Audit, Risk and Assurance Committee

Tuesday 7 July 2026, 10:00 - 13:00

Agenda

10:00 - 10:00
0 min

1. Preliminary Matters

Agenda_ARAC_ 07July2026.pdf (3 pages)

1.1. Welcome and Apologies

Verbal *Chair*

1.2. Declarations of Interest: Board Members Register of Interests 2026/27

ARA_1.2_June 2026_Board Members Declaration Of Interests summary 2026-27.pdf (3 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 / Decision / Ratification

3.1. Minutes of previous meeting held on 23 June 2026

Attached *Chair*

ARA_3.1_ARAC_Unconfirmed Minutes_23June2026 - FinalDraft.pdf (6 pages)

3.2. Committee Action Log

Attached *Chair*

ARA_3.2_Action Log.pdf (1 pages)

10:00 - 10:00
0 min

4. Escalated Items

There are no items for inclusion within this section.

10:00 - 10:00
0 min

5. Items for Assurance

5.1. Internal Audit Progress Report 2025/26

Attached *Head of Internal Audit*

ARA_5.1_Internal Audit Progress Report July 26 Cover.pdf (2 pages)
ARA_5.1a_Internal Audit Progress Report July 26.pdf (11 pages)

5.2. Internal Audit Reports: Budget Setting, Mortality Reviews

Attached *Head of Internal Audit*

ARA_5.2a_Budget Setting Final Internal Audit Report.pdf (10 pages)
ARA_5.2b_Mortality Reviews Final Internal Audit Report.pdf (12 pages)

5.3. External Audit Progress Report

Attached *External Audit*

- ARA_5.3_Audit Wales Audit Committee Update July 2026.pdf (11 pages)

5.4. External Audit Report: Urgent and Emergency Care (Arrangements for Managing Demand)

Attached *External Audit*

- ARA_5.4a_Urgent and Emergency Care Arrangements for Managing Demand.pdf (40 pages)

5.5. Audit Findings Tracker

Attached *Director of Corporate Governance*

- ARA_5.5_Audit Findings_Cover Paper_July2026 (1).pdf (15 pages)
- ARA_5.5a_Internal Audit Findings-Completed since the last report_July2026.pdf (4 pages)
- ARA_5.5b_Internal Audit Findings that are Not Yet Due for Implementation_July2026.pdf (1 pages)
- ARA_5.5c_Internal audit Findings that remain Overdue_July2026.pdf (4 pages)
- ARA_5.5d_Internal Audit Findings_Deadline Revised_July2026.pdf (1 pages)
- ARA_5.5e_External Audit Findings-Completed since the last report_July2026.pdf (10 pages)
- ARA_5.5f_External Audit Findings that are Overdue_July2026.pdf (2 pages)
- ARA_5.5g_External Audit Findings_Deadline Revised_July2026.pdf (2 pages)
- ARA_5.5h_External Audit Findings that are Not Yet Due for Implementation_July2026.pdf (6 pages)

5.6. Information Governance and Records Management Annual Report

Attached *Director of Corporate Governance*

- ARA_5.6_Information Governance Annual Report April 2026- FINAL.pdf (18 pages)

5.7. Counter Fraud Update

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

- ARA_5.7_Counter Fraud_Cover Paper.pdf (2 pages)
- ARA_5.7a_Appendix 1 CF Update Report.pdf (3 pages)

5.8. Welsh Health Circular and Ministerial Directors Report

Attached *Director of Corporate Governance*

- ARA_5.8_Cover Paper_ WHCs and MDs Report_June2026 - New.pdf (6 pages)
- ARA_5.8a_Appendix 1 - WHC Outstanding Since Previous Report New.pdf (4 pages)
- ARA_5.8b_Appendix 2 - WHC Completed Since Previous Report New.pdf (2 pages)
- ARA_5.8c_Appendix 3 - Ministirial Directions Outstanding New.pdf (1 pages)

5.9. Organisational Register of Interests, Gifts and Hospitality

Attached *Director of Corporate Governance*

- ARA_5.9_Cover Report Board Members Delaration of Interests, Gifts & Hospitality.pdf (5 pages)
- ARA_5.9a_Declarations of Interest Board Members.pdf (2 pages)
- ARA_5.9b_Declarations of Interest-Budget Approver.pdf (5 pages)

5.10. Committee Governance Action Plan

Attached *Director of Corporate Governance*

- ARA_5.10_Governance Development Plan 2025-27_Cover paper.pdf (2 pages)
- ARA_5.10a_Committee Effectiveness Continuous Development Plan 2026-27.pdf (2 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. Committee Risk Register Update

Attached *Director of Corporate Governance*

ARA_7.1_Committee Risk Register.pdf (2 pages)

7.2. Confirmation of Clinical Audit Programme

Attached *Executive Medica Director*

ARA_7.2_Confirmation of Clinical Audit Programme.pdf (3 pages)
ARA_7.2a_Clinical Audit Programme 2026-2027 Appendix A.pdf (21 pages)

7.3. Single Tender Waivers

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

ARA_7.3_Single Tender Waiver Report Jul 26.pdf (3 pages)

7.4. Committee Work Programme 2026/2027

Attached *Director of Corporate Governance*

ARA_7.4_Comittee Work Programme 2026-2027.pdf (1 pages)

7.5. PTHB Glossary

Attached *Director of Corporate Governance*

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

7.6. Internal Audit Reports: Standard of Behaviour

ARA_7.6_Standards of Behaviour Final Report.pdf (8 pages)

10:00 - 10:00
0 min

8. Other Matters

8.1. Any other urgent business

Verbal *Chair*

8.2. Items to be brought to the attention of the Board and/or other Committees

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of the next meeting: 06 October 2026 via Microsoft Teams

8.5. Confidential Matters

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Minutes of the Previous In-Committee Meeting held of the 12th May 2026

8.9. WCCIS Update

AUDIT, RISK AND ASSURANCE COMMITTEE
TUESDAY 07 JULY 2026
10:00-13:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT

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

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest • Board Members Register of Interests 2026/27	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 23 June 2026	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	4	**ESCALATED ITEMS**		
There are no items for inclusion within this section.				
	5	**ITEMS FOR ASSURANCE**		
10:10 10	5.1	Internal Audit Progress Report 2025/26	Attached	Head of Internal Audit
10:20 30	5.2	Internal Audit Reports: • Budget Setting • Mortality Reviews	Attached	Head of Internal Audit Ian Virgil Pete Hopgood Kate Wright
10:50 10	5.3	External Audit Progress Report	Attached	External Audit Bethan Hopkins
11:00 20	5.4	External Audit Reports: • Urgent and Emergency Care: Arrangements for Managing Demand	Attached	External Audit Bethan Hopkins Elaine Lorton
11:20 15	5.5	Audit Findings Tracker	Attached	Director of Corporate Governance
11:35	**COMFORT BREAK (10mins)**			
11:45 10	5.6	Information Governance and Records Management Annual Report	Attached	Director of Corporate Governance
11:55 10	5.7	Counter Fraud Update	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
12:05 10	5.8	Welsh Health Circular and Ministerial Directions Report	Attached	Director of Corporate Governance

12:15 10	5.9	Organisational Register of Interests, Gifts and Hospitality	Attached	Director of Corporate Governance
12:25 10	5.10	Committee Governance Action Plan	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Committee Risk Register Update	Attached	Director of Corporate Governance
	7.2	Confirmation of Clinical Audit Programme	Attached	Executive Medical Director
	7.3	Single Tender Waivers **Purpose:** For Information	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
	7.4	Committee Work Programme 2026/2027 **Purpose:** For Information	Attached	Director of Corporate Governance
	7.5	PTHB Glossary **Purpose:** For Information	Attached	Director of Corporate Governance
	7.6	Internal Audit Reports: (Substantial Assurance) • Standard of Behaviour	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
12:35	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: 06 October 2026 via Microsoft Teams		
8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
13:00	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declarations of Interest	Verbal	All
	8.8	Minutes of the previous in committee meeting held on the 12 May 2026	Attached	Director of Corporate Governance

13:1010	8.9	WCCIS Update	Attached	Executive Director of Allied Health Professions, Health Science and Digital

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

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

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

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

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2026-27

Updated: May 2026

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
INDEPENDENT MEMBERS							
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	Nil
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil
Vice Chair	**Rhiannon Beaumont-Wood**	Non Financial professional interests	Outside Employment	Jun-23	Ongoing	Director and Owner of RBW Executive and Professional Coaching	Salaried Employment
		Non Finanical personal interests	Loyalty Interests	Jun-24	31/03/2027	Registrant Council Member - Nursing and Midwifery Countil (NMC)	Renumerated as per Registrant Council Member Terms and Conditions
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL
Independent Member (finance)	**Stephen Elliot**	Non Financial professional interests	Loyalty Interests	17 April 2024	Current	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	NIL
		Non Financial professional interests	Outside Employment	04 February 2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	2012	Current	Partner Director of RA and CJ Consulting Limited	Dividend Payment only
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only
Independent Member (University)	**Simon Wright**	Non Financial professional interests	Loyalty Interests	23 January 2026	Current	Personal: Senior Professional Fellow, Cardiff University- Various Healthcare Programmes	Honoury Role
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment
		Non Financial professional interests	Loyalty Interests	02 January 2020	Ongoing	Labour Party member	NIL
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	Salaried Employment
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None
		Non Financial professional interests	Loyalty Interests	01 September 2024	01.06.2028	Coopted Member of PAVO	None
		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None
		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL
		Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL

Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel •Member of the Community Speed Watch Group	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL
Independent Member (Capital)	**Michael Giannasi**	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated
Independent Member	**Ian Thomas**	NIL	NIL	NIL	NIL	NIL	NIL
EXECUTIVE MEMBERS							
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18 June 2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07 January 2019	01-Apr-28	Occasional Lecturer for University of West of England.	Hourly rate
		Non Financial professional interests	Loyalty Interests	01 April 2026	01-Mar-28	Member of the The Chartered Society of Physiotherapy	NIL
Executive Medical Director	**Kate Wright**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of People and Culture and Transformation	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01 November 2024	01-Nov-27	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated
			Outside Employment	01 September 2025	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL
Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date).
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work
		Indirect Interests	Outside Employment	May-25	Current	Partner - Associate for Practice Solutions	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil

Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - West Wales Care and Repair	Voluntary
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil
		Indirect Interests	Outside Employment	Sep-23	15-May-26	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil
Executive Director of Nursing, Quality, Women and Family Health	**Paul Hooton**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	25/10/2025 Started with PTHB October 2025

AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC)

UNCONFIRMED MINUTES OF THE MEETING HELD ON 23 JUNE 2026 HELD VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ronnie Alexander	RA	Independent Member (General)
Rhiannon Beaumont-Wood	RBW	Independent Member (General)
Mick Giannassi	MG	Independent Member (General) (Vice Chair)
Rhobert Lewis	RL	Independent Member (General)
IN ATTENDANCE		
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Andrea Calise	AC	Internal Audit
Carl Cooper	CC	PTHB Chair
Bethan Hopkins	BH	Audit Wales
Phoebe James	PJ	Audit Wales
Beth Jones	BJ	Corporate Governance Officer
Mike Jones	MJ	Audit Wales
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Beth Powell	BP	Corporate Governance & Risk and Assurance Officer
Sarah Pritchard	SP	Assistant Director of Finance
Hywel Pullen	HP	Deputy Director of Finance (Deputising for Pete Hopgood)
Hayley Thomas	HT	Chief Executive
Ian Virgil	IV	Head of Internal Audit
APOLOGIES FOR ABSENCE:		
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Cathie Poynton	CP	Independent Members (General)
Paul Stocker	PS	Audit Wales
Ian Thomas	IT	Independent Members (General)
Laura Tovey	LT	Audit Wales
Chris Walsh	CW	Independent Member (General)

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/26/026)

As the Chair experienced technical difficulties which prevented them from chairing the meeting, the Vice Chair (MG) assumed the role of Chair. Attendees were welcomed and apologies for absence were received and recorded as noted above.

1.2 DECLARATIONS OF INTEREST (ARA/26/027)

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

HB noted a declaration on behalf of all Board and Executive Members in relation to the information presented within the PTHB Final Accountability Report and Financial Accounts (Item 3.3), specifically acknowledging the inclusion of remuneration disclosures pertaining to all Board members, including her own position. The Committee **NOTED** the declaration.

2. CONSENT AGENDA BUSINESS

No items were requested for inclusion in the main agenda.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (ARA/26/028)

The minutes of the meeting held on the 12 May 2026 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (ARA/26/029)

The Committee **RECEIVED** the Action Log, and the following updates were provided:

HB noted that four actions are currently reported as on track. Members were reminded that the update reflected a relatively short period since the previous meeting. Two actions were recommended for closure.

The Financial Grip and Control Point was included on the agenda and would be addressed as part of the internal audit update. the Regional Integration Fund follow-up had been shared with RBW. A discussion would take place to determine any necessary subsequent actions.

The Committee **ACCEPTED** the Action Log along with the recommendations contained within it.

3.3 PTHB FINAL ACCOUNTABILITY REPORT AND FINANCIAL ACCOUNTS (INCL ISA 260 AND LETTER OF REPRESENTATION) (ARA/26/030)

HB informed the Committee that revised documents had been issued to members late the previous afternoon due to a technical accounting issue which would be explained during this meeting.

HB advised that the draft Accountability Report was considered in May and following members feedback, had been updated to reflect members' comments.

It was confirmed that the Accountability Report comprises three key components: the Corporate Governance Report, the Remuneration and Staff Report, and the Parliamentary Accountability and Audit Report, all of which form important elements of the overall document. The Financial Statements represented the second component of the Annual Report.

HB expressed thanks to IV for his review from a Head of Internal Audit perspective and noted that Audit Wales and Welsh Government had undertaken a review. Minor comments were received and subsequently incorporated, particularly within the Remuneration Report. Thanks, were also extended to Welsh Government colleagues for their review and feedback.

HB confirmed that all comments had been incorporated into the documents presented. It was noted that the preparation of the report represents a significant cross-organisational effort involving multiple teams, including Corporate Governance, Workforce, Finance, Estates and Performance. HB expressed thanks to all those involved for their contributions.

HT thanked HB and acknowledged the significant effort across teams and partners in preparing the report. HT set out her position as Accountable Officer, and confirmed that, based on review and consideration of earlier drafts and wider assurances, she was satisfied that the report and supporting arrangements were robust.

Committee Members noted that, while the report was accurate and supported sign-off, the narrative could better integrate performance achievements of the underlying financial position to reflect affordability and sustainability challenges. This was considered important given the scrutiny associated with the organisation's escalation status.

HT welcomed the observations made and noted the importance of ensuring that the report presented a balanced reflection of the Board's decision-making and the balance between organisational performance and the financial challenges faced, particularly in the context of the Level 4 escalation. The Committee agreed that these decisions and trade-offs should be more explicitly articulated, particularly in the presentation of the report at the AGM, to ensure clarity of context and understanding.

RA noted the importance of maintaining an appropriate balance in the framing of the AGM discussion. He emphasised that, where there are grounds for confidence, the organisation should be clear in communicating its achievements. He cautioned against an overly negative framing and highlighted that considerable progress has been made, which should be acknowledged and communicated with confidence.

FINANCIAL ACCOUNTS

HP presented the financial accounts, noting no changes from those previously presented in draft to the Audit Committee in May. HP highlighted a technical adjustment involving a transfer of £11.073 million between the general fund and revaluation reserve, reflected within the statement of financial position. The adjustment related to the treatment of asset revaluations and impairments.

HP confirmed that this was the only change to the accounts and expressed his thanks to the finance team for their considerable work, particularly in relation to continuing healthcare accounting, as well as to Audit Wales for their constructive engagement in finalising the accounts.

MJ presented the external auditor's report (ISA 260), advising that:

- An unqualified "true and fair" opinion would be issued, alongside a qualified regularity opinion consistent with previous years due to failure to meet financial targets;
- One significant issue had been identified in relation to the accounting treatment of asset impairments, which had been addressed by management;
- One uncorrected misstatement of £2.4 million remains, which management has elected not to adjust in the current year. The auditor confirmed this would not prevent sign-off of the accounts;
- Subject to final review, the accounts were expected to be certified in line with the statutory deadline.

HB clarified that acceptance of the uncorrected misstatement formed part of the Committee's recommendation to the Board to approve the accounts.

The technical nature of the impairment issues was acknowledged, which arose in part from increased recent capital expenditure. The Committee agreed to monitor progress in addressing these matters and requested a future update on actions taken in response to the audit findings.

MG thanked the external auditors for their contribution and advised that, due to time constraints, the Committee would proceed to consider the recommendations. He confirmed that the Committee had reviewed and noted the contents of the report, including that the accounts had been subject to statutory external audit by Audit Wales. It was noted that the outstanding matter previously identified had now been satisfactorily resolved from an accounting perspective.

The Committee:

- **NOTED** the content of the report;
- **NOTED** the accounts have been subject to a statutory audit by Audit Wales (External Audit) with just one remaining area of Work on Property Plant and Equipment to be concluded
- **NOTED** the £2.4m uncorrected misstatement and **SUPPORTED** the decision not to amend the accounts, given the limited overall impact and the complexity of the adjustment process and;
- **RECOMMENDED** to the Board at its meeting on 24 June 2026 for approval and signature of the Annual Report and Financial Accounts for year ended 31 March 2026

4. ESCALATED ITEMS

There were no items for inclusion in this section.

