with appropriate feedback/communications to referrers/patients which will be further developed as clinical model/MDT in PTHB expands. PTHB cancer performance is managed assured through the PTHB Integrated Performance Framework with regular reporting to Board. The PTHB Commissioned Services Performance reporting/assurance framework is also being developed accordingly.

UPDATE (March 2025) following CG audit: Confirmed action completed.

Apr 2025 – Performance is monitored (for PTHB provider and commissioner) through the Integrated Quality and Performance Framework (IQPF) and reported to Board through the Integrated Quality and Performance Report and also reported to Welsh Government Integrated Quality, Planning and Delivery meetings.. A separate Commissioned Services Provider report is being developed as part of the Health Board Strategic Commissioning Framework and annual review of the IQPF

Exec Lead tbc - Operational Lead, David Farnsworth under the new Director of Community Services . Howard and Kate Wright will let us know Ownership following Exec Committee.

September 2024: Jacqui Seaton, Chief Pharmacist, produced a 7 minute briefing highlighting the concerns relating to medical gas cylinder. Focus was on training requirements and incident reporting. Cascaded broadly across the health board.

https://nhs.wales365.sharepoint.com/sites/POW_comm_medicinesmanagement/SiteAssets/SitePages/Oxygen-Cylinders---Risk-of-death-if-used-incorrectly/7-Minute-briefing-Risk-of-death-due-to-incorrect-use-of-oxygen-cylinders-Sept-2024-FINAL.pdf?web=1

Training and incident reports are standing agenda items on the Medical Gases Governance Group - this meets quarterly

SBAR provided to execs on the training requirements - limited appetite to mandate medical gases training. David Farnsworth to ensure that all service managers ensure that all appropriate operational staff undertake medical gases training (on-line) and that processes to be put in place to allow peer to peer opportunities to practice using medical gas cylinders.

06/03/25 Update:

Planned Care continues to provide this certification via ophthalmologists. CVI certification is also available in community optometry in line with current WG specification. It is anticipated that WG guidance development will be continually developed enabling further CVI in the community.

UPDATE (March 2025) following CG audit: Updated in March no further update needed.

Powell Bethan
08/05/2025 16:00:41

Jan 2025 - Work was underway prior to the issue of the WHC to remind of the requirements of the 2019 WHC. This included IC contacting all Leads in PTHB of Priority 1 & 2 and contacting Priomary Care to remind staff about vaccination.

WHC circulated to PTHB priority groups in Nov 2024.

WHC circulated to primary care in Nov 2024 when the updated version came out. Advised that all HCP who have contact with babies between 0-8 weeks need to be vaccinated.

All priority groups advised on staff vaccination, including pertussis in IC immunisation training sessions.

Staff ID requiring vaccination signposted to OH and appointments for vaccination arranged.

IC supporting additional clinics where required.

All staff that are eligible who are undergoing pre-employment checks, e.g. new employees, existing members of staff who are applying for a new role, grade or bank position will be offered a vaccination.

Ongoing review and reminder to priority group staff about importance of vaccination.

January 2025 update: Complete

Jan 2025 - Pharmacy - The Medicines Mananagement Team has supported the establishment of vaccine quantities that are available across the health board and also within community pharmacy.

Jan 2025 - Public Health -Targeted letters sent to eligible patients to inform of importance of flu vaccination and signposting to where to get their vaccine.Opportunistic flu vaccination offered to anyone attending the vaccination centres for their COVID vaccine

List of pharmacies with remaining flu stock handed out to patients attending vaccination clinics if they didnt want to receive flu vaccine at the same time as their COVID Vaccine. Drop in flu vaccinations for adults and children advertised at vaccination centres PTHB website updated to include signposting to GP and Pharmacies. Social Media comms to promote uptake of flu vaccination.

09.04.25 these will be updated when the new Chief Pharmasisit is in post in the next few weeks please, once we have a start date we will keep you updated when they start.

Powell Bethan
08/05/2025 16:00:41

January 2025 - The Health Board has a well developed programme of support in place which supports the transition and training of Internationally Educated Nurses. There is a steering group established and a Pastoral Support Officer appointed and we have to date achieved 100% success through the OSCE exams. This is now integrated as business as usual.
25.03.2025 - Unchanged as we are still awaiting the work to be done nationally

06/02/2025 Planning for the COVID-19 Spring vaccination programme is underway in Powys. Lessons learned session for WRVP took place on 24/01/2025 to inform the planning of the Spring Campaign. Learning from our WRVP campaign, we will continue to offer vaccinations locally to address access challenges in a rural geographic area. Care home visits undertaken throughout March to work through informed consent paperwork inline with protocols.
01/02/2025
Spring Campaign delivery underway commencing with residents of carehomes for older adults. Uptake data will be continuously monitored throughout the campaign with outreach clinics tailored to areas of lower uptake.

Powell Bethan
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06/02/2025 Phased approach to flu vaccination implemented in PTHB with prioritisation of 2&3 flu in September 2024, with adult flu commencing in October. Invitations sent out for COVID vaccination to eligible groups, with communications to frontline health and social care staff to self-present or call to make appt for their vaccination if they would like to receive this.
The vaccination service have worked closely with General Practice and have facilitated contact with patients who have not taken up the offer of flu vaccination to encourage uptake.

Adrian Osborne sent an email confirming that the information has been cascaded through the organisation including via the article on 10.03.25

Powell Bethan
08/05/2025 16:00:41

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All staff that are eligible who are undergoing pre-employment checks, e.g. new employees, existing members of staff who are applying for a new role, grade or bank position will be offered a vaccination.

Ongoing review and reminder to priority group staff about importance of vaccination.