5. ITEMS FOR ASSURANCE

5.1 ENQUIRIES OF MANAGEMENT AND THOSE CHARGED WITH GOVERNANCE (ARA/26/031)

MG confirmed that the Enquiries of Management and those Charged with Governance would be incorporated within the overall recommendation within the Accounts for subsequent submission to the Board for approval.

The Committee **RECEIVED** the Enquires of Management Report.

5.2 HEAD OF INTERNAL AUDIT OPINION FINAL 2025/26 (ARA/26/032)

IV confirmed the report was presented to the May Committee in draft form, and briefly outlined the key changes since that version.

It was noted that the overall Head of Internal Audit Opinion for 2025–26 remains **Reasonable Assurance**, consistent with the draft position.

At the time the draft report was presented in May, four audits had not progressed sufficiently to be included in the overall opinion for 2025–26. Of these, three have now reached at least draft report stage and have therefore been incorporated into the final opinion, bringing the total number of audits informing the 2025–26 opinion to 20. The remaining audit was still in progress and would inform the opinion for 2026–27.

The Committee **CONSIDERD** and **NOTED** the Head of Internal Audit Opinion Final and Annual Report for 2025/26.

5.3 INTERNAL AUDIT PROGRESS REPORT (ARA/26/033)

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

5.4 INTERNAL AUDIT REPORTS (ARA/26/034)

The Committee **RECEIVED** the following Internal Audit Reports:

- Budget Setting
- Mortality Reviews

Due to time constraints, the committee **AGREED** to defer both Internal Audit Reports to the next Committee meeting in July to allow for full consideration.

The Committee **NOTED** receipt of the reports.

6 ITEMS FOR DISCUSSION (ARA/26/035)

There were no items for discussion.

7 CONSENT AGENDA (ARA/26/036)

There were no items for inclusion within this section.

8 OTHER MATTERS

8.1 ANY OTHER BUSINESS (ARA/26/037)

No other business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (ARA/26/038)

No items were raised

8.3 COMMITTEE REFLECTIONS (ARA/26/039)

Feedback would be provided to HB outside of the meeting.

8.4 DATE OF NEXT MEETING (ARA/26/040)

07 July 2026 via Microsoft Teams

8.5 CONFIDENTIAL MATTERS

The following motion was passed:

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

Meeting closed at 10:04.

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- (07 JULY 2026)								
12-May-26	ARA/26/017	DoFC&SS	Single Tender Waiver	To confirm why was a contract specification and formal tender process not utilised, particularly if it was a recurring requirement	**23.06.26 update:** Currently awaiting a response from the Service. An update will be provided at the July meeting. **07.07.26 update** - verbal update will be produced during tne meeting.	Jul-26		On track
OPEN ACTIONS - NOT YET DUE (07 JULY 2026)								
12-May-26	ARA/26/004	DCG	Action Log	To discuss criteria for closure of actions within committee action logs at a Chairs Forum meeting	**23.06.26 update** - item has been added to the next Chair's Forum agenda in September, feedback will be provided following that meeting. **07.07.26 update** - action on track	Oct-26		On track
12-May-26	ARA/26/019	DCG	Policies and Written Controlled Documents	Executive Committee to review whether timescales for policy updates reflect the assessed level of risk due to higher-risk policies were not clearly prioritised within the current timelines, including the overdue Missing Persons Policy.	**23.06.26 update** - all lead Execuitve Directors have received follow up communciation on overdue policies for action, Executive Committee will review the position in September and report to ARAC in October 2026. **07.07.26 update** - action in place as above, next report will be produced in readiness for October Committee meeting to reflect actions.	Oct-26		On track
ACTIONS RECOMMENDED FOR CLOSURE (NONE)								
10-Mar-26	ARA/25/090	DCG	Internal Audit Annual Plan 2026/27	Produce a simple overview map showing all audit related assurance activity in one place including Grant Thornton work, and other relevant reviews. The summary would help the committee clearly see how assurance sources align and avoid duplication, providing greater collective reassurance.	**12.05.2026 update:** action on track for due date **23.06.26 update** - action on track for due date **07.07.26 update -** map produced and shared with Committee members. Map will be integrated into the Audit Committee handbook	Jul-26		Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 5.1

Audit, Risk and Assurance Committee	**07 July 2026**
Subject:	**Internal Audit Progress Report 2026/27**
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	Y	
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	N	

EXECUTIVE SUMMARY:

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

Two audit reports from the 2025/26 plan and one from the 2026/27 plan have been finalised, as follows:

- Mortality Reviews (Reasonable Assurance) (2025/26 plan)
- Budget Setting (Reasonable Assurance) (2025/26 plan)
- Standards of Behaviour (Substantial Assurance) (2026/27 plan)

The full copies of the reports are 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 2026/27 plan was formally approved by the Audit, Risk and Assurance Committee at its March 26 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
July 2026

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2026/27 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 2026/27 was agreed by the Audit, Risk & Assurance Committee in March 2026 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

Three audit reports from the 2025/26 plan have not yet been reviewed by the Committee, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2025/26. Two of the reports were previously submitted to the June meeting but were deferred due to a shortage of time available to review. They are detailed in the table below along with the allocated assurance ratings. The third report on Vaccine Storage is still to be finalised and will be submitted to a future meeting of the Committee

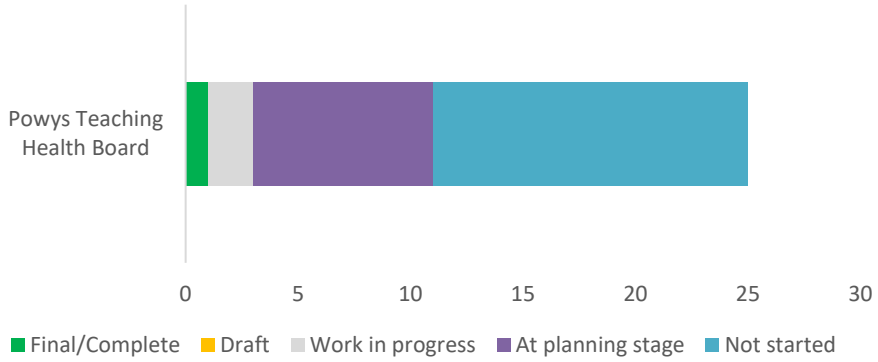
In addition, one audit from the 2026/27 plan has been finalised since the previous meeting of the committee and is also highlighted in the table below.

The full versions of the reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
2025/26 Opinion		
Mortality Reviews	Reasonable	
Budget Setting		
2026/27 Opinion		
Standards of Behaviour	Substantial	

3. Delivery of the 2026/27 Internal Audit Plan

There is a total of 25 reviews included within the 2026/27 Internal Audit Plan, and overall progress at this early stage of the year is summarised below.



The illustration shows that one audit has been finalised so far this year and two are currently work in progress, with a further eight audits at the planning stage.

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

Appendix A also includes details of one further audit from the 2025/26 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2025/26. The outcome from that audit will feed into the 2026/27 Opinion.

4. Changes to the 2026/27 Plan

- Regional Partnership Board Funding – The Assistant Director of Partnership Development requested that the timing of this audit is moved from Quarter 2 to Quarter 3 due to the requirement to focus on the implementation of the key agreed actions during Quarter 2.
- Site Co-ordination – The Associate Director of Capital, Estates and Support Services requested that the timing of this audit is moved from Quarter 1 to Quarter 3 due to the ongoing implementation of the site Co-ordination process.

5. Assurance on Recommendation Tracking

The Health Board's Internal Audit Action Tracker provides the Committee with information on the current progress that has been made towards the implementation of Internal Audit actions. The information within the Tracker is based on responses provided by Health Board management confirming the current progress.

Each year we undertake a process of reviewing a sample of the entries within the tracker, in order to validate the stated position and provide additional assurance to the Committee.

Our audit sample focused on the actions reported to the Committee through 2025/26 as complete. As part of our assurance process, we are required to review a minimum

of 50% of closed high priority actions and 10% of closed medium priority actions. From a total of 18 high priority and 43 medium priority actions reported as complete, we selected 9 high priority (54%) and 5 medium priority (12%) to form our sample. We then obtained evidence to establish if the actions were complete.

Sufficient information was identified as part of our testing to confirm that all of the sampled actions had been correctly recorded as complete.

The exercise has highlighted that the Committee can be assured that the progress information detailed within the Tracker for 2025/26 was accurate.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2025/26 Plan								
Learning Disabilities Eligibility Assessment & Care Co-ordination Processes	Review of the eligibility assessment and care co-ordination processes operating within the Learning Disabilities service.		Primary, Community Care and Mental Health	1		Work in Progress		October
2026/27 Plan								
Standards of Behaviour (Declarations of Interests, Gifts and Hospitality)	Review the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour, including declarations of interest and declarations of gifts, hospitality and sponsorship.	2	Corporate Governance	1		Final Report	Substantial	July
Follow-up: Digital Systems	Follow-up of 2025/26 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	16	Allied Health Professions, Health Sciences & Digital	1		Work in Progress		October
Capital Systems (Targeted Estates Fund)	To obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated funds.	8	Finance, Capital & Support Services	1		Planning		October
Point of Care Testing	Review the arrangements in place for point of care testing within GP Practices and how the Health Board is receiving oversight and assurance on these.	15	Allied Health Professions, Health Sciences & Digital	1		Planning – Draft brief issued		October
Care at Home Services	Review of the plans and processes in place to provide care within patient's homes to avoid admission to hospital. Covering the work of GPs, Primary Care Team, Community Care Teams and virtual wards, targeting high risk patients.	17	Primary, Community Care & Mental Health	1		Planning – Final brief issued		October

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Escalation Status Governance / Actions	Review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation action plan.	5	Finance, Capital & Support Services / Planning, Performance & Commissioning	2		Work in Progress		October
Service Level Business Continuity Plans	Review of the quality and robustness of plans in place within individual service areas to ensure continuity of service in the event of a loss of critical services.	14	Allied Health Professions, Health Sciences & Digital	2		Planning		October
Themes from Internal Audit Work	Potential advisory engagement providing analysis of the themes from Internal audits undertaken for the Health Board over previous years.	3	Corporate Governance	3				January
Core Financial Systems	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	6	Finance, Capital & Support Services	3		Planning		January
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22. To include review of Security Services.	10	Finance, Capital & Support Services	~~1~~	3	Planning – draft brief issued		January
Regional Partnership Board Funding	Review of how the Health Board is managing the risks associated with projects and posts that are funded via the RPB on a non-recurrent basis.	12	Public Health	~~2~~	3	Planning		January
Population Health Framework	Review how plans included within the Framework are integrated into the Health Board's Annual Planning process for 26/27 to support the shift to health promotion.	13	Public health	3				January
Agency Staff Usage	Review of controls in place around the use of non-ward based agency staff for AHPs, Medics and community nursing.	19	Primary, Community Care & Mental Health	3		Planning		January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Better Together Transformation Programme	Review of the first phase engagement, lessons learned and how they have informed planning for the second phase.	21	People & Culture	3				January
Internal Escalation Process	Review of the Health Board's Internal Escalation process to establish if the policy is fit for purpose and if it has been applied effectively.	25	Planning, Performance & Commissioning	3				January
Estates Assurance – Control of Contractors	Evaluate the processes and procedures that support the management and control of contractors working for the Health Board. Ensuring compliance with Right to Work requirements, Health & Safety Executive (HSE) and other associated legislation.	*7*	*Finance, Capital & Support Services*	3				*January*
Llandrindod Hospital Capital Project	To consider the governance, management and control arrangements being applied at the project with particular emphasis on the delivery of the project in accordance with the approved Business Justification Case requirements.	*9*	*Finance, Capital & Support Services*	3				*January*
Management of Medical Staff	Review of the processes around management of medical staff. Potentially covering medical staff induction / In-reach medical staff / consultant contract / Medical staff rostering / medical staff sickness, annual leave or study leave management.	*11*	*Medical*	3				*March*
Neuro Diversity Action Plan	Review of the Neuro Diversity service and the implementation of the action plan developed following the service being in local escalation. Potentially include review of the ongoing arrangements for monitoring and reporting of service delivery around waiting time targets and wider quality indicators.	*23*	*Nursing, Quality, Women & Family Health*	3				*March*
Delivery of actions from the External Review	Review of the processes for the development, delivery and reporting of the actions arising from the external review completed by Grant Thornton.	4	Finance, Capital & Support Services / Planning,	4				March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
			Performance & Commissioning					
MH and LD Triage and Assessment Process	Review phase 2 of the project covering the assessment of patients. Following on from audit of the phase 1 SPOA service in 25/26.	18	Primary, Community Care & Mental Health	4				March
Health & Safety	Review of the governance and oversight arrangements for Health & Safety following recent changes to arrangements, sub-committee structure and Executive responsibility.	20	People & Culture	4				March
Risk Management / Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance	4				May
Transition from Child to Adult Services	Review of the processes and controls around the transition from child into adult services, following completion of the Health Board's Transition Improvement Programme.	22	Nursing, Quality, Women & Family Health	4				May
Quality & Safety Governance	Review of the appropriateness and effectiveness of the Quality and Safety Governance arrangements within the Health Board, to ensure compliance with the Duty of Quality and Duty of Candour.	24	Nursing, Quality, Women & Family Health	4				May

Reviews removed from the plan

Assurance Opinions

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

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Budget setting

Final Internal Audit Report 2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-03
Fieldwork	January - May 2026
Executive Sign Off	9th June 2026
Audit Committee	July 2026
Executive Lead	Director of Finance, Capital & Support Services
Audit Team	Ian Virgill, Head of Internal Audit Andrea Calise, Audit Manager

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

Executive Summary

Purpose

The review of budget setting arrangements was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board'). The review set out to assess how the Health Board allocates resources to meet its agreed budget.

Overview

Under the NHS Finances (Wales) Act 2014, local health boards and NHS trusts have a statutory duty to prepare a three-year Integrated Medium Term Plan (IMTP), which is updated annually, that sets out how they will comply with their financial break-even duties over a rolling three-year period. The Well-being of Future Generations (Wales) Act 2015 set in law the need to consider the long-term strategic approach to deliver a better future including within financial planning and budget setting.

The Health Board was unable to develop a three-year plan that met the statutory break-even duty, and therefore an Annual Plan was developed for 2025/26 in line with the NHS Wales Planning Framework. The Annual Plan (2025/26) was discussed at the Board meeting in March 2025, prior to submission to Welsh Government. Noting the forecast underlying deficit of £38.4m, this plan could not be approved as the Health Board would not comply with its duty to achieve financial breakeven. A subsequent Accounting Officer letter was submitted to Welsh Government in May 2025 which confirmed actions to revise the financial forecast to a deficit of £28.3m.

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

- The Budgetary Control Procedure published in September 2021 has been overdue a review since September 2024.
- There is no mechanism to record or monitor the completion of budget holder training.
- Accountability Letters meet core delegation requirements but contain limited contextual information on the financial health of the Health Board. Testing also noted delays issuing and signing of letters.
- During 2025/26 savings schemes were at different stages of development at the point of budget setting, with evidence that schemes were still being identified and developed towards the end of the financial year.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

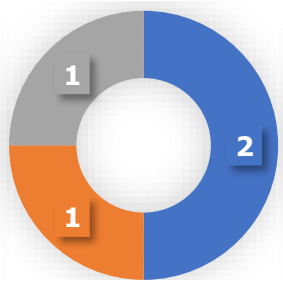
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The health board has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	1,4	**Reasonable**
2	There is clear and robust challenge of the Financial Plan, its assumptions, and associated risks by senior management, the Board and its committees, and Welsh Government.	-	**Substantial**
3	Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and the health board has sufficient internal resources, skills and systems to enable effective budget planning.	2	**Reasonable**
4	Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	3	**Reasonable**
5	Effective processes are in place within the Service Groups in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	4	**Reasonable**

Management Actions

0	4
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The health board has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	Reasonable

Overview / Summary of Observations

The Health Board has established a structured and comprehensive financial planning approach aligned to Welsh Government requirements, underpinned by a clearly defined planning cycle, formal governance arrangements and the use of nationally prescribed guidance and templates.

The 2025/26 Financial Plan was developed through an iterative process involving Board Development Sessions, Executive Committee scrutiny and Core Group input, demonstrating robust challenge and integration across finance, workforce, commissioning and operational planning. The process was explicitly aligned to organisational priorities through the themes of Risk, Recovery and Sustainability, reflecting both the Health Board's statutory duties and its Level 4 escalation status.

Recognising its significant underlying deficit, the Health Board was unable to submit a balanced and approvable Integrated Medium Term Plan (IMTP) and appropriately submitted an Annual Plan in line with Welsh Government guidance. The Plan demonstrates a clear understanding of the organisation's financial pressures, including commissioning costs, Continuing Healthcare growth and workforce expenditure, and is supported by detailed planning assumptions and scenario modelling to inform decision making and prioritisation.

The £28m forecast deficit within the Annual Plan included a significant savings requirement of £23m. We have noted within Finding 5 below that schemes were not fully developed to meet the required savings at the point that budgets were set. This creates additional pressure on the Health Board's ability to meet the forecast position, and at Month 12 the reported position was an overspend of £33m which is £5m higher than forecast.

While the financial planning framework is assessed as robust and operating effectively in design, we note that the Budgetary Control Procedure underpinning financial management is out of date. **(Key Finding 1)**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Budgetary Control procedure is out of date** The Health Board has developed a Budgetary Control Procedure which is intended to define roles, responsibilities, and the processes required to ensure effective financial management and budgetary control. The current procedure was issued in September 2021 and has a review date of September 2024. The document is now overdue for review	Inconsistency in the application of budgetary controls and reduced clarity over roles and responsibilities.	**Agreed Action:** A formal review of the Budgetary Control Procedure will be undertaken to ensure it remains current and continues to support effective financial management and governance arrangements. The procedure will be updated as required, approved through the appropriate governance route, and reissued to relevant staff. **Expected Evidence of Implementation:** • Updated and approved Budgetary Control Procedure document • Evidence of formal review and approval (e.g. committee/Board minutes)

		Medium Priority	**Officer:** Assistant Director of Finance **Target Implementation Date:** 31st *August 2026*
	Theme: Policies & Procedures	Control Operation	

Objective 2: There is clear and robust challenge of the Financial Plan, its assumptions, and associated risks by senior management, the Board and its committees, and Welsh Government.	**Substantial**

Overview / Summary of Observations

A comprehensive governance framework has been put in place to support the oversight, scrutiny and challenge of the Health Board's financial planning process. The development of the 2025/26 Annual Plan was subject to regular and structured engagement across multiple levels of the organisation, with defined roles for technical review, executive scrutiny and formal decision making. In particular, the Core Group functioned as the central coordination forum, enabling detailed testing and alignment of assumptions across finance, commissioning, workforce and performance prior to escalation.

Challenge was applied throughout the planning cycle via Executive Committee, Board Development sessions and formal Committee oversight, allowing key financial assumptions and risks to be tested and refined ahead of Board approval. This included scrutiny of affordability, savings delivery, commissioning demand and financial risks, with clear evidence that assumptions evolved in response to emerging information and external pressures. Scenario modelling further supported decision making by demonstrating the impact of different financial and demand assumptions.

Objective 3: Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and the health board has sufficient internal resources, skills and systems to enable effective budget planning.	**Reasonable**

Overview / Summary of Observations

Budget setting is underpinned by a centrally controlled, ledger driven model using Oracle financial data, ensuring that budgets are based on validated financial information. Access to core planning tools is appropriately restricted to senior Finance staff, reducing the risk of unauthorised amendment. Budget holders are not directly involved in constructing budgets but are engaged throughout the process via early discussions on financial assumptions and ongoing support from Finance Business Partners. Evidence from service areas indicates that this engagement is embedded in practice and valued by operational leads.

Formal training materials are available to support budget holders in understanding financial processes, governance and reporting requirements. However, there is no mechanism to record or monitor training completion, and therefore it is not possible to confirm whether all budget holders have received appropriate and up to date training. **(Key Finding 2)**

Key Findings		Risk & Impact	Agreed Management Action
2	**Budget holder training record** While the Health Board has developed a comprehensive training package for budget holders, there is no formal mechanism to record, monitor or evidence completion of training across the organisation. Training is currently delivered through a combination of circulated materials and ongoing support from Finance Business Partners; however, there is no central register capturing who has undertaken training, when it was completed, or when refresher training is required. As a result, the Health Board cannot demonstrate that all budget holders have received consistent and up to date training aligned to their responsibilities. This is particularly important given the organisation's financial position and the need to maintain strong financial control, governance and oversight across all service areas.	Budget holders do not have sufficient or up-to-date knowledge of financial processes, controls and responsibilities, which may lead to inconsistent application of financial procedures, weakened budgetary control	**Agreed Action:** A formal process to record and monitor budget holder training will be implemented, this will include the development of budget holder guides, online modules developed with the Finance Academy ensuring training coverage includes financial control, governance and savings delivery expectations, as well as the continuation of targeted support where needed by the Finance and procurement teams. **Expected Evidence of Implementation:** • Development of budget holder guides. • Centralised training register/log • Evidence of completed training (attendance records / system reports) • Updated training policy or guidance outlining requirements for budget holders • Communication or rollout plan of online modules and completion records.
		Medium Priority	**Officer:** Assistant Director of Finance **Target Implementation Date:** *31st March 2027*
	Theme: Finance Management & Control	Control Operation	

Objective 4: Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	Reasonable

Overview / Summary of Observations

Roles and responsibilities for the budget setting processes are set out within the Standing Financial Instructions (SFIs) and Scheme of Delegation, which together provide a clear framework for financial governance. These documents establish defined responsibilities for the Board, Chief Executive, Director of Finance and budget holders, and require formal delegation of budgets through written Accountability Letters.

Fieldwork interviews confirmed that these arrangements are understood and applied in practice, with Accountability Letters operating as the primary mechanism for confirming delegated financial responsibilities.

Testing found that whilst Accountability Letters meet core requirements for delegation and acceptance, they provide limited contextual information on the Health Board's wider financial position, savings requirements and key risks when compared to peer organisations. We also note that the timing of Accountability Letter sign-off, which occurs several months after the start of the financial year, does not align with the Budgetary Control procedure's expectations.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Accountability letters** Comparison of Powys Teaching Health Board Accountability Letters with those used by other NHS organisations (Swansea Bay UHB and Welsh Ambulance Services Trust) identified that, while Powys' letters clearly meet core requirements for formal budget delegation and acceptance, they contain less contextual narrative on the overall organisational financial position, savings expectations and key risks. No key elements of accountability or delegation were missing; differences relate primarily to style and level of contextual information. In addition, the Financial Control Procedure (FCP) sets out expectations for the timeliness of issuing and signing Accountability Letters, requiring that letters are issued within 28 days of Welsh Government agreement and formally signed within a further 28 days. A review of the budget allocation and accountability letter sign off process for the 2025/26 noted that in practice, the timing of sign-off may be influenced by operational considerations (such as waiting for funding confirmations), which may not align with the requirements of the procedure.	Budget holders may not fully understand how their budgets contribute to the Health Board's overall financial position, increasing the risk of inconsistent decision-making, weaker financial control and reduced ownership of cost pressures.	**Agreed Action:** The standard Accountability Letter template will be enhanced to include a brief, consistent section summarising the Health Board's overall financial position, high-level savings requirements and principal financial risks, to support greater transparency and shared understanding among budget holders. In addition, arrangements for issuing and signing Accountability Letters will be reviewed against the timeliness requirements set out in the Financial Control Procedure (FCP). **Expected Evidence of Implementation:** Evidence of an updated Accountability Letter template, including a standardised section summarising: • The Health Board's overall financial position; • High-level savings requirements; and • Principal financial risks. Completed Accountability Letters demonstrating consistent inclusion of this information across directorates. Documented review of the timeliness requirements within the Financial Control Procedure (FCP)

		Medium Priority	**Officer:** Assistant Director of Finance
	Theme: Finance Management & Control	Control Operation	**Target Implementation Date:** 30th June 2026

Objective 5: Effective processes are in place within the Service Groups in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	**Substantial**

Overview / Summary of Observations

Budgets are established at organisational level and then allocated to directorates and services, ensuring a consistent position across the Health Board. While budgets are not formally re-approved within service groups, discussions with budget holders confirmed that they are reviewed and understood prior to acceptance, supported by ongoing engagement with Finance. Accountability Letters provide the formal mechanism for confirming delegation and responsibility, with testing confirming they were issued, signed and aligned to the Financial Plan and financial system, demonstrating that budgets are appropriately communicated and understood.

Budget amendments during the year are managed through established virement processes, with sample testing confirming that changes are supported by a clear rationale, appropriately approved and accurately reflected in the ledger.

Review of Finance and Performance Committee papers throughout 2025/26 identified that not all saving's schemes were identified at the point budgets were set, with gaps in saving targets still requiring action towards the end of the financial year.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Development and Delivery of Savings Schemes** Savings targets are incorporated into the Financial Plan; however, evidence indicates that not all schemes are fully developed or deliverable at the point of budget setting. A gap in identified schemes persisted into the financial year (e.g. £4.8m at Month 7), with further risk that a proportion of schemes are non-recurrent. Audit Wales also highlighted within their Structured Assessment report that savings delivery was off track during the year, with a significant proportion of targets still requiring delivery in year. This reduces assurance over the achievability of the Financial Plan and increases reliance on reactive, in year measures rather than planned, sustainable savings.	Savings targets are not fully deliverable, leading to increased financial pressure, in-year deficits and reliance on short-term or non-recurrent measures, reducing the Health Board's ability to achieve sustainable financial balance.	**Agreed Action:** The financial planning process will be strengthened to ensure that savings schemes are developed, risk assessed and sufficiently detailed prior to inclusion in the Financial Plan, with clear delivery plans, ownership and timelines. Reporting will be enhanced to include clear visibility of delivery progress, including schemes at risk, gaps against target and mitigating actions. **Expected Evidence of Implementation:** Comprehensive savings plan with: • Fully developed schemes at start of year Clear RAG status and delivery profiling

			• Evidence of Executive / Committee review and challenge Regular reporting showing: • Actual savings delivered vs target Delivery risks and mitigations
		Medium Priority	**Officer:** Assistant Director of Finance **Target Implementation Date:** 31st *January 2027*
	Theme: Finance Management & Control	Control Operation	

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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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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Mortality Reviews

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-24
Fieldwork	January - May 2026
Executive Sign Off	8th June 2026
Audit Committee	June 2026
Executive Lead	Kate Wright, Medical Director
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for mortality reviews, including the processes for dealing with deaths that are referred to the Health Board by the Medical Examiner for further review.

In 2013 the Chief Medical Officer for NHS Wales recommended that all patients who die in a hospital in NHS Wales have a mortality review. The purpose of the reviews is to generate learning about the quality of care and treatment and to identify and act on any concerns in the post-Francis era of candour.

The Medical Examiner Service for Wales provides independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to His Majesty's Coroner.

The Medical Examiner Service was created because it was recognised that an independent scrutiny of a death, undertaken by a Medical Examiner, who is a qualified and trained doctor but who is independent of any care provided and the organisation who provided it, allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

The Medical Examiner Service for Wales has been operational and covering all areas of Wales since 1st January 2021, scrutinising deaths that have occurred both in hospital and in the community. However, the impact of COVID 19 meant that the capacity required to scrutinise all deaths in Wales not referred directly to a Coroner was not reached. The UK Government passed the required legislation for the scrutiny of all deaths not referred directly to a coroner by a medical examiner to be a legal requirement from September 2024.

Overview

We have concluded **Reasonable** assurance on this area. The core process for interacting with the Medical Examiner Service following a patient's death is generally functioning appropriately, although some elements of governance and application require strengthening to ensure the ongoing timeliness and effectiveness of the mortality review process.

The key matters requiring management attention include:

- An up-to-date approved policy is not in place, although work is in progress to rectify this.
- Further development of the Medical Examiner Service pages on the intranet is required.
- Deaths are not always promptly recorded on the Welsh Patient Administration System (WPAS).
- A review should be undertaken to determine the best mechanism to record and evidence panel reviews.
- Improvements are needed to the process for recording and evidencing responses to Medical Examiner Scrutiny Summaries received.
- Structured action regarding Medical Examiner Scrutiny Summaries is not up-to-date.
- An up-to-date Medical Examiner Service newsletter should be produced

Full details of matters arising are provided 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:

- The Medical Examiner Service contact details on the public website are for the Mid & West Wales region whereas the South Wales East region covers Powys.

Scope & Assurance Summary

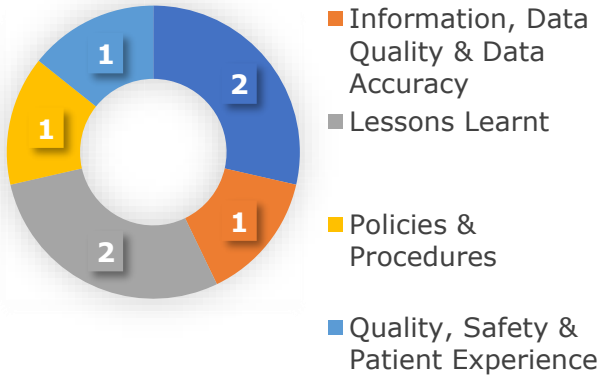
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place setting out the mortality reviews process and interaction with the Medical Examiner Service.	1, 2	**Reasonable**
2	Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death.	3	**Reasonable**
3	Cases referred by the Medical Examiner are subject to appropriate review within the Health Board.	4, 5, 6	**Limited**
4	Adequate review and reporting of the mortality review process is undertaken within Service Groups, with dissemination across the Service Groups and escalation to Health Board Committees to ensure lessons are learned.	7	**Reasonable**

Management Actions

1 High Priority

6 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Health Board has appropriate policies and procedures in place setting out the mortality reviews process and interaction with the Medical Examiner Service.	**Reasonable**

Overview / Summary of Observations

GNP 081 'Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals' (the "Policy") is the current approved policy in place in relation to the mortality reviews process and interaction with the Medical Examiner Service. This is included on the Policies intranet page but was issued in May 2023 and has passed its scheduled date for review. However, an updated policy, standard operating procedure and terms of reference have since been developed, although they have not undergone an approval process.

The current approved policy appropriately covers the process to be followed from the death of a patient through to providing information to the Medical Examiner Service. However, it does not cover how the Health Board should deal with Medical Examiner Service Scrutiny Summaries subsequently received, although this is covered within the other documents which have since been developed.

The intranet and public website generally include appropriate information regarding the Medical Examiner Service although a couple of areas of improvement were identified.

An online Lunch & Learn session was held in January 2026 where the Lead Medical Examiner for Wales presented information on the GP's role in the certification of deaths and compliance with statutory requirements which was recorded and is available on the intranet. Whilst we note that the number of attendees/views is a relatively low proportion of the number of Powys GPs at around 20%, the Health Board's Medical Director has confirmed that the Medical Examiner also carried out visits to the GP practices within Powys.

	Key Findings	Risk & Impact	Agreed Management Action
1	**An up-to-date approved policy is not in place** The current policy in relation to the mortality reviews process and interaction with the Medical Examiner Service, which is included on the policies intranet page, is overdue for review. Powell Bethan 07/07/2026 16:11:14	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** The policy in relation to the mortality reviews process and interaction with the Medical Examiner Service will be finalised, approved and added to the policies intranet page. **Expected Evidence of Implementation:** An up-to-date approved policy in relation to the mortality reviews process and interaction with the Medical Examiner Service is included on the policies intranet page.
		Medium Priority	**Officer:** Interim Head of Q&S **Target Implementation Date:** 31 July 2026
	Theme: Policies & Procedures	Control Operation	

2	**Medical Examiner Service Learn More section on the intranet** The Medical Examiner Service Learn More section on the intranet is currently empty.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** The Medical Examiner Service Learn More section on the intranet will be populated with appropriate information.
			Expected Evidence of Implementation: Copies of relevant information within the Medical Examiner Service Learn More section on the intranet.
		Medium Priority	**Officer:** Bereavement Clinical Lead
	Theme: Communication & Engagement	Control Operation	**Target Implementation Date:** 31 August 2026

Objective 2: Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death.	**Reasonable**

Overview / Summary of Observations

The process from death to providing information to the Medical Examiner Service is as follows:

- The death is initially input onto the Welsh Patient Administration System (WPAS) by the ward so that relevant staff are aware of the death.
- Medical and nursing notes and charts are scanned by the ward and provided to the Information Governance Team who submit them to the Medical Examiner Service via the secure portal email system in accordance with data protection Subject Access Request requirements.
- The Medical Examiner Service reviews the medical records and liaises with the doctor to agree completion of the Medical Certificate of Cause of Death (MCCD) which is then provided to the next of kin so that they can obtain a death certificate from the Registry Office.
- If the Medical Examiner choses to issue a Scrutiny Summary, this is sent to the Health Board's dedicated email address for the points identified to be followed up and appropriate action taken, which is recorded and managed via the mortality module of the RL Datix computer system.

The Health Board's Policy set's out internal timescales for the recording of deaths and provision of information, including input of the death onto WPAS within 1 hour. However, there are no external timeframe targets imposed by the Medical Examiner Service, NHS Wales or Welsh Government. Therefore, we have taken a reasonableness approach when considering the time taken from date of death to finalisation of the MCCD and a Medical Examiner Scrutiny Summary being issued.

We reviewed the WPAS report for all deaths recorded in 2025/26 which indicated that only 42% of the 208 deaths were recorded in WPAS within 1 calendar day, with the time taken to record the remainder set out in the key finding below. Whilst this highlights that deaths are not being consistently recorded within the required 1 hour stated within the Policy, information provided by the Information Governance Team indicated that there were only a small number of deaths where there was a delay in providing the medical history documentation to the Medical Examiner Service, with the length of these delays being minimal. This is also supported by the data recorded on the 'Medical Examiner Service: Health Board Ranking' dashboard, which identifies that the Health Board's time between date of death and provision of notes is 2.52 days.

We also reviewed the spread of deaths across the various wards which did not highlight any anomalies which required further investigation.