Jan 2025 - Pharmacy - The Medicines Management Team has supported the establishment of vaccine quantities that are available across the health board and also within community pharmacy.

Jan 2025 - Public Health - Targeted letters sent to eligible patients to inform of importance of flu vaccination and signposting to where to get their vaccine.

Opportunistic flu vaccination offered to anyone attending the vaccination centres for their COVID vaccine

List of pharmacies with remaining flu stock handed out to patients attending vaccination clinics if they didn't want to receive flu vaccine at the same time as their COVID Vaccine

Drop in flu vaccinations for adults and children advertised at vaccination centres

PTHB website updated to include signposting to GP and Pharmacies

Social Media comms to promote uptake of flu vaccination

06/02/2025 Planning for the COVID-19 Spring vaccination programme is underway in Powys. Lessons learned session for WRVP took place on 24/01/2025 to inform the planning of the Spring Campaign. Learning from our WRVP campaign, we will continue to offer vaccinations locally to address access challenges in a rural geographic area.

06/02/2025 Phased approach to flu vaccination implemented in PTHB with prioritisation of 2&3 flu in September 2024, with adult flu commencing in October.
Invitations sent out for COVID vaccination to eligible groups, with communications to frontline health and social care staff to self-present or call to make appt for their vaccination if they would like to receive this. The vaccination service have worked closely with General Practice and have facilitated contact with patients who have not taken up the offer of flu vaccination to encourage uptake.

Plans align with WHC.

28.04.25 update: As part of our transition to Data Bricks Lakehouse Platform we have already adopted the standard as outlined in the table

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28.04.2025 update: In response to this WHC, OTHB's action plan was submitted to WG in October 2023. A monthly strategic working group was established of senior representatives from across clinical and non-clinical professions to complete the actions. This included ensuring that SUS was appropriately sponsored through an Exec Lead and IM Champion, and establishing a mechanism for staff to understand how to raise concerns, which resulted in the 'Our Voice' portal on the intranet as place for all staff to go to for support to speak up. This has included contracting an external service through Vivup to independently hear concerns and report them back into the organisation. In addition a training course has also been designed and delivery started to help staff have a toolkit of conversations that they can discuss in team meetings to help develop psychological safety. All of the above has been supported through communications through multiple channels.
28.04.2025 update: WHC was issued in June 2023 via the SSP alerts system
28.04.2025 update: WHC was issued in April 2023 via the SSP alerts system
28.04.2025 update: Theatres and Endoscopy and OPD are compliant with the NatSSIPs 8 sequential standards for major and minor procedures. All 8 elements as defined in the document are in place through the WHO checklist processes.

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28.04.2025 update: Revisions implemented into the PTHB Standing Orders.

28.04.2025 update: Change of schedule implemented in line with WG guidance and supply of vaccine. HPV vaccine in schools is now a single vaccine programme

28.04.2025 update: WHC implemented across all vaccination centres in PTHB, with 15 minute post vaccination observation period in place for all groups mentioned

28.04.2025 update: WHC implemented testing sites at Bronllys & Gungrog, Welshpool which closed March 2023. Mobile testing van supplied by WAST decommissioned in line with WG guidelines. Testing currently undertaken in line with clinical need

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28.04.2025 update: Programme implemented and progress reported.

28.04.2025 update: Complete and in place as part of regular monthly reporting to WG and Board via MMR and Board reports.

29.04.2025 update: PTHB has recently recruited an antimicrobial stewardship pharmacist to manage the Antimicrobial Stewardship Improvement plan, which captures the requirements of the WHC improvement goals and trajectories (informed by the National Action Plan). This plan, and associated actions, is updated and presented quarterly to the PTHB antimicrobial stewardship group, chaired by the Chief Pharmacist, with representation from all relevant stakeholders, that reports to the IPC Group.

29.04.2025 update: Incident management framework in place to align to the requirements, published 2023

29.04.2025 update: Monitored and compliant through Implementation framework aligned to the Quality & Engagement act, namely Duty of Quality and Duty of Candour.

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May 2025: Service groups have confirmed they do not carry out any of the procedures listed

February 2025 update: Noting context of PTHB with in reach service provision, small teams, diagnostics/OP only no treatment pathways with MDT taking place outside PTHB. Powys Provider USC pathways are managed in accordance with the updated WHC guidance, enhanced tracking in place for PTHB with appropriate feedback/communications to referrers/patients which will be further developed as clinical model/MDT in PTHB expands. PTHB cancer performance is managed assured through the PTHB Integrated Performance Framework with regular reporting to Board. The PTHB Commissioned Services Performance reporting/assurance framework is also being developed accordingly.

September 2024. In a meeting of the Powys Blood Transfusion group chaired by the Medical Director relevant staff in the Health Board including colleagues in the Workforce Directorate and the Community Services Directorate were made aware of this opportunity for non-medically registered clinical staff to become qualified to authorise a blood transfusion. At this time however there is no immediate case for our staff to undertake this training. It will remain however an option for the future.

January 2024 needs MDT discussion with Clinical Execs CR/CM/KW

September 2024. No direct involvement of the Medical Directorate in this programme.

January 2024 NatSSIPs are in place in OPD – completed NatSSIPs in Theatres are currently being reviewed by the clinical leadership team this will complete in early Q1 2024/5

January 2024 NatSSIPs are in place in OPD – completed. NatSSIPs in Theatres are currently being reviewed by the clinical leadership team this will complete in early Q1 2024/5

September 2024. complete

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January 2024 needs MDT discussion with Clinical Execs CR/CM/KW

January 2024 needs MDT discussion with Clinical Execs CR/CM/KW

September 2024. Unclear whether the Medical Director has a specific role in what is primarily a Workforce Directorate Issue

29.08.2024 - This WHC has now been **SUPERCEDED** by **WHC 2024 031**. Responsibility for reporting against this sits with the Variable Pay Reduction Group which is Chaired by Pete Hopgood.

23-09-2024 - Services use ONS and Register of Geographic Codes (RGC).

This WHC will remain applicable until replaced by the next iteration in 2025.

shared with staff (we have added it to the intranet: PTHB Staff Flu and COVID Clinics WC 16th and 23rd December).

The principles and processes described in this guidance apply to all aseptic preparation of medicinal products in NHS pharmacy aseptic facilities in Wales, other than those products manufactured under an MHRA authorisation. The guidance therefore applies to all NHS pharmacy aseptic facilities undertaking preparation of sterile medicinal products under the Section 10 exemption.

PTHB does not have any aseptic facilities where aseptic products are prepared under the Section 10 exemption. This WHC is therefore not relevant to PTHB.

Aseptic preparation is defined as: reconstitution of an injectable medicine or any other aseptic manipulation when undertaken within NHS aseptic facilities to produce a labelled ready-to-administer presentation of a medicine, in accordance with a prescription provided by a practitioner, for a specific patient. Reconstitution of injectable medicines in clinical areas is out of scope of this guidance.

Aseptic preparation is defined as: reconstitution of an injectable medicine or any other aseptic manipulation when undertaken within NHS aseptic facilities to produce a labelled ready-to-administer presentation of a medicine, in accordance with a prescription provided by a practitioner, for a specific patient. Reconstitution of

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 WHC 2024_006 - National Clinical Guidelin	
 WHC_2024_017 Implementation of Non-pay El	
 WHC 2024 013 - Governance on interim appo	
 WHC 2024 022 - Dispute Arbitration Proces	
 WHC 2024 026 - 202425 LHB, SHA & Trust Mo	

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 WHC 2024 029 - Certification of Vision I	
 WHC 2024 027 - All Wales Critical Care Es	
 WHC 2024 031 - Agency workforce reduction	
 WHC 2024 037 winter-respiratory-framework	
 WHC 2024 020 - New treatment fund directi	

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 WHC 2024 007 - Guidelines for managing pa	
 WHC 2024 036PHD - Final - Welsh Health Oxygen Cylinders - Reg  WHC 2023 039 -	
 WHC 2024 039 - Pre-Transfusion Sample Com	

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 WHC 2024 043 - Pertussis Vaccine for Heal	
 WHC 2024 045 - Spotting Sepsis in Childre	
 WHC 2024 046 - Influenza (flu) Vaccinatio	

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WHC 2024 021 -
Welcome to Wales - Policy



WHC 2024 047 -
COVID-19 Spring Programme

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 WHC 2024 033 - The Winter Respiratory Pro  Adobe Acrobat Document	
 WHC 2025 001 - Welsh Health Circular - NH	

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 WHC 2024 027 - All Wales Critical Care Es	
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 WHC 2024 036 - Oxygen Cylinders - Reg 28	
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 WHC 2024 046 - Influenza (flu) Vaccinatio Powell Bethan 08/05/2025 16:00:41	

 WHC 2024 047 - COVID-19 Spring Programme	
 WHC 2024 033 - The Winter Respiratory Pro	
 WHC 2024 001 - Changes to accessing LFT a	
 WHC 2023 018 - Introduction of HL7 FH IP a	

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 WHC 2023 036 - Speaking up Safely Framewo	
 WHC 2023 019 - Support of prevention of s	
 WHC 2023 011 - NICE Guidance on Self-harm	
 WHC 2023 030 - National Safety Standards	

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 WHC 2023 015 - COVID-19 Vaccination Obvers	
 WHC 2023 007 - Patient Testing Framework	

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 WHC 2023 012 - 2023/24 LHB, SHA and Trust	
 WHC 2023 031- AMR & HCAI IMPROVEMENT GOAL	
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 WHC 2023 013 - Health and Care Quality St	

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 WHC 2023 046 - All-Wales Control Framework	
 WHC 2024 014 introducing-ons-geographic-c	
 WHC 2024 038 - AMR and HCAI Improvement G	
 WHC 2024 033 - The Winter Respiratory Pro	
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Appendix 3 - MD’s currently outstanding (not

WHC No.	Name of WHC	Date Issued	Date received	Date Circulated (PTHB - Internal)
WG24-01	Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05.01.2024		
WG24-02	The National Health Service (Wales Eye Care Services) (Wales) Directions 2024	05.01.2024		

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WG-24-17	Managed Introduction of New Medicines into the NHS in Wales directions 2009 (amendment Wales Directions 2024)	29.04.2024	18.02.2025	
WG-24-39	The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024	27.08.2024	18.02.2025	

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t yet due, partially complete and no progress)

Overarching Actions Required

Each Local Health Board must prepare, for its area, an administrative list.(2) Subject to paragraph (3), the administrative list must consist of a list of the qualified practitioners who provide or assist in the provision of ophthalmic services and must contain the following information—

(a) the qualified practitioner's full name; (b) the qualified practitioner's professional registration number; (c) the date of the qualified practitioner's first registration in the register;

(d) the date that the qualified practitioner's name was first included in the administrative list; (e) the ophthalmic services that the qualified practitioner provides or assists with.

(3) A Local Health Board is not required to include in an administrative list information about qualified (1) 2016 No. 11 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. (2) 2016 No. 10 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. practitioners who are already included in a combined list prepared and published by that Local Health Board under regulations 10(1) and 11(1) of the 2023 Regulations.