From our detailed testing of a sample of 12 deaths we identified the following:

- In all cases, a detailed patient medical history was provided to the Medical Examiner Service.
- The number of calendar days from death to the MCCD being issued was:

Number of calendar days	Proportion
0 – 7 days	7/12 deaths (58%)
8 – 14 days	3/12 deaths (25%)
15+ days	2/12 deaths (17%) 16 and 42 days respectively

However, as noted above, there are no external timeframe targets imposed on the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
3	**Deaths are not promptly recorded on WPAS** Only 42% of the 208 deaths in 2025/26 were recorded in WPAS within 1 calendar day, with the analysis of time taken being as follows: Whilst this is not causing a delay in the submission of notes to the Medical Examiner Service, it does highlight that deaths are not being consistently recorded on WPAS within the required 1 hour stipulated within the Health Board's policy.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** Wards will be reminded that all deaths should be promptly recorded in WPAS.
			Expected Evidence of Implementation: Deaths are promptly recorded in WPAS.
		Medium Priority	**Officer:** Interim Head of Q&S **Target Implementation Date:** 31 July 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Number of calendar days taken to record deaths in WPAS	%
< 1	42
1 – 4	39
5 – 7	2
7 – 14	4
14 – 21	4
> 21	9

Objective 3: Cases referred by the Medical Examiner are subject to appropriate review within the Health Board.	**Limited**

Overview / Summary of Observations

If the Medical Examiner Service choses to issue a Scrutiny Summary, this is sent to the Health Board's dedicated email address for appropriate action to be taken. This is recorded and managed via the mortality module of the RL Datix system which is a nationally prescribed system which Health Boards are expected to use to manage these cases.

The Bereavement Clinical Lead is responsible for initially reviewing the Medical Examiner Scrutiny Summaries received which are then dealt with in various ways according to the nature and severity of the points raised.

There are no external timeframe targets imposed by the Medical Examiner Service, NHS Wales or Welsh Government. Therefore, we have taken a reasonableness approach to the time taken to respond to points raised according to their nature and severity.

In addition to recording the reviews in the mortality module of the RL Datix system, a Learning from deaths panel dashboard spreadsheet in also used in relation to the panel reviews. However, this essentially duplicates the information recorded in Datix and our sample testing identified examples of data inconsistently recorded between them.

The Health Board is not required to send responses to the Medical Examiner Service. Action taken by the Health Board in response to points raised only needs to be communicated internally.

We obtained a report of all Medical Examiner Scrutiny Summaries received between 1 April 2025 and 15 January 2026 and, for a sample of 12, considered whether the evidence recorded in Datix and the Learning from deaths panel dashboard spreadsheet confirmed that appropriate action was taken regarding points raised in the Medical Examiner Service Scrutiny Summary and whether appropriate supporting documentation is filed within Datix. Findings were identified in 11 cases, which are summarised below.

Furthermore, no structured action has been taken regarding Medical Examiner Scrutiny Summaries received since 15 January 2026 due to staffing issues, although we have been informed by the Head of Professional Practice and Standards (Nursing) that the Assistant Medical Director has been informally reviewing them for serious / urgent matters that cannot wait.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Learning from deaths panel dashboard spreadsheet** In addition to recording the reviews in the mortality module of the RL Datix system, which is a nationally prescribed system which Health Boards are expected to use to manage these cases, a Learning from deaths panel dashboard spreadsheet in also used in relation to the panel reviews. However, this essentially duplicates the information recorded in Datix and our sample testing below identified examples of data inconsistently recorded between them or incompletely recorded in the Learning from deaths panel dashboard spreadsheet:	Threats to patient safety/opportunities to improve mortality rates are not adequately identified or addressed/implemented.	**Agreed Action:** The mortality module of the RL Datix system will be used as the primary mechanism to record and evidence action taken in response to Medical Examiner Scrutiny Summaries received and a review will be undertaken to determine the best mechanism to record and evidence the panel reviews.

	• In two cases, the action taken was not fully recorded in the Learning from deaths panel dashboard spreadsheet and in one further case it was not recorded at all in the spreadsheet. • In three cases, the review panel date in the Learning from deaths panel dashboard spreadsheet was blank and in one case, the date closed was blank.		**Expected Evidence of Implementation:** The mortality module of the RL Datix system is consistently used and an appropriate mechanism has been put in place to record and evidence the panel reviews.
		Medium Priority	**Officer:** Interim Head of Q&S / Bereavement Clinical Lead **Target Implementation Date:** 31 August 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	
5	**Responses to action points in Medical Examiner Scrutiny Summaries received** For a sample of Medical Examiner Scrutiny Summaries received between 1 April 2025 and 15 January 2026, we considered whether the evidence recorded in Datix and the Learning from deaths panel dashboard spreadsheet confirmed that appropriate action was taken regarding points raised in the Medical Examiner Service Scrutiny Summaries and whether appropriate supporting documentation is retained within Datix. The following findings were identified: • In two cases, a letter was sent out to follow up the points raised but a reply was not received and this was not followed up, and in one case, while follow up of the Medical Examiner points raised was initiated, an adequate response was only received six months later. • In three cases, the review panel date was after the date closed. • In one case, while it went to review panel which determined that further investigation was appropriate, it did not go a second time to consider the result of the investigation. • Datix included numerous cells where data was missing, and while we acknowledge that not all cells in this national system are mandatory, we consider that completeness of data in Datix cells is preferable.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** We will ensure that: • All required responses are obtained in a timely manner. • Cases will only be closed on Datix after the review panel has confirmed that this should occur. • Where a review panel has determined that further investigation is required, the case will be returned to the review panel to consider the result of the investigation. • Data is recorded in all cells in Datix.
			Expected Evidence of Implementation: Appropriate action is taken for all future cases, and this is fully recorded and evidenced within Datix.
		Medium Priority	**Officer:** Bereavement Clinical Lead **Target Implementation Date:** 30 September 2026
	Theme: Lessons Learnt	Control Operation	

6	**Structured action regarding Medical Examiner Scrutiny Summaries is not up to date** No structured action has been taken regarding Medical Examiner Scrutiny Summaries received since 15 January 2026 due to staffing issues, although we have been informed by the Head of Professional Practice and Standards (Nursing) that the Assistant Medical Director has been informally reviewing them for serious / urgent matters that cannot wait.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** Structured action regarding Medical Examiner Scrutiny Summaries will be brought up to date i.e. the points raised in the Medical Examiner Service Scrutiny Summaries will be fed back to staff for lessons to be learnt and Datix will be updated to record the points raised and the Health Board's responses to them. **Expected Evidence of Implementation:** Structured action is up to date and recorded in Datix for all Medical Examiner Scrutiny Summaries received.
		High Priority	**Officer:** Interim Head of Q&S / Bereavement Clinical Lead
	Theme: Lessons Learnt	Control Operation	**Target Implementation Date:** 31 July 2026

Objective 4: Adequate review and reporting of the mortality review process is undertaken within Service Groups, with dissemination across the Service Groups and escalation to Health Board Committees to ensure lessons are learned.	**Reasonable**

Overview / Summary of Observations

The Medical Examiner Service intranet page includes a Medical Examiner Newsletter which provides a detailed and comprehensive overview of ME reviews for April – October 2025 which includes numbers, themes identified and learning and improvement actions which was also disseminated via the Practice Managers Meeting. However, a subsequent newsletter covering the period from November 2025 has not been produced.

Medical Examiner slides have been presented at the Integrated Quality and Performance Group which provides coordinated oversight of service performance and comprises Executive representation from all areas of the Health Board.

Appropriate oversight information has also generally been presented to the Patient Experience, Quality and Safety (PEQS) Committee, although this has been impacted more recently by the staffing issues identified under objective 3.

	Key Findings	Risk & Impact	Agreed Management Action
7	**An up-to-date Medical Examiner Service newsletter should be produced** A Medical Examiner Service newsletter which includes numbers, themes identified and learning and improvement actions has only been produced up to October 2025.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** An up-to-date Medical Examiner Service newsletter from November 2025 onwards will be produced and disseminated. **Expected Evidence of Implementation:** Medical Examiner Service newsletters are produced and disseminated in a timely manner.
		Medium Priority	**Officer:** Bereavement Clinical Lead **Target Implementation Date:** 31 August 2026
	Theme: Communication & Engagement	Control Operation	

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.

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Archwilio Cymru
Audit Wales

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

Date issued: July 2026

Contents

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Introduction

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 May 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor 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.

Accounts audit update

Audit of the 2025-26 Health Charities Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive.
- **Focus of the work:** To provide an audit opinion on the 2025-26 Health Charities Annual Report and Accounts
- **Status:** Not yet started. Timetable for draft accounts and Audit certification to be agreed to meet the 31 January 2027 deadline.
- **Expected committee date:** to be confirmed

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive.
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning Commenced December 2025 and now complete. Interim work completed December 2025 to March 2026. Final Audit complete and Accounts Report taken to Board 24 June 2026. AGW issued opinion 26 June 2026 meeting WG deadline.
- **Expected committee date:** June 2026

Performance audit update

Review of arrangements for managing agency staff

- **Executive Lead:** Executive Director of People, Culture and Transformation
- **Focus of the work:** 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.
- **Status**: Draft report with the Health Board for clearance
- **Expected committee date:** October 2026

Review of urgent and emergency care

- **Executive Lead:** Executive Director of Primary, Community Care and Mental Health
- **Focus of the work:** This work has examined different aspects of the urgent and emergency care system and includes analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working.

  The work has examined the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1).

  We have also reviewed 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).
- **Status:** Part 1 – Reporting
- **Expected committee date:** Part 1 – July 2026, Part 2 October 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
- **Focus of the work:** This work 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.
- **Status:** Fieldwork
- **Expected committee date:** October 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations. It will also inform our thinking on whether to undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).
- **Status:** Planning
- **Expected committee date:** January 2027

Local work 2026 - Review of Workforce Planning Arrangements Follow Up

- **Executive Lead:** Executive Director of People, Culture and Transformation
- **Focus of the work:** This work will follow up our review of 2024 Review of Workforce Planning Arrangements. In doing so, we will examine progress made in the implementation of previous recommendations.
- **Status:** Scoping
- **Expected committee date:** January 2027

All-Wales thematic review of the management and prevention of diabetes

- **Executive Lead:** TBC
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.
- **Status:** Scoping
- **Expected committee date:** March 2027

Other relevant publications

Since the last committee update, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

NHS urgent and emergency care – a system under constant pressure	June 2026
NHS planned care – fit for the future?	June 2026

Since the last committee update, Audit Wales has also published the following corporate documents.

Strategic Equality Plan for 2026–2030	April 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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Audit Wales

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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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Audit Wales

Urgent and Emergency Care: Arrangements for Managing Demand – Powys Teaching Health Board

Date issued: March 2026

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Summary report

About this report

1 This report sets out the findings from the Auditor General's review of the arrangements for managing demand for urgent and emergency care at Powys Teaching Health Board (the Health Board). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, is reported separately.

2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system operates effectively and efficiently. The Welsh Government's Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our work, the urgent and emergency care system in Wales continued to be under significant pressure.

3 Our work has examined the Health Board's arrangements for managing the demand for urgent and emergency care to reduce unnecessary pressure on the system. It has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.

4 The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

Key facts and figures

Primary Care Services[1]	
759	Number of GP urgent and acute appointments[2] available per day per 100,000 head of GP population in December 2025 compared with the all-Wales average of 660. This is a decrease of 28% since December 2024.
954	Number of GP out-of-hours contacts per month per 100,000 head of GP population in July 2024 compared with an all-Wales average of 973.
0	Number of contacts at an Urgent Primary Care Centre (UPCC), compared with an all-Wales average of 433 per 100,000 head of GP population in March 2025.

Ambulance Services	
152%	Increase in Category A (red) ambulance calls between March 2019 and March 2025 compared with an all-Wales average of 159%.
47%	Category A (red) ambulance calls responded to within eight minutes in March 2025, compared with the all-Wales average of 50% and a national target of 65%. This is a reduction of 19% from March 2019.
10%	Patients handed over from ambulance crews to the emergency department within 15 minutes of arrival in March 2025, compared with the all-Wales average of 14% and a national target of 100%. This is a decrease of 80% from March 2019.

[1] The Health Board does not have Urgent Primary Care Centres as it has considered them impractical due to its rurality.

[2] Urgent and acute appointments are defined as appointments for urgent or acute conditions which have occurred over the short-term.

Hospital Services	
22%	Decrease in the number of attendances at the Health Board's Minor Injuries Departments between March 2019 and March 2025, compared with an all-Wales average decrease of 1%.
00:41	Average time spent in the Health Board's Emergency Departments in March 2025, compared with the all-Wales average of five hours, 27 minutes. This is a decrease of six minutes since March 2019.

Funding	
£18.1 million	Additional monies allocated to the Health Board for the period 2022-25 to recover planned and urgent and emergency care over and above the Health Board's core funding.
£1.7 million	Additional in-year monies received by the Health Board in 2023-24 and 2024-25 to support delivery of the ambitions of the Six Goals Programme.

Key messages

Overall conclusion

5 Overall, we found that **the Health Board plans services using comprehensive data, but further action is needed to improve access to alternative pathways, strengthen patient and staff engagement and clarify resource requirements.**

Key Findings

Planning Arrangements

6 The Health Board has used comprehensive information to inform its urgent and emergency care plans. Plans draw on data such as population needs and wellbeing assessments. This information has shaped the Health Board's clear strategic vision for a home-first approach and strengthened recovery, rehabilitation and reablement services. Plans recognise key risks affecting urgent and emergency care, though the Health Board could more clearly align these risks to the urgent and emergency care workstreams.

7 Whilst plans align with the Six Goals Programme and outline workstreams such as an Integrated Flow Hub and enhanced Minor Injuries Units, they remain high-level and do not describe how new pathways will operate. Plans also lack detail on workforce and training needs as well as how Six Goals funding will be used in-year and what future funding requirements are.

Accessing Services

8 There are some arrangements in place to encourage people to access appropriate care. For example, a useful Health Board website, social media campaigns, and navigation training to staff. However, there is limited analysis of whether this communication is effective in ensuring patients are accessing the correct services or reducing demand on emergency services. GP practices generally offer strong signposting, but dental practices provide limited guidance, contributing to high 111 demand for dental issues. Public awareness is not routinely evaluated, and the impact of communication initiatives is unclear.

9 Community pharmacies deliver enhanced services but face workforce and capacity constraints. Rising emergency demand and high-acuity presentations continue to place pressure on the system, though Minor Injury Units perform well and some preventative activity, such as falls work in care homes, are showing early signs of improvement.

Scrutiny and monitoring arrangements

10 Scrutiny and monitoring arrangements for demand management initiatives are variable. Health Board plans include measures and key deliverables which the

Health Board monitor through quarterly performance reports to Board and Committees. However, they do not routinely include specific detail on whether alternative clinical pathways are effective. Work to gather direct patient and staff feedback on service changes is also inconsistent. There are examples where scrutiny and monitoring of an alternative pathway have been successful such as the temporary service changes to Minor Injuries Unit opening times in autumn 2024. But the Health Board would benefit from a much stronger approach to monitoring the impact of arrangements. This should demonstrate whether clinical pathways are having the desired impact on managing urgent and emergency care demand.

11 The Health Board has integrated oversight of the Six Goals Programme into its existing governance processes. While the Board receives narrative updates against the actions to deliver the Six Goals Programme priorities, reports do not show the impact on demand or capacity. Although financial reports outline Six Goals Programme expenditure, they do not evaluate efficiency or effectiveness, and learning from pilots is not reflected in formal financial reporting.

Recommendations

12 **Exhibit 1** details the recommendations arising from our work. The Health Board's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Identifying future resources R1 The Health Board's plans should identify required levels of resource and staffing to achieve its Six Goals ambitions. This should include how the Health Board will manage any underspends or any future funding requirements and any workforce and training requirements (**Exhibit 2**).
Communication plans R2 The Health Board should develop a formal communication plan for Urgent and Emergency Care Services which sets out how the Health Board will communicate any service changes and alternative clinical pathways to staff and the public. This will ensure that patients are accessing the right care at the right time and help manage demand (**Paragraph 20**).

Recommendations

Signposting patients to dental services

R3 The Health Board should ensure dental practices provide clear and accessible information about urgent and emergency dental provision on their websites and phonelines (**Paragraph 25**).

Direct line referrals for WAST

R4 The Health Board should work with GPs to ensure WAST can access a direct line for referrals and queries into a patient's GP practice rather than having to use the main triage line (**Paragraph 41**).

Reporting data on access to services

R5 The Health Board should strengthen tracking and reporting data to show if patients are accessing services appropriately. This includes how alternative clinical pathways are reducing demand on emergency departments (**Exhibit 9).**

Use of patient feedback to inform plans

R6 The Health Board should demonstrate how it uses feedback from patients to inform and develop plans and activity to manage demand for urgent and emergency care services (**Exhibit 9**).

Staff feedback on impact of service changes

R7 The Health Board should introduce regular mechanisms for staff feedback to identify potential weaknesses or learning in relation to the provision of urgent and emergency care services. This should include feedback from key partners including primary care and WAST (**Exhibit 9**).

Oversight of urgent and emergency care at committee and board level

R8 The Health Board should ensure reports about Six Goals Programme activity are detailed enough to allow for scrutiny and oversight of urgent care performance including assurance on the effectiveness of plans and actions taken to better meet demand (**Exhibit 10**)

Recommendations

Oversight of economy, efficiency, and effectiveness of project investments

R9 To increase transparency and strengthen assurance that monies allocated to urgent and emergency care are being spent wisely, the Health Board should include information within regular finance reports to the Finance and Performance Committee to provide oversight whether investments provide value for money (**Exhibit 10**).