(4) Each Local Health Board must publish its administrative list and make a copy available for inspection at— (a) its offices, and (b) any other place in its area it considers appropriate.

(5) Each Local Health Board must— (a) send a copy of its administrative list to the relevant Local Medical Committee and the relevant Local Optical Committee, and (b) at intervals of not more than 3 months, notify each of them of any alteration made in that list

) The Eye Health Examination Service Committee (Wales) Directions 2016(2) are amended as follows. (2) In paragraph 1.1 of Schedule 1 (interpretation), at the appropriate places insert—“2023 Regulations” means the National Health Service (Ophthalmic Services) (Wales) Regulations 2023(3);“the Act” means the National Health Service (Wales) Act 2006;“the administrative list” means the administrative list prepared and published by a Local Health Board in accordance with the Wales Eye Care Services (Administrative List) (Wales) Directions 2024(1);“;

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The 2003 Directions are amended in accordance with subparagraph (2).
(2) After paragraph 2B(2) insert—“(3) The requirement in paragraph 2 to make a healthcare intervention available within a 2 month implementation period will not apply if one or more of the following circumstances apply—
(a) NICE extends the implementation period as confirmed in the Final Appraisal Determination, or
(b) the Welsh Ministers make a determination to extend the implementation period.
(4) If one of the circumstances listed in paragraph 2B(3) apply, the usual 2 month implementation period for introduction of the health care intervention will be replaced with the extended period recommended by NICE or the Welsh Ministers.”

Amendment of the 2009 Directions

3.—(1) The 2009 Directions are amended in accordance with subparagraph (2).

(2) After paragraph 2A(2) insert -

The requirement in paragraph 2 to make a medicine available within a 2 month implementation period will not apply if one or more of the following circumstances apply—

- (a) AWMMSG has recommended the implementation period is extended, or
- (b) the Welsh Ministers make a determination to extend the implementation period.
- (4) If one of the circumstances listed in paragraph 2A(3) apply, the usual 2 month implementation period for introduction of the medicine will be replaced with the extended period recommended by AWMMSG or the Welsh Ministers.”

Each Local Health Board and each NHS Trust must exercise its functions in accordance with the relevant provisions of the National Framework for the Commissioning of Care and Support in Wales: Code of Practice, which was issued by the Welsh Ministers on 24 July 2024 and which came into force on 1 September 2024.

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Lead Executive	Expected Date of Completion	Status
Director of Primary Care	N/A	Partially Complete
Director of Primary Care, Community and Mental Health	N/A	Partially Complete

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Medical Director	Immediate	Partially Complete
Diretor of Planning, Performance and Commissioning	Immediate	Partially Complete

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Comments

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February 2024 - enhanced optometry services (WGOS3 and WGOS5 IPOS Urgent) have been established, arranging and accredited practitioner lists are held by NWSSP. WGOS4 is yet to be established nationally and will require the same process once launched.

Jan 2025 - Lead Exc changed . Re assigned to Primary Care.

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May 2025: Confirmed almost complete, cheking with colleagues for confirmation from commissioning perspective

April 2025 – the code applies to the commissioning of care and support – examples include provision of a care home service in the context of CHC or provision of any care and support by Health Boards or Trusts in context of funded nursing care; and also includes any formal partnership arrangements including arrangements between NHS bodies and Local Authorities for collaborative, joint or integrated commissioning arrangements. Further update required within PTHB re CHC and funded nursing car; update requesting from Powys County Council on progress in implementing the Framework.

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Appendix 4 - MDs completed since the last re

WHC No.	Name of WHC	Date Issued	Date received	Date Circulated (PTHB - Internal)
1MD	Our programme for transforming and modernising planned care and reducing waiting lists in Wales	26.04.2022		
WG24-06	NATIONAL HEALTH SERVICE, WALES The National Health Service Joint Commissioning Committee (Wales)	06.02.2024		
WG-24-09	The National Health Service (Wales Eye Care Services) (Wales) (No. 2) Directions 2024	28.03.2024	18.02.2025	
WG-24-10 (amendment to WG-24-04)	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024	18.04.2024	18.02.2025	

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WG-24-20	The Primary Medical Services (Directed Supplementary Services) (Wales) Directions 2024	13.06.2024	18.02.2025	
WG-24-21	The Primary Medical Services (Pertussis Immunisation for Pregnant and Post-natal Women) (Directed Supplementary Services) (Wales) Directions	12.06.2024	18.02.2025	
WG-24-22	The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Supplementary Services) (Wales) Directions 2024	12.06.2024	18.02.2025	
WG-24-23	The Primary Medical Services (Oral Anti-coagulation with Warfarin) (Directed Supplementary Service) (Wales) Directions 2024	12.06.2024	18.02.2025	

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WG-24-24	The Primary Medical Services (Hormone Treatment Scheme for Adult Transgender Patients) (Directed Supplementary Service) (Wales) Directions 2024	12.06.2024	18.02.2025	
WG-24-25	The Primary Medical Services (Antivirals for Prophylaxis of Seasonal Influenza in Care Home Outbreaks) (Directed Supplementary Service) (Wales) Directions 2024	12.06.2024	18.02.2025	
WG-24-26	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024	12.06.2024	18.02.2025	
WG-24-28	The Alternative Provider Medical Services (Wales) Directions 2024	01.07.2024	18.02.2025	
WG-24-38	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024	22.08.2024	18.02.2025	
WG-24-42	The Pharmaceutical Services (Clinical Services) (Wales) (Amendment) Directions 2024	27.08.2024	18.02.2025	
WG-24-43 (amendment to WG-24-04 & WG-24-10)	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2024	09.10.2024	18.02.2025	

WG-24-26 (amendment to WG-24-04/ WG-24-10/ WG-24-43)	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) ~~Directions 2024~~	26.11.2024	18.02.2025	
WG-24-49	The Local Health Board Medical Services (Wales) Directions 2024	02.12.2024	18.02.2025	
WG-24-53	The Primary Medical Services (Complex Multi- Morbidity and Frailty) (Directed Supplementary Service) (Wales) Directions 2024	18.12.2024	18.02.2025	
WG-25-02	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	28.01.2025	18.02.2025	

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WG-25-05	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	30.01.2025	18.02.2025	
WG-25-06	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025	06.02.2025	18.02.2025	

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4MD	STATEMENT OF GENERAL OPHTHALMIC SERVICES REMUNERATION AND FEE DIRECTIONS	14.02.2025	18.02.2025	

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Overarching Actions Required

This plan sets out a number of clear priorities for action over the next four years. They focus on immediate actions to release capacity to enable the NHS to see and treat more people and some slightly longer-term actions which will continue to transform the service, in line with the vision set out in A Healthier Wales.

3.—(1) The Local Health Boards must jointly exercise the relevant functions from 1 April 2024.
(2) For the purpose of these Directions, the relevant functions are the planning, securing and commissioning of—
(a) specialised services for—
(i) cancer and blood disorders,

Eye services to be available in primary care. Each Local Health Board must prepare and publish, for its area, an eye health needs assessment in accordance with these Directions. An eye health needs assessment prepared in accordance with direction 4 must relate to all of WGOS 1–5 provided under arrangements made by the Local Health Board. The Local Health Boards must jointly exercise the functions in directions 8 to 12 in accordance with these Directions. The Local Health Boards must arrange for the preparation and publication of standard operating procedures in accordance with paragraphs (2) to (4). The Local Health Boards must consider, and if content approve, the annual budget plan prepared and submitted to the joint committee by the host NHS body in accordance with paragraph 8 of the Schedule. The Local Health

The title of these Directions is the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024.
(2) These Directions are given to Local Health Boards. They relate to the payments to be made by Local Health Boards to a GMS contractor under a GMS contract.
(3) These Directions are made on 18 April 2024 and come into force on 19 April 2024, and have effect from 1 April 2024.

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Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act (primary medical services) of providing primary medical services within its area, or securing the provision of such services within its area, by (as part of its discharge of those functions) establishing (if it has not already done so), operating and, as appropriate, revising the following schemes for its area—

(a) a Violent Patients Scheme, the underlying purpose of which is to ensure that there are sufficient arrangements in place to provide primary medical services to patients that have been subject to

(1) 2002 c.17

(2) 2014 c.7

(3) S.I. 2002/253

3 immediate removal from a patient list of a primary medical services contractor in its area because of an act or threat of violence;

(b) a Minor Surgery Scheme, the underlying purpose of which is to ensure that a wide range of minor surgical procedures are made available as part of the primary medical services provided within the Local Health Board's area;

(c) a Learning Disabilities Scheme, the underlying purpose of which is to deliver a health check to patients with learning disabilities to improve the quality of care provided through general medical services with the objective of the enhancement of the quality of life and the independence of those patients.

Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act of providing primary medical services within its area, or securing the provision of such services within its area, by (as part of its discharge of those functions) establishing (if it has not already done so), operating and, as appropriate, revising a Pertussis Immunisation for Pregnant and Post-natal Women Scheme, the underlying purpose of which is to extend the temporary programme of pertussis vaccination of pregnant and post-natal women in response to ongoing increased levels of pertussis activity

Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act of providing primary medical services within its area or securing the provision of such services in its area, by (as part of its discharge of those functions) establishing (if it has not already done so), operating and, as appropriate, revising a General Practice Influenza and Pneumococcal Immunisation Scheme, through GMS contractors, the underlying purpose of which is to ensure that patients in each Local Health Board's area who are at risk of influenza or pneumococcal infection are offered immunisation

Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act of providing primary medical services within its area, or securing the provision of such services within its area, by (as part of its discharge of those functions) establishing (if it has not already done so), operating and, as appropriate, revising an Oral Anti-coagulation with Warfarin Scheme (Level A) for its area, with those GMS contractors accredited to provide this service, the underlying purpose of which is to ensure that GMS contractors manage its patients with post-myocardial infarction, atrial fibrillation (AF), deep vein thrombosis and other disorders with warfarin