Planning arrangements

13 This section considers whether the Health Board has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:

- being informed by relevant and up to date information;
- identifying and seeking to address key risks associated with urgent and emergency care services;
- aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
- identifying the current and required levels of resource and staffing to achieve the intended ambitions.

14 We reviewed the Heath Board's plan to deliver the Six Goals for Urgent and Emergency Care Programme. The Health Board has integrated this within its Integrated Plan (2024-2029) and Annual Plans (2024-25 and 2025-26). This approach is different to other health boards which have a standalone Six Goals Plan.

15 We found that **plans are underpinned by strong data and understanding of the Powys population, however, they do not clearly set out the workforce and funding requirements or the detailed delivery structures necessary to achieve the intended ambitions for urgent and emergency care.**

16 The findings that have led us to this conclusion are summarised in **Exhibit 2**.

Exhibit 2: approach to planning urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Are plans informed by relevant and up-to-date information?	**Yes**	The Health Board's plans draw on population needs and wellbeing assessments, alongside insights from the 'Better Together' discovery phase[3]. These inform long-term transformation priorities within the Integrated Plan (2024–2029), which promotes a home-first approach with stronger recovery, rehabilitation and reablement services.

[3] The Health Board's 'Better Together' programme involved gathering insights and understanding challenges of the Powys population to inform transformation in the medium to longer term.

Audit question	Yes/ No/ Partially	Findings
		Plans contain demand and activity assumptions, which include a predicted rise in emergency activity. Plans also provide performance trajectories for provider and commissioned services against ministerial priorities.
Do plans seek to address key risks associated with urgent and emergency care services?	**Partially**	The Health Board's plans acknowledge the key risks affecting urgent and emergency care. For example, the reliance on other providers to provide emergency care services. The Integrated Plan (2024-29), and Annual Plan 2025-26, has a key area of delivery to expand community based urgent care to prevent hospital conveyance. Demand for dental services is also a key risk within the region, and the Annual Plan 2025-26 includes a long-term ambition to develop a Dental Collaborative with other stakeholders across Powys to deal with rising demand. The Health Board's Strategic Risk Register highlights overarching risks, including challenges in realising the benefits of transformation and pressures on primary care capacity, but the Health Board has not explicitly aligned these risks to the specific workstreams designed to improve urgent and emergency care services.
Do plans align with the requirements of the Six Goals for Urgent and Emergency Care Programme, and clearly set out how the alternative clinical pathways will work?	**Partially**	The Health Board's plans largely align with the requirements of the Six Goals Programme but do not clearly set out how alternative clinical pathways will work. The Integrated Plan (2024–2029) outlines how the Health Board will deliver the Six Goals Programme under 'Strategic Priority 9: Deliver the Six Goals Programme'. The Annual Plan (2025-26) reflects this under 'Strategic Priority 10: System Resilience'. A series of delivery plans and workstreams underpin the priorities, including developments such as an Integrated Flow Hub to improve clinician access and enhanced Minor Injuries Unit provision to support care closer to home. However, these delivery plans are high-level and do not set out how the new pathways will operate in practice.

Audit question	Yes/ No/ Partially	Findings
		The Six Goals Programme has set ambitions for health boards to establish Same Day Emergency Care (SDEC) units and Urgent Primary Care Centres (UPCCs) to help manage urgent and emergency care demand. As the Health Board does not provide acute surgical and medical care, SDEC units are not applicable, but UPPCs are. Due to rurality, the Health Board has decided not to set up UPCCs.
Do plans identify the current and required levels of resource and staffing to achieve the intended ambitions?	**Partially**	The Health Board was allocated £835,000 annually in 2023-24 and 2024-25 to support its delivery of the Six Goals Programme. The Executive Committee received an options paper at the end of 2024 outlining three potential levels of financial commitment for 2025-26. This paper offers a useful insight into how the Health Board intended to resource and staff its Six Goals ambitions. An additional £835,000 has been allocated for 2025-26. However, relevant information is not included in the Health Board's Annual Plan 2025-26 or the Integrated Plan (2024-29). Plans contain no information on whether the allocation is sufficient to achieve its workstreams, how the Health Board will manage any underspends, or any funding requirements in future years. Plans also lack any information on the workforce and training requirements. (**Recommendation 1**).

Source: Audit Wales

Accessing services

17 This section considers whether the Health Board has robust arrangements in place to encourage and enable people to access the right care, in the right place, at the right time, and whether these are working. We were specifically looking for evidence of:

- effective signposting of patients to the urgent and emergency care services that best meets their needs;
- staff having good knowledge of, and information on the range of services available to patients, and
- changes to service delivery resulting in improvements in access to urgent and emergency care services.

18 We found that **the Health Board signposts services, but activity is fragmented and it needs to widen pathway access. Despite strong performance within community pharmacy provision and access to minor injury units, urgent and emergency care performance remains challenging.**

Signposting of services to the public

19 We found that **the Health Board provides some useful information, but lacks a strategic communications plan, resulting in inconsistent signposting and limited assurance that public messages are effective.**

Communication plans

20 The Health Board does not have a communication plan which sets out how it ensures staff and patient awareness of how and when to access urgent and emergency care services **(Recommendation 2).**

21 The Health Board uses its social media and website to provide information about services across Powys including how to access them and opening times. The Health Board also works collaboratively at a local level to try to signpost the public to appropriate services. For example, the Powys Association for Voluntary Organisations (PAVO) are based in clusters across the Health Board. PAVO engage with the community to ensure people are aware of service changes and hold awareness days for certain conditions.

Public information

22 The first point of call for most patients with an urgent need may be their GP, and our review of available data suggests that, between April 2024 and December 2025, the Health Board's GP practices provided a higher level of urgent and acute appointments per day (875 appointments per day) than the all-Wales average (732 appointments per day) per 100,000 head of GP population. However, the rate has steadily deceased since December 2024. Furthermore, these are only available during the day, and in times of high demand and out of hours, patients need to be signposted to alternative services that may be better placed to meet their urgent care needs.

23 Our review of the Health Board's website found some useful information on urgent and emergency care services. The website has an accessible 'Help Us, Help You' section on the homepage. This provides links for a tool for skin rashes, information on the common ailments scheme and what urgent care services are on offer. The Health Board delivers its urgent care provision through ShropDoc[4] and Minor Injuries Units (MIUs). The website contains comprehensive information in relation to MIUs, including the updated opening hours introduced in November 2024, contact numbers and examples of conditions the MUIs can treat, as well as advising patients to phone first to ensure the units are the right setting for their need. There is advice on when to call 999 in an emergency, and the website also includes information on NHS 111, and the Mental Health '111, Press 2' service.

24 We also considered information available to the public via GP and dental practices to assess whether there was clear signposting for patients if they have urgent or emergency care needs out of hours. **Exhibit 3** sets out the results of this work, which reviewed the websites and out of hours answer phone messages of five GP practices and four dental practices[5].

[4] A collaborative of GPs providing urgent primary care services for patients across Powys.

[5] The sample included a mix of NHS and private dental practices.

Exhibit 3: results of the review of GP and dental practice information (October 2024)

Indicator	This Health Board	All-Wales position
% of GP practice websites with clear signposting	60.0	56.8
% of GP practice answerphone messages with clear signposting	100.0	89.5
% of dental practice websites with clear signposting	50.0	36.7
% of dental practice answerphone messages with clear signposting	25.0	86.7

Source: Audit Wales

25 All the GP practices we sampled provide strong signposting to urgent and emergency care, with all sampled phonelines and most websites offering clear information, performing slightly above the all-Wales position. Signposting through dental practices is much weaker. Only half of the sampled dental websites offered clear information, and two practices had no website at all. There was limited signposting via dental practice phonelines, with only a quarter offering clear guidance and some having no answerphone service. Whilst the Health Board has implemented some effective messaging via GP practices, much more work needs to be done to ensure clear signposting via dental practices, particularly via answerphones (**Recommendation 3)**.

26 Across Wales, between 450,000 – 500,000 people access the 111 website each month. The Health Board has a lower rate of 111 calls per 100,000 head of GP population, with 111 calls made by Health Board residents accounting for 3% of all calls in February 2024. The top five reasons for calls are set out in **Exhibit 4**.

Exhibit 4: top five reasons for calling 111 (February 2024)[6]

This Health Board	% of all calls	All-Wales position	% of all calls
Dental problems	14.8	Dental problems	4.1
Abdominal pain	3.5	Abdominal pain	2.4
Chest pain	1.9	Chest pain	1.6
Cough	1.6	Cough	1.4
Rash	1.4	Rash	1.0

Source: Ambulance Services Indicators

27 By far, the biggest reason for calling the 111 service in the Health Board area is for dental problems, with the percentage the second highest across Wales. This is despite data showing that the Health Board had the highest average number of dental contracts per 100,000 head of GP population (20.5) compared to the all-Wales average (14.7) during 2024-25. As discussed in **paragraph 25**, our sample of dental phonelines and websites showed that there is scope to strengthen public signposting to urgent dental care services.

28 Although Powys still has relatively high dental contract provision, the number of contracts fell from 24.1 in 2022–23 to 20.5 in 2024-25 because several practices closed. A Llais[7] update to the Board in May 2025 highlighted significant difficulties for residents in accessing NHS dentists, leading many to access private provision or face long waiting lists.

29 To increase capacity for unregistered patients, the Health Board introduced a temporary mobile dental unit at Bronllys Hospital in February 2025, operating five days a week. It actively promoted this service through its website and social media. This initiative has been popular with the public and the Health Board intend to add another mobile dental unit in Newtown. It is not clear whether these are intended as permanent fixtures. While this helps in the short term, the Health Board recognises that it needs a sustainable solution. Plans to develop a Dental Collaborative as set out in the Annual Plan 2025-26 however have a 'low' delivery confidence rating due to the Health Board's reliance on actions from external organisations.

[6] Due to ongoing issues with the new 111 system implemented in April 2024, there has been no data on the 111-service reported since February 2024.

[7] Llais is an independent statutory body set up by the Welsh Government to give the people of Wales a stronger voice in the planning and delivery of their health and social care services.

Patient awareness

30 The Health Board does not currently evaluate how effective its public communication is. This makes it difficult for the Health Board to assure itself that its messages are reaching the right audiences and effectively influencing how people choose and access urgent and emergency care services.

31 Primary care services recognise managing patient behaviour is important to prevent them accessing the wrong service for their condition, for example going to the GP for dental pain. One of the primary care cluster priorities for 2026-27 is a communications project to provide a patient handbook for better care navigation for their needs. This is helpful but should be part of a much more broad and strategic approach to communication planning.

Staff awareness and ability to refer

32 We found that **whilst some arrangements support staff awareness of community pathways, the Health Board needs to broaden access to alternative urgent care services and improve pathway communication.**

Promoting staff awareness of services

33 In the absence of a communications plan, it is not clear how the Health Board engages its staff on plans to manage demand for urgent and emergency care.

34 It does, however, provide mandatory training for new staff on care navigation, as well as training for Minor Injury Unit staff on urgent care provision. As of October 2025, the Health Board was reporting good compliance rates with mandatory and statutory training at 89% against a target of 85%.

35 The Welsh Ambulance Services NHS Trust (WAST) holds a directory of service for each health board area which has details of available referral pathways for urgent and emergency care. It is the responsibility of the Health Board to ensure that this directory is kept up to date with accurate information. The Health Board effectively supports this directory by providing monthly oversight and input to ensure the information is up-to-date and accurate. However, our review noted that this process is manual and depends on staff keeping up to date on new or evolving services and initiatives.

Referring to services

36 The Health Board consistently has a low rate of patients that call 999 dealt with through ‘consult and close’ over-the-phone advice or signposting, compared to the all-Wales average (10.3% compared with 15.1% in April 2024). Of those calls, the proportion directed to alternative services is also lower than the all-Wales average (62.9% compared with 72.9%).

37 The 111 service also directs a low proportion of patients to alternative services. **Exhibit 5** sets out the extent to which the 111 service has been able to direct patients away from emergency departments.

Exhibit 5: referral to other services (February 2024)

Indicator	This Health Board	All-Wales position
% of 111 calls referred to GP out of hours	39.9	41.0
% of 111 calls referred to another health profession	3.5	2.4
% of 111 calls referred to dental services	11.7	9.9

Source: DHCW Urgent and Emergency Care Dashboard, Ambulance Services Indicators

38 During 2023-24, the rate at which 111 staff referred patients to the Health Board's GP out-of-hours service was broadly in line with the all-Wales position. However, 111 staff have consistently referred higher proportions of calls to other health professionals and urgent dental services. This aligns with the data in **Exhibit 4** and shows a need to strengthen access to dental pathways.

39 In the same period, an average of 74 calls per month (4.8%) were downgraded by 999 and transferred to 111, indicating they were less urgent. However, of these calls, 32.3% were returned from 111 back to the 999 phoneline to be considered for an ambulance dispatch. This is higher than the all-Wales average of 27.6%. This suggests there is scope to increase the availability of alternative pathways for patients with urgent but non-life-threatening needs.

40 The extent to which ambulance crews can 'see and treat' patients at scene within the Health Board area is below the all-Wales average (11.7% compared to 14.3% in March 2025). The 'see and treat' rate has generally been in line with the all-Wales average for the past 12 months. In addition, the percentage of patients who were referred to alternative care services was higher than the all-Wales position in February 2025 (14.5.% compared with 11.9%).

41 From our work, it is clear the Health Board and WAST are trying to work together to keep people at home to prevent conveyance to hospital. Currently WAST can refer cases to a patients' GP for treatment, but there is no direct phone line for them to do this. This means ambulance crews must use the main triage line and wait in a queue like the rest of the public. This does not make referrals easy or quick, and it would be useful and more efficient if WAST had a direct line to use to refer to GPs **(Recommendation 4)**.

42 During 2023-24 the Health Board piloted the use of Advanced Paramedic Practitioners (APPs) within GP practices to enable more complex and acute patients to be treated in the community and reduce conveyance to hospital. This

was funded through Six Goals Programme money. We were told there was mixed feedback on the pilot, but it ended when funding was not continued into 2025-26.

Services to help manage demand

43 We found that **there is good uptake of enhanced pharmacy services despite limited numbers, but low use of the common ailment scheme and difficulties securing prescribing supervisors constrain their full potential in supporting urgent care access.**

Community pharmacy services

44 For 2024-25, the Health Board had the lowest number of community pharmacies per 100,000 head of GP population in Wales, at 16.2 (compared to 20.8 at an all-Wales level). Each one of the Health Board's community pharmacies signed up to provide the common ailment scheme in 2024-25. This scheme allows pharmacists to assess and treat a common list of minor ailments[8]. However, should antibiotics be required, then patients would need to be referred to their GP. The number of common ailment consultations per 100,000 head of GP population for 2024-25 was the lowest in Wales (9,536 compared with an all-Wales average of 14,000). The most common ailments reported were conjunctivitis, hay fever, and threadworms.

45 To supplement the scheme, some community pharmacies have also signed up to provide additional enhanced services, which further increase the ability of community pharmacists to respond to minor ailments. This includes providing the sore throat treat and test service, and the independent prescribing service. Both services enable the community pharmacist to prescribe antibiotics. In addition, community pharmacists can also provide the additional hours services, which allows them to extend their opening hours and provide bank holiday cover. The uptake of these is set out in **Exhibit 6**.

[8] Common ailments scheme, 2021.

Exhibit 6: uptake of enhanced services in community pharmacies (2024-25)

Indicator	This Health Board	All-Wales position
% of community pharmacies providing the sore throat treat and test service	96	89
% of community pharmacies providing the independent prescribing service	35	39
% of community pharmacies providing additional hours services	65	8

Source: StatsWales

46 The Health Board's community pharmacies deliver higher levels of enhanced services than all-Wales average. Powys' rural geography places greater emphasis on locally accessible services, and enhanced community pharmacy services are well used. Since the introduction of the new community pharmacy contract in April 2022, nearly all pharmacies provide the Sore Throat Test and Treat Service. The Health Board has the highest number of pharmacies providing additional hours service, although the number has fallen since 2022-23. The uptake of the independent prescribing service has increased since 2022–23, with the proportion of pharmacies offering the service just below the all-Wales position.

47 A Community Pharmacy Performance Report presented in December 2025 highlighted significant growth in activity, with 7,140 common ailments consultations completed in the first four months of 2025–26—already more than half of the previous year's total. The Health Board views community pharmacies as a key part of local service delivery but continues to face challenges securing Designated Prescribing Partners to supervise pharmacists undertaking independent prescribing training.

Impact of service changes on urgent and emergency care performance

48 We found that **rising emergency demand and persistent handover delays continue to challenge urgent care performance, though minor injury units continue to perform well.**

Ambulance performance

49 Since the pandemic, 999 calls to the ambulance service across the Health Board have continued to rise. The number of red calls received is now substantially higher than the level experienced by the service pre-pandemic with an average of

198 calls per month between April 2024 and March 2025[9], compared to an average of 80 between April 2018 and March 2019. Whilst continuing to account for most 999 calls, the number of amber calls decreased slightly since the pandemic with an average of 1,135 calls per month between April 2024 and March 2025 (compared to 1,146 between April 2018 and March 2019).

50 Despite the overall increase in ambulance demand, the rate at which ambulance crews convey patients to hospital has reduced since pre-pandemic levels from 64.8% (April 2018 - March 2019), to 62.3% (April 2024 – March 2025). The rate is consistent with the all-Wales average (63.3%). **Exhibit 7** sets out the destination for all conveyances.