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. Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act (primary medical services) of providing primary medical services within its area or securing the provision of such services in its area. As part of its discharge of those functions each Local Health Board must establish (if it has not already done so), operate and, as appropriate, revise, a Hormone Treatment Scheme for Adult Transgender Patients. The underlying purpose of which is to ensure appropriate support for adult patients (aged 18 and over) who require ongoing hormonal therapy after the local gender care team have— (a) initiated and optimised a patient's hormone treatment, and ~~(b) completed the transfer of care document at Appendix D to the Specification~~
Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act (primary medical services) of providing primary medical services within its area or securing the provision of such services in its area. As part of its discharge of those functions each Local Health Board must establish (if it has not already done so), operate and, as appropriate, revise, a scheme ensuring the provision of antiviral prophylaxis for seasonal influenza to patients in care homes, through GMS contractors, in
Each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its functions under section 41 of the Act (primary medical services) of providing primary medical services within its area or securing the provision of such services in its area. As part of its discharge of those functions each Local Health Board must establish (if it has not already done so), operate and, as appropriate, revise a Type 2 Diabetes Mellitus Care Scheme for adults for its area, the underlying purpose of which is to ensure that GMS contractors monitor and ~~manage their patients in primary care with Type 2 Diabetes~~
Where a Local Health Board has entered into an APMS contract, before the coming into force of these Directions, which does not comply with these Directions it must, where it has power under that APMS contract to impose a variation of the APMS contract, exercise that power so as to ensure that the APMS contract is compatible with these Directions
Each Local Health Board must establish, operate and, as appropriate, revise a Scheme in accordance with these Directions and the relevant specification. (2) The underlying purpose of the Scheme is to enable the provision of services to administer RSV vaccinations and immunisations as part of the health service in Wales by dentists, general medical practitioners, opticians and NHS pharmacists. Primary Care Contracted Services: Immunisations Scheme for RSV: Each Local Health Board must enter into arrangements for the provision of services under the
Remove Seasonal Influenza Service from the Clinical Community Pharmacy Service (CCPS). Include Seasonal Influenza Service as a directed clinical service. Enable pharmacy technicians to deliver Seasonal Influenza Vaccination Service via patient group direction. This service change will start on 1 October 2024. Enable pharmacy technicians to deliver Contraception Services under Clinical Community Pharmacy Service (CCPS). This service change will be start on 1 February 2025
Contractors are to offer vaccines and immunisations in respect of the diseases listed in column 1 of Table 1 (whether or not there is any localised outbreak of any of the diseases mentioned in Chapter 4) to persons who do not intend to travel abroad and provide such immunisations in the circumstances set out in column 2 of that Table

The Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013(b) which came into force on 11 June 2013, as amended by Directions listed in Annex J of the Schedule to these Directions.

Where a Local Health Board wishes to provide primary medical services pursuant to section 41(2)(a) of the 2006 Act, it must establish one or more practices for this purpose and must in respect of each practice prepare a practice statement which must set out— (a) the services to be provided; (b) the address of each of the premises to be used for the provision of such services; (c) to whom the practice is to provide services, including, where appropriate, by reference to an area within which a person resident would be entitled to receive services from the practice;

Each Local Health Board is required under section 41 of the 2006 Act (primary medical services) to exercise its functions so as to provide, or secure the provision of, primary medical services within its area.

(2) As part of its discharge of those functions each Local Health Board must establish (if it has not already done so), operate and, as appropriate, revise a Complex Multi-Morbidity and Frailty Scheme.

(3) The underlying purpose of this Scheme is to support the identification of the top 0.5% high risk population to—

(a) increase pre-emptive, proactive and anticipatory care,

(b) decrease unplanned admissions, and

(c) decrease unplanned interventions.

Complex Multi-Morbidity and Frailty Scheme

4.—(1) As part of its Scheme, each Local Health Board must offer to enter into arrangements for the provision of services in accordance with the Complex Multi-Morbidity and Frailty Scheme Specification

Amendments to the General Dental Services Statement of Financial Entitlements 2. The Directions given by Welsh Ministers to Local Health Boards as to the General Dental Services Statement of Financial Entitlements(3), which came into force on 24 April 2009

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The Directions given by the Welsh Ministers to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements(3), which came into force on 24 April 2009, are amended as follows. Amendment to section 2

3. In section 2 (negotiated annual agreement values), for paragraph 2.10 substitute—

"2.10 The percentage determined by the Welsh Ministers for the financial year commencing on 1 April 2023 is 5%."

Amendment to section 7

4. Section 7 (payments in respect of vocational training) is amended as follows—

(a) in paragraph 7.2(c) (eligibility for payments in respect of vocational training), for "£3,084"

substitute "£3,416";

(b) in paragraph 7.4(c) (applications for payments under this section), for "£3,084" substitute "£3,416";

(c) in paragraph 7.5 (vocational training payments to be made)—

(i) in sub-paragraph (a), for "£1,010" substitute "£1,061";

(ii) in sub-paragraph (b), for "£3,084" substitute "£3,416"; and

(iii) in sub-paragraph (d), for "£5,982" substitute "£6,281"

All contractors will complete these 3 objectives (A, B and C) by the end of the QI period 31st March 2025:

A. At the start of the QI cycle, the practice clinical team will review practice-level Prescribing Safely data indicators (Listed at Annex A) and agree at least two themes for targeted improvement. These may be selected because:

- Indicators where the practice has the highest levels of prescribing;
- Indicators where the practice is furthest from the health board average prescribing levels; and/or
- Indicators where there is a high-risk of harm through errors in prescribing.

This selection should not include indicators covered in local prescribing incentive schemes.

B. Practices will undertake QI project activity designed to reduce rates of prescribing against each of the indicators under the identified themes.

This could include (but not be limited to):

- Using GP systems to identify possible prescribing issues;
- Inviting patients to surgery for review;
- Ensuring patients have appropriate tests for known side effects;
- Making arrangements for ongoing review; and
- Educational meetings with prescribers.

C. The practice clinical team will meet at the end of the QI cycle to review progress against the identified themes and to agree project outputs, including how learning

The Welsh Ministers, in exercise of the powers conferred by sections 12(3), 76, 77 and 203(9) and (10) of the National Health Service (Wales) Act 2006(1) ("the 2006 Act") make the following determination as to the remuneration to be paid to those providing general ophthalmic services and give the following directions in respect of the remuneration to be paid to those providing eye examination services under the National Health Service (Ophthalmic Services) (Wales) Regulations 2023 and other ~~for remuneration to those providing those services~~

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Lead Executive	Expected Date of Completion	Status
Director of Primary Care, Community and Mental Health	apr-26	Complete
Director of Planning, Performance and Commissioning Capital & Support Services/ Medical Director	N/A	Complete
Director of Primary Care, Community and Mental Health		Complete
Director of Finance, Capital and Support Services	Immediate	Complete

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Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Nursing, Quality, Women and Family Health	Immediate	Complete
Director of Public Health & Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Primary Care, Community and Mental Health	Immediate	Complete

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Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Primary Care, Community and Mental Health	Immediate	Complete
Director of Public Health & Director of Primary Care, Community and Mental Health	Immediate	Complete
Medical Director	Immediate	Complete
Director of Finance, Capital and Support Services & Director of Public Health	Immediate	Complete

Director of Primary Care, Community and Mental Health	01.04.2025	Complete
Director of Primary, Community Care and Mental Health		Complete
Director of Primary Care, Community and Mental Health		Complete
Director of Finance, Capital and Support Services/ Director of Primary Care, Community and Mental Health		Complete

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Director of Finance, Capital and Support Services/ Director of Primary Care, Community and Mental Health		Complete
Director of Finance, Capital and Support Services/ Director of Primary Care, Community and Mental Health	31.03.2025	Complete

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Director of Primary Care, Community and Mental Health		Complete

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Comments

March 2025 update: Planned Care Transformation Board in place with Exec leadership. Better Together Plan with Planned Care Transformation Priorities and Deliverables for 25/26 also incorporated into the IMTP with priority specialities ophthalmology & orthopaedics.

Planned Care Board in place within PTHB to oversee all service transformation reporting into IPR and informing IMPT. Planned care plans in place in line with GIRFT & NHS wales Planned Care Clinical Implementation Network objectives. Work on-going at regional level in terms of mutual aid

08.04.25 - This is under Primary Care - JCC established and actions taken accordingly so complete

UPDATE (March 2025) following CG audit: Eye Health Needs Assessment completed and approved by Eye Care Collaborative Group on **02/04/25**. To be submitted to Exec Committee 16/04/25 for onward submission to Eye Care Wales Committee on 28/04/25

April 2025 - Implemented and followed.

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UPDATE (March 2025) following CG audit: Appropriate arrangements in place on a pan powys basis

WG-24-21 – We offer pertussis vaccinations to all pregnant women in the antenatal period. Uptake is good. Completed.

UPDATE (March 2025) following CG audit: 100% of GP practices participated in the 24/25 influenza immunisation programme

UPDATE (March 2025) following CG audit: 100% of GP practices offer oral anticoagulation warfarin services

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UPDATE (March 2025) following CG audit: A number of practices signed up to offer the service when patients are discharged from the Local Gender team service

UPDATE (March 2025) following CG audit: 100% of GP practices offer this service when needed

UPDATE (March 2025) following CG audit: 100% of GP practices offer this service when needed

UPDATE (March 2025) following CG audit: APMS contract with Shropdoc for the delivery of GMS at Presteigne Medical Practice being transferred via a CVN to comply with the new directions

Six GP Practices opted in to participate in 'routine' RSV vaccination at age 75 years, commencing in September 2024, with patients of remaining practices offered through Health Board Vaccination Service. Catch-up programme being delivered through HB Vaccination Service and commenced in January 2025. Pregnant women being offered vaccination through midwifery service.

May 2025: is being managed nationally (I contribute to the national discussions that have led to this WHC) and we have adopted everything that has come out of national groups. Confirmed as complete.

Can I also check please is this solely to be responsibility of the Executive Director of Planning, Performance and Commissioning given the requirements around CHC and funded nursing care?

Completed by Bethan
09/05/2025 16:00:41

UPDATE (March 2025) complete

30.04.2025 update: This relates to the unified contract changes that were introduced as part of contract negotiations and has been fully implemented.

UPDATE (March 2025) following CG audit: Existing Community Resource Team and Virtual ward already in place delivering this service. Practice opportunity to identify new patients not being captured under existing arrangements

UPDATE (March 2025) following CG audit: Implemented and appropriate uplifts applied.
April 2025 - Implemented and followed.

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UPDATE (March 2025) following CG audit: Implemented and appropriate uplifts applied.
April 2025 - Implemented and followed.

UPDATE (March 2025) following CG audit: 100% of practices participating in QI projects. Practice submissions currently being received and will be reviewed in line with national timescales

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UPDATE (March 2025) following CG audit: Implemented and appropriate uplifts applied.

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WHC		
Transform	 Adobe Acrobat Document ing Planned	
 WG24-06 nhs-wales-joint-commissioning-com		
 WG-24-09_The-na tional-health-service-wale		
 WG-24-10_The-di rections-to-local-health-b		

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 WHC_2024 020 NTF Exemption May 2024 Engli	
 WG-24-21_The-pr imary-medical-services-per	
 WG-24-22_Primar y-medical-services-influen	
 WG-24-23_Primar y-medical-services-oral-an	

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 WG-24-24_Primary-medical-services-hormone	
 WG-24-25_Primary-medical-services-antivir	
 WG-24-26_Directi ons-to-local-health-board	
 WG-24-28_The-alt ernative-provider-medical	
 WG-24-38_Primary-care-contracted-services	
 WG-24-42_Pharm aceutical-Services-Clinical	
 WG-24-43_Directi ons-to-local-health-board	

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 WG-24-26_Primary-medical-services-type	 WHC 2023 039 - PMD - Final - Welsh Health	
 WG-24-49_Local-health-board-medical-se		
 WG-24-53_Directi ons-the-pms-complex-m		
 WG-24-53a_speci fication-complex-multi-n		
 WG-25-02_Directi ons-to-local-health-board		