Exhibit 7: conveyance destination as a proportion of total conveyance (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of patients conveyed to major emergency departments	91.4		88.8
% of patients conveyed to minor injuries units	1.9		6.2
% of patients conveyed to other unit e.g. mental health or maternity unit	6.8		1.8

Source: Ambulance Services Indicators

51 Ambulance crews convey a higher proportion of patients to major Emergency Departments than the all-Wales average. During 2024-25 the Health Board conveyed a significantly lower percentage of patients to its minor injuries units, but higher rates of patients to other units. We heard that Powys patients often delay seeking help, self-managing their conditions, or using lower-acuity services for longer, which means they tend to present with more complex needs when they do contact emergency services.

52 There has been some evidence that the Health Board has taken preventative measures to reduce the impact on the front door. In 2022-23 the Health Board along with Powys County Council and WAST secured some funding to train care home staff to safely lift residents who have fallen by using a specialised cushion. Initial outcomes were positive. Between November 2022 and April 2023, the data showed there were 25% less attendances by WAST for falls in care homes which attended familiarisation sessions compared with care homes that did not. Over the same period, data showed a 3% higher conveyance rate for homes which attended

[9] From July 2025, the way in which ambulance calls and responses were categorised changed. As a result, ambulance service indicators have changed.

familiarisation sessions (60%) versus homes which did not attend (57%). The project ended in March 2023 due to non-recurrent funding. It is the Health Board's intention to take the learning from this into the design of its falls pathway.

53 Data shows that ambulance handover delays for the Health Board's patients have improved in recent months but continue to be unacceptably high. The average percentage of ambulance handovers completed within 15 minutes between December 2024 and November 2025 was 15.2%, against a national target of 100%. This performance was lower than the all-Wales position of 21.1%. However, this does show improvement compared with the previous 12-month period, where performance was 12.6% for Powys against an all-Wales average of 16.3%.

54 The Health Board lost on average 696 hours every month between December 2024 and November 2025. This equates to 58 12-hour shifts where patients were waiting in an ambulance outside of hospital for treatment and paramedics were unable to respond to other calls. The July 2025 Integrated Quality and Performance Report at Board did note ongoing work with WAST and the Joint Commissioning Committee to develop an improvement plan for Powys to improve handover delays. The report noted all emergency department providers have been asked to improve flow but there is limited information on what this looks like in practice.

55 Handover delays inhibit the ability of ambulance staff to respond to other urgent calls in the community. Ambulance response times continue to be challenging and below performance targets, although they are slightly better than or in line with the all-Wales average (**Exhibit 8**).

Exhibit 8: red and amber call response times (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of red calls responded to within eight minutes	47.3		48.7
Median response to amber calls (minutes)	62		112

Source: Ambulance Service Indicators

56 The percentage of red calls responded to within eight minutes is significantly below the target of 65%. On average, the response time to amber calls between March 2024 and February 2025 was one hour and two minutes, rising to six hours 32 minutes for those who waited the longest. Performance had deteriorated since the previous 12-month period.

Emergency Department/Minor Injury Unit performance

57 The Health Board does not have acute emergency departments. Patients needing this level of service will access the nearest relevant site. Due to the geographical nature of Powys, this could be any of the Welsh health boards or English providers such as Shrewsbury and Telford Hospital NHS Trust or Wye Valley NHS Trust.

58 The Health Board operates four Minor Injury Units across Powys. Emergency Nurse Practitioners lead these units and can treat a range of injuries and problems such as broken bones, wounds and minor burns and sprains. The MIUs are walk in services but the public are encouraged to phone before attending in case they can be referred to a more suitable service.

59 Within the Health Board, the rate of attendances at its Minor Injuries Units per 100,000 head of GP population has been consistently higher than the all-Wales position, with 903 average attendances a month between December 2024 and November 2025 (compared to an all-Wales average of 792). Except for seasonal fluctuations the levels of attendance have remained consistent since April 2023. Waiting time performance at Minor Injuries Units has been consistently positive with between 99% and 100% performance against a target of 95% the last few years.

60 Responding to financial challenges, in October 2024 the Health Board adjusted opening hours at Brecon and Llandrindod Wells Minor Injuries Units to 8am-8pm to create a more sustainable service for staff and patients. A review of these changes in July 2025 identified no increases at GP surgeries because of the service change, and no substantial changes in the number of patients attending MIUs since the same period last year.

Scrutiny and monitoring arrangements

61 This section considers whether the Health Board is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:

- arrangements for monitoring the impact of alternative clinical pathways; and
- effective oversight and scrutiny of the delivery of plans for urgent and emergency care.

62 We found that **while governance structures are in place, limited monitoring and feedback constrain assurance on the impact of urgent and emergency care services.**

Monitoring impact

63 We found that **there is limited monitoring and feedback of urgent and emergency care services which limit assurances of whether services and pathways are working effectively**.

64 The findings that have led us to this conclusion are summarised in **Exhibit 9**.

Exhibit 9: approach to monitoring impact of alternative pathways on urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Is the Health Board tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	**Partially**	The Health Board has robust data on the number and volume of patients accessing services in Powys and other Welsh health boards but less information on whether those services are appropriate for their needs. Accessing information for those who have attended English emergency departments is more problematic. Receiving and analysing data from English NHS Trusts is a time consuming and a largely manual task. The Health Board monitors measures and key deliverables for urgent and emergency care each quarter, but this reporting does not demonstrate whether alternative clinical pathways are effective. The exception is Minor Injuries Units, which have recently undergone a more detailed analysis. The Health Board could benefit from collecting more detailed data for its patients and use this information to determine if those patients are accessing services appropriately **(Recommendation 5)**.
Is regular patient feedback being sought and used to inform and improve plans?	**No**	The Health Board does not routinely seek direct patient feedback to inform and improve urgent and emergency care services. While feedback has been gathered for specific service changes, such as adjustments to Minor Injury Unit opening times in October 2024, and additional insight is provided through Llais, the approach is not consistent or systematic. The Health Board recognises this gap and has recently appointed a People's Experience Framework Coordinator to strengthen how patient feedback is collected and used. The impact of this role will need to be demonstrated to show how feedback is informing and improving plans (**Recommendation 6**).
Is there regular staff feedback on the impact of changes to services and	**Partially**	The Health Board does not routinely seek staff feedback to capture how services are working, including primary care. In relation to changes to Minor Injuries Unit opening times in October 2024 the Health

Audit question	Yes/ No/ Partially	Findings
pilots to identify and apply lessons?		Board held a staff workshop to gather feedback. Staff feedback contributed to the decision to extend the opening hour changes. The Health Board should apply these processes to broader changes to urgent and emergency care services and include key partners such as primary care and WAST **(Recommendation 7)**.

Source: Audit Wales

Oversight and scrutiny

65 We found that **whilst governance arrangements are in place, they currently provide limited insight of the impact or effectiveness of investment into urgent and emergency care services.**

66 The findings that have led us to this conclusion are summarised in **Exhibit 10**.

Exhibit 10: approach to oversight and scrutiny of urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	**Yes**	Governance of the Six Goals Programme sits within the Health Board's Frailty and Community Programme Board. The Director of Primary, Community Care and Mental Health chairs the work of this Programme Board. Bi-monthly papers to the Programme Board provide updates against each of the ministerial priorities which resource and shape delivery of the Six Goals themselves. This includes key achievements for the month, impact, and outcome data if available, a RAG status, delivery risks and mitigations and key performance measures and trajectories. However, this detailed information is internal.

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	**Partial**	Oversight of urgent and emergency care is undertaken as part of the quarterly Integrated Plan Progress Report updates to Executive Committee, Finance and Performance Committee and Board. Urgent and emergency care activity falls under the Health Board's strategic theme of 'Joined Up Care'. There is a range of supporting activity in the Annual Plan 2025-26 which includes 'Enhancing the provision of the Health Board's urgent care services' with deliverables including 'Conducting a review of current clinical practices and processes to establish key insights to inform the transformation of urgent care services' and 'Review and scope key clinical pathways to improve the delivery of urgent care and inform future service design'. It is unclear how these are different or why these has not already been done. It is also unclear how committees and Board can take assurance these high-level actions are effective to better meet demand. Oversight is limited to these reports and includes no specific detailed updates against the internal Six Goals Plan. Whilst scrutiny in the Health Board is generally effective, it is difficult for committees and Board to undertake detailed scrutiny of such high-level information (**Recommendation 8**).
Are there arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government?	**No**	The Health Board produces monthly highlight reports specific to the Six Goals Programme which are shared internally. These provide a useful insight into key achievements each month, performance trajectories and some risk and mitigations. However, they do not include any insight into value for money of investments. There is no information in the monthly Finance Performance Report to the Finance and Performance Committee about urgent and emergency care funding. The Monthly Monitoring Returns 2025-26 show at Month 10 the Health Board has underspent on its allocation of urgent and emergency care funding in every month except for January 2026 and was behind profile by £141,000. The Health Board was forecasting that it would spend the remaining budget by 31 March although this would require spending in the last two months of the year to have more than doubled that spent monthly in the previous 10 months.

Audit question	Yes/ No/ Partially	Findings
		Whilst we heard that pilots are evaluated and a business case created for successful ones, this activity is not included in the financial or performance reporting to provide oversight of whether investments are value for money (**Recommendation 9**).

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 11 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 11: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Integrated Plan and Annual Plans • Six Goal Programme Plan and progress reports, including submissions to Welsh Government • Performance reports on urgent and emergency care to Board and committees • Papers relevant to appropriately managing urgent and emergency care demand
Interviews	We interviewed the following: • Executive Medical Director • Welsh Ambulance Service Operations Manager • Assistant Director of Primary Care Services • Clinical Change Manager (Unscheduled Care) • Senior Manager for Unscheduled Care • Assistant Director, Community Services Group • Interim Assistant Director, Community Services Group • Head of Primary Care • Llais Regional Director
Group discussions	We held group discussions with the following: • GP Cluster Leads
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • DHCW Urgent and Emergency Care Dashboard; • StatsWales; and

Element of audit approach	Description
	• Data provided by Welsh Government and ShropDoc in relation to GP out of hours services.
Website and practice reviews	We reviewed the Health Board's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services. We reviewed a sample of five GP practice websites and answerphones and four dental websites and answerphones in the region.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 12 sets out the audit criteria that we used to deliver this work.

Exhibit 12: audit criteria

Audit questions	Audit criteria
Does the Health Board have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	• Strategies and/or plans relating to urgent and emergency care: – are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients. – identify and seek to address key risks associated with demand for urgent and emergency care services. – align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand. – include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required levels of resource and	• Strategies and/or plans detail the: – resource requirements and identified funding to support any changes to service delivery included within the strategy/plan.

Audit questions	Audit criteria
staffing to achieve the ambitions?	– workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?	
Is the Health Board effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Health Board provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, GP/dentist websites and phone lines, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between Health Boards and GP clusters / dentists / paramedics / pharmacists about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).

Audit questions	Audit criteria
Is there evidence that changes to service delivery are resulting in better demand management?	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates a good range of GP appointment availability. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
Is the Health Board doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Health Board monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Health Board tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Health Board can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate.

Audit questions	Audit criteria
care and alternative clinical pathways?	• There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 13 sets out the Health Board's management response to the recommendations made because of this audit. The completed management response will be inserted once considered by the Health Board's Audit Risk and Assurance Committee

Exhibit 13: management response

Recommendation	Management response	Completion date	Responsible officer
Identifying future resources **R1** The Health Boards plans should identify required levels of resource and staffing to achieve its Six Goals ambitions. This should include how the Health Board will manage any underspends or any future funding requirements and any workforce and training requirements (**Exhibit 2**).	**Accepted** The Health Board has a clear six goals plan, including resourcing, notwithstanding the ongoing requirement to deliver this under a non-recurrent funding model. With a move towards possible recurrent funding, it will be possible to demonstrate a longer-term resilient staffing model which better delivers against the planning objectives.	September 2026	Clinical Change Manager, Six Goals
Communication plans	**Accepted and Completed**	April 2026	Deputy Director, Communications, Engagement &

Recommendation	Management response	Completion date	Responsible officer
R2 The Health Board should develop a formal communication plan for Urgent and Emergency Care Services which sets out how the Health Board will communicate any service changes and alternative clinical pathways to staff and the public. This will ensure that patients are accessing the right care at the right time and help manage demand (**Paragraph 20**).	Public facing communications in place to support patient access, updated locally to reflect service changes: (Help Us Help You - Powys Teaching Health Board) Alongside this, the Health Board has established the Better Together programme to shape the future of adult physical and mental health community services, including urgent care. Engagement has been undertaken on the case for change and future service models, with feedback captured in an engagement report. This insight is informing the development of options and recommendations, with formal consultation anticipated later in 2026.		Corporate Governance
Signposting patients to dental services R3 The Health Board should ensure dental practices provide clear and accessible information about urgent and emergency dental provision on their websites and phonelines (**Paragraph 25**).	**Accepted** Clear messaging around how to access urgent and emergency dental care isn't consistent across dental practices. Action plans in place to update phonelines and websites (where applicable). Non-compliance to be followed up in year-end review meetings.	June 2026	Assistant Director of Primary Care
Direct line referrals for WAST R4 The Health Board should work with GPs to ensure WAST can access a direct line for referrals and queries into a patient's GP practice rather	**Partially Accept** GMS is routinely strongly encouraged to provide a direct line for professionals including WAST queries. The Health Board will revisit with individual practices to identify any barriers, noting it is not a contractual obligation to do so.	June 2026	Head of Primary Care

Recommendation	Management response	Completion date	Responsible officer
than having to use the main triage line (**Paragraph 41**).			
Reporting data on access to services R5 The Health Board should strengthen tracking and reporting data to show if patients are accessing services appropriately. This includes how alternative clinical pathways are reducing demand on emergency departments (**Exhibit 9**).	**Accepted** In addition to existing internal key performance indicators and reportable metrics, the Health Board are developing an enhanced dashboard to track the impacts of newly developing services that seek to support earlier hospital discharge and admission avoidance.	June 2026	Data and Business Intelligence Lead
Use of patient feedback to inform plans R6 The Health Board should demonstrate how it uses feedback from patients to inform and develop plans and activity to manage demand for urgent and emergency care services (**Exhibit 9**).	**Accepted** PTHB is continuing to embed the NHS Wales People's Experience Framework in our learning and improvement. A self-assessment against the People's Experience Framework has been undertaken within Unscheduled Care services and this has informed our plan for strengthening patient feedback at the heart of service improvement within these services. Key themes are drawn together into quarterly Four Quadrant Reports.	April 2026	Senior Manager, Unscheduled Care
Staff feedback on impact of service changes	**Accepted** In addition to the actions at R6. The organisation is undertaking significant planning for transformation	December 2026	Assistant Director,

Recommendation	Management response	Completion date	Responsible officer
R7 The Health Board should introduce regular mechanisms for staff feedback to identify potential weaknesses or learning in relation to the provision of urgent and emergency care services. This should include feedback from key partners including primary care and WAST (**Exhibit 9**)	across urgent care pathways, and through engagement have received active feedback on existing pathways from local teams and system partners. Ongoing development will ensure that future changes continue to provide feedback mechanisms to actively track impacts and drive opportunities for further change.		Community Services Group
Oversight of urgent and emergency care at committee and board level R8 The Health Board should ensure reports about Six Goals Programme activity are detailed enough to allow for scrutiny and oversight of urgent care performance including assurance on the effectiveness of plans and actions taken to better meet demand (**Exhibit 10**).	**Partially Accepted** Ongoing reporting to programme board continues, with Executive sign off and where required further update to Executive committee. Available for adoption by Finance & performance committee and Board as required.	April 2026	Assistant Director, Community Services Group
Oversight of economy, efficiency, and effectiveness of project investments R9 To increase transparency and strengthen assurance that monies allocated to urgent and emergency care are being spent wisely, the	**Accepted** To explore how existing programme Board reporting (including financial delivery) can be better used to inform the reporting via Finance & Performance Committee.	September 2026	Clinical Change Manager, Six Goals

Recommendation	Management response	Completion date	Responsible officer
Health Board should include information within regular finance reports to the Finance and Performance Committee to provide oversight whether investments provide value for money (**Exhibit 10**).			

Source: Audit Wales

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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.

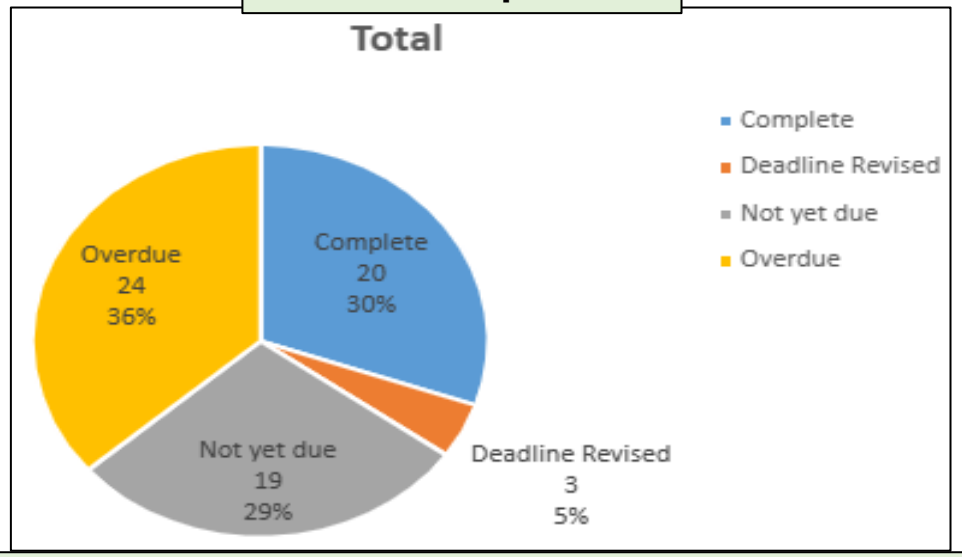
Subject:	Audit Findings Tracking Report (Internal and External Audit)
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance, Risk and Assurance Manager
Purpose:	The purpose of this report is to provide the Executive Committee with an overview of the position relating to the implementation of Audit findings, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 11 June 2026.
Recommendations:	The Committee is asked to: • **DISCUSS** the current position of Internal and External audit findings that remain overdue and findings that have had their deadlines revised; • **CONSIDER** the current position of all Internal and External Overdue audit findings given High Priority ratings and; • **TAKE ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit findings.

Executive Summary:	This report provides a summary of the overall position of Internal and External Audit Findings as well as an update of the work that has been underway since the previous Audit, Risk and Assurance Committee on 10 March 2026. The report provides an increased focus on overdue findings, findings which have had their deadlines revised and those findings given a High priority rating at the time of the Audit work undertaken. The full detail is available for all findings and are appended to this report.
	
	• **Internal Audit Recommendations that:**
	  • **are Overdue**
	  • **have been COMPLETED since the previous report**
	  • **are NOT YET DUE for implementation**
	  • **have had their DEADLINE REVISED**
	
	• **External Audit Recommendations that:**
	  • **Are OVERDUE**
	  • **have been COMPLETED since the previous report**
	  • **are NOT YET DUE for implementation**
	
	The report confirms there are no outstanding recommendations from Local Counter Fraud Services Pro-Active Exercises.
	The Committee should note, Internal Audit reports which have an 'Advisory' assurance rating with no trackable deadlines or recommendations, are not tracked. The next report will be provided in March 2027.

SUMMARY POSITION – Internal Audit Findings

Narrative of position: The pie charts below shows the overall position of Internal Audit findings. There has been an improvement in the number findings marked as fully complete for this period (a 19% increase since the previous report in March 2026). The Corporate Governance team has increased their focus working with directorates to ensure that all leads are reviewing and updating actions regularly. As evidenced in the pie charts, ongoing increased efforts of the teams to close overdue actions with an increased focus on the highest priority can be noted.

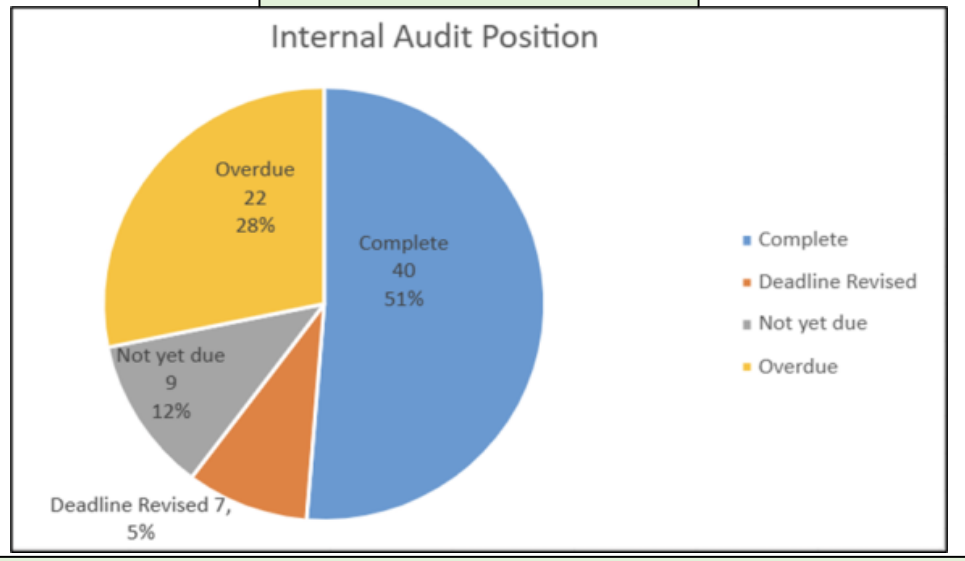
March 2026 position



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

- 20 findings have been completed since the last report; (30%)
- 3 findings had their Deadlines Revised; (5%)
- 19 findings are Not Yet Due for implementation and; (29%)
- 24 findings are Overdue. (36%)
- There are 66 internal Audit findings in total on the live tracker as of January 2026.

July 2026 position



Summary of Internal Audit Findings since the last report in March 2026:

- 40 findings have been completed since the last report; (51%)
- 7 findings had their Deadlines Revised; (5%)
- 9 findings are Not Yet Due for implementation and; (12%)
- 22 findings are Overdue. (28%)
- There are 78 internal Audit findings in total on the live tracker as of July 2026.

Internal Audit Activity- OVERDUE Summary

The following charts relate to overdue Internal Audit Findings and highlights the total 'overdue' actions based on the originally assigned due date. The position as at the last ARAC in March 2026 is included as a comparator for the July 2026 position. The actions are split by Directorate, Assurance rating and Internal Audit priority as assigned at the finalisation of the Audit Review.

MARCH 2026 POSITION Internal Audit Activity– Overdue Findings

Internal Audit Priority	Director of Allied Health Professions, Health Sciences & Digital		Director of Corporate Governance	Director of Nursing, Quality, Women & Family Health	Director of Finance, Capital and Support Services	Director of Primary, community Care and Mental Health		Total
	Limited Assurance	**Reasonable Assurance**	**Reasonable Assurance**	**Reasonable Assurance**	**Substantial Assurance**	**Reasonable Assurance**	**Substantial Assurance**	
High	5	0	0	3	0	0	0	**8**
Medium	1	1	1	6	1	4	2	**16**
Low	0	0	0	0	0	0	0	**0**
Total	**6**	**1**	**1**	**9**	**1**	**4**	**2**	**24**

MARCH Summary:
23 findings from are overdue from 2024/2025 and 2025/2026, 1 is overdue from 2022/2023.

Completion Status
- 24 are partially completed

Priority
- 8 are high priority
- 16 are medium priority
- There are no low priority

Assurance rating
- 6 relate to limited assurance reports
- 15 relate to reasonable assurance reports
- 3 relate to Substantial assurance reports

JULY 2026 POSITION Internal Audit Activity– Overdue Findings

Internal Audit Priority	Director of Allied Health Professions, Health Sciences & Digital	(No comparator) Director of Improvement & Transformation	Director of Nursing, Quality, Women & Family Health	Director of Finance, Capital and Support Services	Director of Primary, community Care and Mental Health		Total
	Reasonable Assurance	**Reasonable Assurance**	**Reasonable Assurance**	**Reasonable Assurance**	**Reasonable Assurance**	**Substantial Assurance**	
High	1	0	3	0	2	0	**6**
Medium	2	1	4	1	6	2	**16**
Low	0	0	0	0	0	0	**0**
Total	**3**	**1**	**7**	**1**	**8**	**2**	**22**

JULY Summary:
9 findings from are overdue from 2024/2025 and 13 are overdue from 2025/2026.

Completion/No Progress Status
- 21 actions are partially completed
- 1 action has made no progress

Priority
- 6 actions are of high priority
- 16 actions are of medium priority
- There are no low priority

Assurance rating
- 20 relate to reasonable assurance reports
- 2 relate to Substantial assurance reports

Internal Audit Activity- OVERDUE Narrative

- In March, the Committee acknowledged a number of audit actions which were currently delayed. The Corporate Governance team has undertaken engagement exercises with the responsible leads to understand the position of the overdue actions and provide support to enable closure where possible.
- The previous report in March 2026 reported 24 findings were overdue. The current position shows 22 findings overdue, 1 of these actions have made No progress. 21 findings are partially complete and have been given anticipated completion dates to reflect their position on why the action remains open.
- The current position shows that there has been an increase in the number of updates being provided this period, and a notable increase in the actions marked as fully complete and approved by the Executive Director.
- Since the previous report in March 2026, of the overdue Internal Limited assurance actions that fall within the portfolio of the Director of Allied Health Professions, Health Sciences & Digital, all 6 overdue actions have now been completed.

Next Steps and actions:

- Corporate Governance we will be moving into the next phase of engaging with leads to understand the position of all those overdue findings which have made no progress since the previous report in March.
- Discussions are ongoing with leads to enhance the user friendliness of the system to manage audit trackers for colleagues and also for Audit Leads to have visibility of actions for their areas.

SUMMARY POSITION – Overdue Internal Audit High Priority by Executive Director

- The current position for Internal Audits with High-priority ratings bring a highlighted focus to actions that either need further attention or present a higher risk to the organisation. This is the first step towards triangulating the data we collect making scrutiny for Committee Members more meaningful and focus driven on areas that may need improvement.
- The areas of focus highlighted in the tables provided, indicate those actions which are longest overdue based on their original implementation
- completion date. There are a total of 6 overdue, high-priority audit findings.
- The Committee are asked to review and discuss the High-Priority findings and the progress of work underway.
- Further updates will be provided to the ARAC Committee in the next report in October 2026.

Executive Director of Allied Health Professions, Health Sciences & Digital

Ref No/ Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	Barriers to implementation including any interdependencies	No of months passed deadline	Anticipated date of completion
252618 Clinical Supervision Powell Bethan 07/07/2026 16:11:14	Reasonable	High	R1	Awareness sessions for supervisors and supervisees to highlight the benefits of live supervision will be run to ensure all staff have live supervision annually in line with the clinical supervision policy.	**May 2026 update:** Psychology & Psychological Therapies. Awareness sessions delivered (or planned to be delivered in June/July) as part of LPMHSS Team Meeting, Adult Psychology Team Meeting, CEN Team Meeting, & OA Psychology Team Meetings, PIPIN Meetings, Mental Health Practitioner Forum, Counselling & Psychotherapy Forum, & via Managerial Supervision.	Psychology & Psychological Therapies. All clinical staff are acessing regular (at least monthly) clinical supervision Re: Live Observation barriers: (i) IG permission to record clinical sessions (ii) Geographical & logistic challenges with supervisors attending clinical sessions in person (iii) Clinician anxiety around live observation	1	**October 2026**

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

Executive Director of Nursing, Quality, Women and Family Health

Ref No/ Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	Barriers to implementation including any interdependencies	No of months passed deadline	Anticipated date of completion
242519 Additional Learning Needs	Reasonable	High	R2	Training initiatives will be revisited; a training schedule will be produced, informed by existing or refreshed data about staff knowledge and confidence, and details of training availability will be made available to relevant staff. Records will then be maintained of attendance at completed training.	**May 2026 update:** Training for Therapies staff with leadership responsibilities has taken place. Training for wider Children's Therapies staff is scheduled for June 2026; the impact of this training will be evaluated. Awareness-raising training is also being delivered to CAMHS professionals in June 2026. No further training needs have been identified but this will continue to be reviewed moving forward.	Staff capacity, need to resolve operational process issues prior to training delivery	7	**June 2026**
242519 Additional Learning Needs			R3	Monitoring procedures in relation to the partnership's Strategic Priorities Plan will be reviewed and it will be ensured that regular reports are made at an appropriately senior level, with reference to the reviewed governance arrangements specified in Key Finding 1.	**May 2026 update:** Strategic Plan continues to be updated iteratively but has not yet been reviewed by the W&C Q&P Meeting. This has been scheduled for the June 2026 Q&P meeting	Competing priorities including digital issues	7	**June 2026**
252622 Duty of Candour			R1	The Incident Management Framework will define and document the specific Health Board / Committee responsible for the signoff of the IMF. This will be included in the document to ensure accountability and clarity. The IMF will define and document clear responsibilities for relevant roles within the Health Board for identifying, investigating, and monitoring Duty of Candour cases. A detailed organisational structure will be developed and included within the Framework that outlines the lines of accountability for monitoring and reporting Duty of Candour. This will specify the roles and responsibilities at the Clinical Service Group, Committee, and Board levels. The IMF will be amended to show the correct timeframe for conducting the RIRMs.	**May 2026 update:** The IMF is under review to align to LTP since the launch. This is anticipated to be completed by September 2026 due to competing pressures with embedding LTP and developing and establishing the LTP SoP in practice.	Capacity of the Quality & Safety Team	5	**September 2026**

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

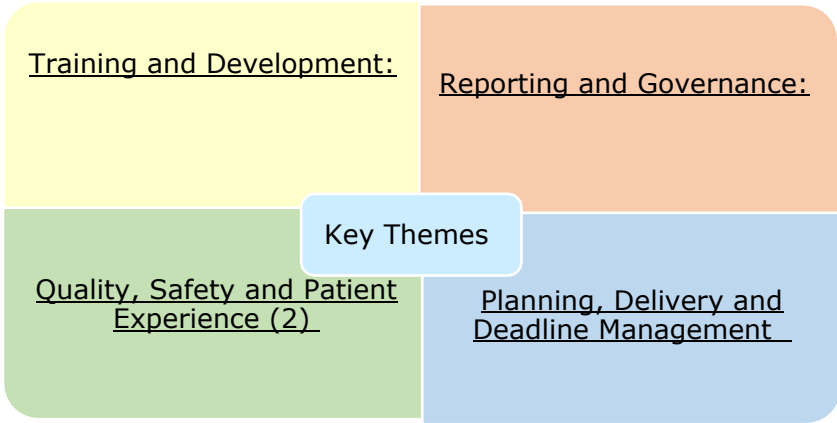
Executive Director of Primary, Community Care and Mental Health

Ref No/ Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	Barriers to implementation including any interdependencies	No of months passed deadline	Anticipated date of completion
252611 Mental Health and Learning Disability Triage and Assessment Process	Reasonable	High	R1	An Operational Delivery Group will be established for the SPOA which will formalise operational governance arrangements for the service. It will report into MH&LD SMT via the Service Quality Improvement and Development (SQID) workstream and align to the deliverables identified in the Transformation Workstream reporting progress to the Better Together Project Board. The SPOA will also formalise the reporting of Quality & Safety related governance into the QUAILS meeting, which is an SMT workstream, this will be on a monthly basis.	Terms of reference for SQID updated to reflect new governance responsibility. New structure for SMT now in place to support the operational delivery group in target setting and for ongoing monitoring. SMT will report though to DMT on any exceptions or escalations as required. BCP for 111p2 SPOA complete.	Not provided	2	Not provided
252611 Mental Health and Learning Disability Triage and Assessment Process			R4	SPOA Service management will prepare for regular reporting of its demand, capacity, triage call timescales and performance management activity data to SQID which reports to MH & LD Directorate senior management. Improved data and reporting capacity has been highlighted as a service requirement as part of the WCCIS Replacement tendering process, it is recognised that additional work will need to be carried out to ensure that configuration of the new system delivers anticipated outcomes in terms of demand, capacity and activity reporting.	Terms of reference for SQID updated to reflect new governance responsibility. New structure for SMT now in place to support the operational delivery group in target setting and for ongoing monitoring. SMT will report though to DMT on any exceptions or escalations as required. BCP for 111p2 SPOA complete	Not provided	2	Not provided

Key Themes – Limited Assurance Internal Audit Findings given High Priority ratings

Limited Assurance & High Priority Internal Audit Reports

Executive Lead	Internal Audit Report Title– High Priority only	Status
Executive Director of Allied, Health Professions, Health Science & Digital	Mattresses	Complete
	Digital System Uptake	Partially Complete- Deadline Revised: July 2026



Summary

There is a total of 2 Limited Assurance Internal Audit reports, with 10 identified findings. 6 findings are of high-priority rating and 4 findings are of medium priority rating.

Of the 6 high-priority findings, 2 of the key themes relate to Quality, Safety and Patient Experience.

SUMMARY of DEADLINE REVISED Internal Audit Findings

The following table relates to Internal Audit actions with their deadlines proposed as 'Revised' by Executive Directors. The position as at the last ARAC in March 2026 is included within the narrative below as a comparator for the July 2026 ARAC position. The actions are also split by the priority of High, Medium and Low as assigned at the finalisation of the Audit Review

March 2026 position

Internal Audit – Deadline Revised Summary

Internal Audit Priority	Director of Finance, Capital and Support Services	Director of Primary, Community Care & Mental Health	Total
	Reasonable Assurance	**Reasonable Assurance**	
High	0	0	**0**
Medium	1	2	**3**
Low	0	0	**0**
Total	**1**	**2**	**3**

July 2026 position

Internal Audit – Deadline Revised Summary

Internal Audit Priority	Director of Finance, Capital and Support Services	Director of Primary, Community Care & Mental Health		Director of Corporate Governance	Director of Allied Health Professions, Health Science & Digital	Total
	Substantial Assurance	**Substantial Assurance**	**Reasonable Assurance**	**Reasonable Assurance**	**Limited Assurance**	
High	0	0	0	0	1	**1**
Medium	2	2	1	1	0	**6**
Low	0	0	0	0	0	**0**
Total	**2**	**2**	**1**	**1**	**1**	**7**

Summary:
A total of 7 Internal Audit Findings have had their deadlines revised all of which are partially completed. (4 findings were presented in 2024/2025 and 3 findings were presented in 2025/2026 financial year). 4 findings are from Substantial Assurance rating reports, 2 are Reasonable Assurance and 1 is from a Limited Assurance report.