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Powys Teaching
Health Board

Agenda item: 7.3

Audit, Risk and Assurance Committee		Date of Meeting: 13 May 2025	
Subject:	Audit, Risk and Assurance Committee Annual Report 2024/2025		
Presented & Approved by:	Director of Corporate Governance/Board Secretary		
Prepared by:	Deputy Board Secretary		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
The purpose of this report is to provide the Audit, Risk and Assurance Committee Report for 2024/2025.			
RECOMMENDATION(S):			
It is recommended that the Audit, Risk and Assurance Committee:			
• CONSIDER the Audit, Risk and Assurance Committee Annual Report for 2024/2025 summarising the key areas of business activity undertaken; • RECOMMEND the report to the Board for the 21 May 2025 meeting.			
Approve/Take Assurance		Discuss	Note
Y		Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	
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	

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1. Introduction

The Audit, Risk and Assurance Committee has been established by the Board in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

This report summarises the key areas of business activity undertaken by the Audit, Risk and assurance Committee over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

2. Roles and Responsibilities

The Terms of Reference for Committee were reviewed and agreed by the Board in March 2024.

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

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk managements arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

2.1 Membership of the Committee

The membership of the Committee during 2024/25 was:

Name	Role	Attendance
Steve Elliot	Independent Member and Chair of the Committee	5/5
Christopher Walsh	Independent Member	3/5
Ronnie Alexander	Independent Member	4/5
Rhobert Lewis	Independent Member (to October 2024)	3/3
Ian Thomas	Independent Member (from March 2025)	1/1

2.2 Others in Attendance

During 2024/25, the following staff attended the Committee:

Name	Role	Attendance
Pete Hopgood	Director of Finance, Capital and Support Services	5/5
Hayley Thomas	Chief Executive Officer	4/5
Carl Cooper	PTHB Chair	5/5
Helen Bushell	Director of Corporate Governance/Board Secretary	5/5

Other Directors and officers attended during the year to present reports which related to their areas of responsibility as required.

2.3 Meeting frequency

During 2024/25 the Committee met five times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held four times a year and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business. The Committee holds a planned additional meeting each year to review the Draft Annual Report and Account, this was held on 14 May 2024.

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3. Activity in 2024/25

3.1 Main Areas of Committee Activity 2024/25

ITEMS FOR ASSURANCE	
Internal Audit Update and Reports (as required)	Each Meeting
External Audit Update and Reports (as required)	Each Meeting
Counter Fraud Update and Reports (as required)	Each Meeting
Single Tender Waivers (including extensions to contracts) (as required)	Each Meeting
PTHB Draft Accountability Report and Financial Accounts	May 2024
Audit Recommendation Tracker	May 2024
Head of Internal Audit Opinion Draft	May 2024
Counter Fraud Annual Report 2023/24	May 2024
Single Tender Waivers Annual Report	May 2024
Single Tender Waivers (including extensions to contracts)	May 2024
Losses and Special Payments Annual Report	May 2024
Post Payment Verification Year End	May 2024
Risk Management Update	May 2024
Audit Wales ISA260 Audit Report including Letter of Representation	July 2024
Head of Internal Audit Opinion 2023/24	July 2024
Hosted Body annual report (HCRW)	July 2024
Confirmation of Clinical Audit Programme	July 2024
Confirmation Clinical Audit Programme in place	July and October 2024
Audit Recommendation Tracker	October 2024 and March 2025
Board Assurance Framework	October 2024
Losses and Special Payments	October 2024
Information Governance Performance Report	October 2024
Standards of Behaviour:	October 2024 and March 2025

• Declarations / Register of Interests Gifts and Hospitality	
Welsh Health Circular (WHC) Tracker	October 2024
Post Payment Verification Mid Year Report	January 2025
Records Management	January 2025
Financial Controls 2024/25	March 2025
Information Governance Performance Report	March 2025
Approach to the Annual Accounts	March 2025
ITEMS FOR APPROVAL / RECOMMENDATION TO THE BOARD	
Review of Standing Orders	May 2024
External Audit Plan 2024	May 2024
Annual Report and Accounts 2023-24, including: - the Performance Report; - the Accountability Report, including: - Corporate Governance Report - Remuneration and Staff Report - Parliamentary Accountability and Audit Report; - the Financial Statements 2023-24	July 2024
Enquiries of Management and those charged with Governance	
Internal Audit Annual Plan 2025/26	March 2025
External Audit Annual Plan 2025/26	March 2025
Review of Standing Orders and Standing Financial Instructions	March 2025
Counter Fraud Work Plan 2025/2026	March 2025
Audit Handbook	March 2025
Risk Management Framework	March 2025

ESCALATED ITEMS	
No items were escalated	
IN-COMMITTEE ITEMS	
No items were considered In-Committee	
CORPORATE GOVERNANCE	
Committee Annual Report	May 2024
Committee Work Programme	Each Meeting

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3.2 Work programme and action log

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

4. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2024/25, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report or that are already visible in the corporate risk register.

The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board. The reporting template was developed in year and made consistent across all committees.

5. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach balancing the need to reduce pressure on staff where possible, whilst ensuring the Committee fulfils its responsibilities.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key adaptations made this year included:

- The construct of the Committee meeting agendas remained flexible, and the application of a risk-based approach to the selection of agenda items.
- The use of the consent agenda where appropriate to ensure the timeliness of information to the Committee given the fast moving pace of some agenda areas.
- The introduction of circulation of final internal audit reports to members when received rather than with the papers to lessen the length of papers to be absorbed in the lead up to the Committee.

The Committee has undertaken its annual effectiveness review process. The outcome and recommendations following this review will be reported to the Board in May 2025.

-

6. Planned Activity in 2025/26

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme when it is presented to the Board in May 2025.

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Powys Teaching Health Board Glossary (April 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
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
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
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

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