The number of actions which have had their deadlines revised, exceeding their original due date has increased by 4 during this reporting period. Increased focus is required to ensure that all leads are updating actions regularly and the correct leads are assigned to actions.

Detail of DEADLINE REVISED Internal Audit Findings

Internal Audit – Deadline Revised detail

Directorate	Internal Audit Title	Audit Assurance rating	Priority Rating	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline
Director of Finance, Capital and Support Services	Core Financial Systems – Treasury Management	Substantial	Medium	March 2025	July 2026	There is currently Local Health Board review of policy process underway which is due to conclude during 24/25. All FCPs will be reviewed and where required approval undertaken and where required review frequency included within the document.	**May 2026:** Due to capacity issues with vacancies having to be covered this has not been progressed as intended. Movement has been made in that it has been agreed under the new framework that these can be internally approved and will progress on this basis in next Quarter
Director of Finance, Capital and Support Services	Core Financial Systems – Treasury Management	Substantial	Medium	April 2026	September 2026	Guidance on self-assessment audits will be documented within the Food Safety Procedures under the existing section 6 "Monitoring Compliance". This guidance will: • Describe the process for completing audits; • Define the frequency that audits will be undertaken by differing levels of management; and • Identify roles and responsibilities for completing audits and monitoring output actions to ensure these are completed.	**May 2026:** There has been some resource challenges in the Facilities Management team have delayed overall completion but progress made.
Director of Corporate Governance	Risk Management and Assurance	Reasonable	Medium	November 2025	December 2026	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.	**May 2026:** Solution provided through the Once for Wales team, this is currently being tested and if practical, roll out of the Datix risk module will resume. A training video and support materials have been produced. Roll out, once ready, will be slower than desired due to planned staff absences.
Director of Allied, Health Professions, Health Science and Digital.	Digital System Uptake	Limited	High	March 2026	July 2026	A Change Management Framework was started in draft as part of the EPMA programme, where an interim Change Manager was appointed on a fixed term basis up until March 2025. This is a known area for improvement, and we accept this is a role that is essential, however due to how digital projects are funded, there is not a permanent Change Manager in post. The size of the organisation, the rurality of PTHB and the funding available is often a challenge to recruit the required change management	**May 2026:** The framework is near completion, which has been developed based on Kotters 8 steps methodology and best practice. This provides a step by step guide incorporating templates and checklists that forma part of our digital portfolio programme of work. This can then be used for evidence and assurance.

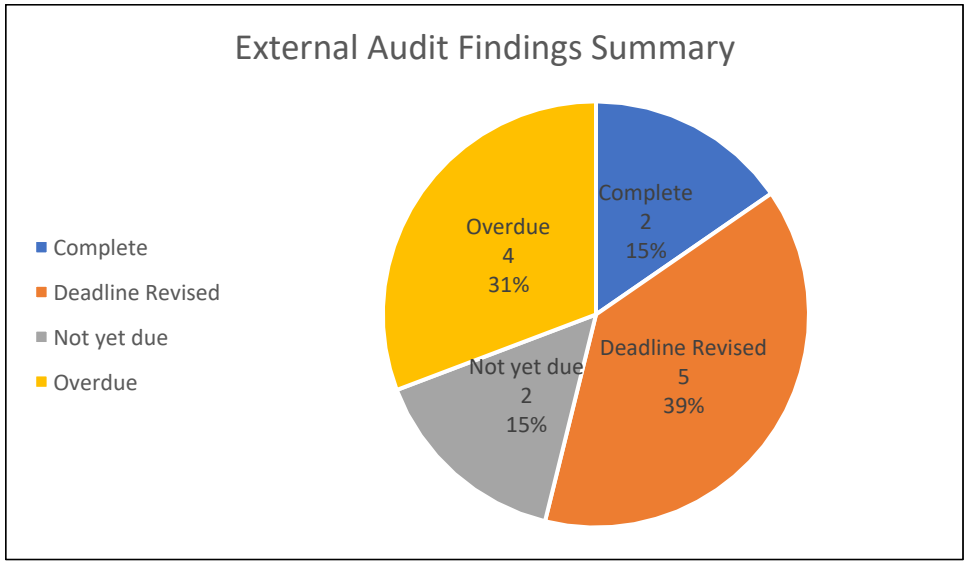
Detail of DEADLINE REVISED Internal Audit Findings

Internal Audit – Deadline Revised detail

Directorate	Internal Audit Title	Audit Assurance rating	Priority Rating	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline
Director of Primary, Community Care and Mental Health Services	General Medical Services Unified Contract Assurance Framework	Substantial	Medium	December 2025	April 2026 **April 2027**	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.	**May 2026:** No national progress to update, however the national group are working through, therefore there is some progress happening. National timeline for updated framework is 01/04/27
Director of Primary, Community Care and Mental Health Services	General Medical Services Unified Contract Assurance Framework	Substantial	Medium	April 2026	April 2026 **April 2027**	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.	**May 2026:** No national progress to update, however the national group are working through, therefore there is some progress happening. National timeline for updated framework is 01/04/27
Director of Primary, Community Care and Mental Health Services	Continuing Healthcare	Substantial	Medium	November 2025	August 2026 **September 2026**	To provide perspective on the scale of improvement works undertaken, tighten governance and provide greater assurance, the Improvement Plan will be summarised with a dashboard presented at every committee meeting. The "Programme dashboard" will include the summary built into the plan illustrating: • Number of workstreams completed • Number of workstreams in progress • Number of workstreams at risk Narrative will then be provided on key achievements for the period and, where risks have been highlighted, what actions are being implemented to mitigate.	**May 2026:** Schedule of works in place with external contractor to develop and deliver improvement plan. Expectation that plan will deliver by end September 2026.

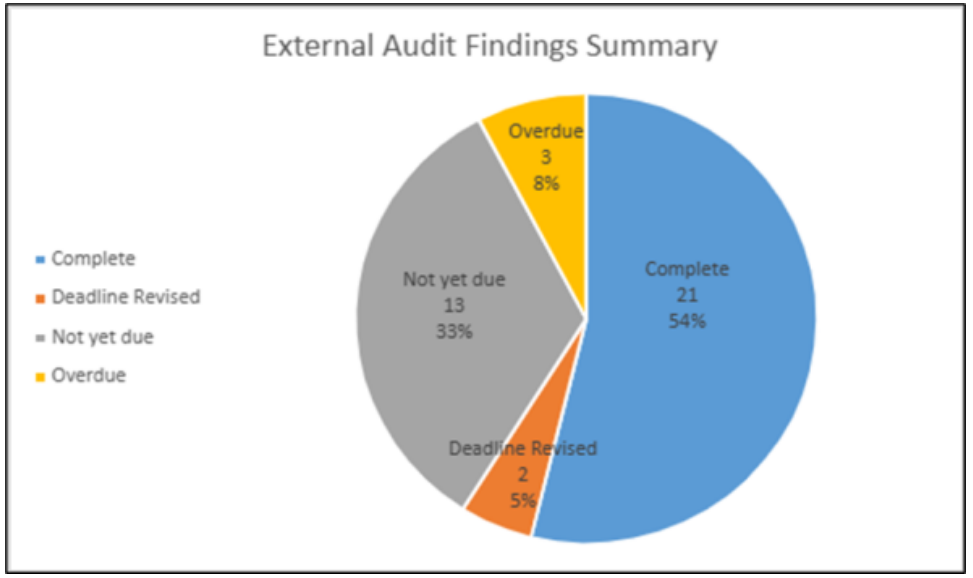
SUMMARY POSITION – External Audit Findings

March 2026 position



Note that: External Audits are not given a priority or an assurance rating and therefore focus is given to those audits that are Overdue, have had their deadlines revised and are of High Priority ratings.

July 2026 position



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

- There are 13 External Audit findings on the live tracker as of February 2026.
- 5 findings had their Deadlines Revised; (39%)
- 4 findings are Overdue, of which 3 are partially complete and 1 has made no progress, (31%)
- 2 findings have been completed since the last report. (15%)
- 2 findings are not yet due (15%)
- 2 of the overdue audit findings are from 2023/2024 and 2 are from 2024/2025.

Summary of External Audit Findings since the last report in March 2026:

- There are 39 External Audit findings on the live tracker as of July 2026.
- 2 findings had their Deadlines Revised; (5%)
- 3 findings are Overdue, all of which are partially complete (8%)
- 21 findings have been completed since the last report. (54%)
- 13 findings are not yet due (33%)

Of the overdue audit findings:

- 1 is from 2023/2024, 1 is from 2024/2025 and 1 is from 2025/2026.

Narrative of position: The pie charts above show the overall position of External Audit findings and the progress made since the last report to the Audit, Risk and aAssurance Committee in March 2026. There has been an improvement in the number findings marked as fully complete for this period (a 39% increase since the previous report). The Corporate Governance team has increased their focus working with directorates to ensure that all leads are reviewing and updating actions regularly. As evidenced in the pie charts, ongoing increased efforts of the teams to close overdue actions with an increased focus on the highest priority can be noted.

Detail of OVERDUE External Audit Findings

OVERDUE External Audit Findings by Directorate

Directorate	External Audit Title	Management Response	Progress of Work underway	Status	No of months passed deadline
Director of Corporate Governance/ Director of Nursing, Quality, Women and Family Health	Structured Assessment 2023	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	Solution provided through the Once for Wales team, this is currently being tested and if practical, roll out of the Datix risk module will resume. A training video and support materials have been produced. Roll out, once ready, will be slower than desired due to planned staff absences. Date change requested to align with similar recommendations from internal audit.	Partially Complete	3
Director of Corporate Governance	Structured Assessment 2025	The Risk Management Framework and Board Assurance Framework will be reviewed and aligned to ensure consistency and clarity.	The Strategic Risk Register is due to be reviewed by the Board following approval of the 2026/27 Integrated plan in line with annual process, this will in turn inform a review of Strategic/Operational risks with the intention to integrate Organisational Risks into Committee Risk Registers when the Organisational Risk Register is of an appropriate level of maturity.	Partially Complete	1
Director of Primary Care, Community and Mental Health	Primary Care	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects at cluster level through 'start well', 'live well', 'age well' programmes – a bottom-up approach to increase cluster maturity. Progress will be monitored via the ACD readiness checklist and assurance provided through the RPB Executive Group	No update provided	Partially Complete	1

Detail of DEADLINE REVISED External Audit Findings

External Audit – Deadline Revised detail

Directorate	Internal Audit Title	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline	Status
Director of Corporate Governance	Structured Assessment 2025	June 2026	July 2026	The Health Board will arrange a specific training session on finance for Independent Members.	Scheduled for July Board Development.	Partially Complete
Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Tackling the Planned Care Challenges	December 2025	March 2026	The Getting It Right First-Time actions now form part of the CIN Optimisation Frameworks and key transformation priorities reported/assured via the PTHB Planned Care Board. PTHB has agreed with NHS Executive that PTHB will focus on ophthalmology and orthopaedics as key priority areas identified in the PTHB. Key to progressing recommendations is speciality medical leadership and supporting clinical infrastructure which require investment proposals to resource Progress on key priority areas are provided to the Board as part of Transformation, Integrated Performance and Annual Plan Reporting. The HB is currently awaiting feedback from NHS Wales Planned Care Programme in terms of optimisation framework maturity matrix returns submitted in Q1 2025/26. Transformation Fund Bids were developed to support GIRFT progress within PTHB including speciality leadership, MDT infrastructure and Programme management. A successful internal investment bid for MSK/Orthopaedics has provided funding to appoint a speciality consultant lead for orthopaedics and supporting MSK infrastructure a similar investment proposal is being developed in 25/26 for ophthalmology. Progress report on Optimisation Frameworks including GIRFT to be provided as part of Performance & Finance Committee update. 3.2 SLAs with all providers are under significant challenge due to DGH pressures. The Planned Care Team continues to develop an MDT approach to support service sustainability shift left from reliance on consultant led model with digital healthcare underpinning wherever possible this is a long-term goal focus is currently on ophthalmology and orthopaedics. As part of Better Together workstream review of PTHB commissioning across Planned Care will be undertaken to review opportunities to mitigate in reach fragilities. 3.3 Theatre Transformation Plan in place as part of key priorities within PTHB community context no DGH, medical model. Working with regional partners to explore opportunities for mutual maximising utilisation of PTHB theatre estate at regional level.	All actions now wrapped up into external review. Clinical priority areas for clinical optimisation agreed with WG (Ophthalmology and Orthopaedics). Further progress demonstrated in improved productivity within ophthalmology through increased numbers of cataract surgery per list, though fragility of SLA arrangements remains a risk factor. Further clinical engagement planned with team to support developments. Clinical leadership [roles appointed to (including orthopaedics) with programme of improvement expected to fall under monitoring of Better Together implementation programme.	Partially Complete

Appendices:

The following appendices are provided with more details:

- 2.6a – Internal audit - Findings Completed since last report
- 2.6b – Internal audit - Findings Not Yet Due
- 2.6c – Internal audit – Findings that are Overdue
- 2.6d – Internal audit - Findings with Revised Deadlines
- 2.6e – External audit - Findings Completed since last report
- 2.6f – External audit – Findings that are Overdue
- 2.6g – External audit - Findings with Revised Deadlines
- 2.6h- External audit – Findings Not Yet Due

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
222318	2022/2023	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Assistant Director of Therapies and Health Science	R3	Medium	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	okt-23	okt-25	Complete	Complete		Meeting held with WOD 28.03.2023 - recruitment process and ESR capability to be looked into further to support achievement of this recommendation. **November 2023:** WOD engagement with ESR team and NWSSP regarding potential to strengthen process through existing TRAC/ESR systems. Delayed meeting due to WOD/NWSSP capacity but re-engaged Nov 2023 and meeting planned. Deadline revised to reflect this. **July 2024:** No progress on this action following secondment of Deputy Director of AHPs & HS for first half of 2024. Reengagement with WOD required. **December 2024** - No progress made as Deputy Director of AHPs & HS was on secondment for first half of 2024 and was then successful in getting a new role, leaving the post vacant. Reengagement with WOD required when new deputy Director in post . **February 2025 -** Review undertaken to assess feasibility of this action for delivery with view remaining that this should be acheivable with appropriate engagement. HR engaged by new Deputy Director of AHPs & HS to recommence progression of this action. Meeting scheduled for March 25 with key stakeholders to re-explore options and establish an action plan with associated timelines for delivery. **August 2025 -** This work was deprioritised due to capacity to be reviewed in October 25. **January 2026 -** Ongoing with new Deputy AHP & HCS (Started in role 05.01.26). No progress to be reported at this stage. **May 2026 update:** Confirmation automation and monitoring in place. Completed.	capacity in WOD	low risk and manual processes	Achieved	Digital automation in place ensuring Professional Registration Numbers transferred from Trac directly to ESR on appointment to Powys THB. Monitoring in place as part of quarterly audit cycle of all registered employee professional registration status as per PTHB / CDP 014 REGISTRATION POLICY	30	6	apr-26	mar-23
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Amie Symes	R5	Medium	The system by which notifications of suspected cases where additional learning needs have been identified and are issued to parents / carers and the Local Authority is yet to be established.	The system will be finalised and validated.Progress reports will be made in the ALN Update to the PPPH Committee.	01.12.2025		Complete	Complete		**August 2025 update:** The appropriate sharing of information between teams is taking place. Plan to now add this to the digital platform and monitor in the same way as requests made for infomration by education. **May 2026 update:** System is in place by which Health Board professionals notify the Local Authority where suspected additional learning needs are identified in preschool children. Data is regularly shared via the ALN Integrated Steering Group that provides assurance that the Health Board is appropriately fulfilling its statutory duty to notify the Local Authority where probable ALN in pre-school children is identified.	N/A	N/A	Completed	Yes	4	1515	apr-26	
242522	2024/2025	Cancer Services	Reasonable	Medical Director		R3	High	Fragmented IT Infrastructure for national cancer services performance: Despite formal agreements and governance structures, the Health Board faces several challenges in tracking cancer patients (Powys residents) across providers (English and Welsh). The majority of issues are outside the Health Board's control and relate to the national IT infrastructure in place: • There is no shared SCP Pathway Identifier, making it difficult to follow patients transferred between providers. • Commissioning performance Data from English providers is centrally held by the Commissioning service Unit and is provided to the Health Board Monthly. However, we note that the data is pseudo-anonymised and cannot be traced back to individual patients. • The HB often receives information only after treatment has commenced. Attempts to access NHS England's central data warehouse have been made by the Digital and Performance team however these have not resulted in a solution. Currently there is reliance on manual data feeds from individual English trusts which introduces inconsistency and administrative burden. There is a lack of clarity and consistency in recording the point of suspicion dates by Welsh providers. This is critical because the point of suspicion is the official start of the SCP clock and directly impacts performance metrics and patient tracking.There are also operational delays in diagnostics and histology commissioned services. Delays in reporting which can leave patients in a suspected status but still open on the WPAS system, awaiting confirmation. This affects the ability to close/downgrade pathways and accurately reflect the point of suspicion and subsequently meet the milestones against the SCP targets. We note that this is an intentional approach put in place by the Health Board where pathways are not downgraded until consultants	The Health Board will continue to advocate, engage and work with providers and with DHCW/NHS Wales and NHS England to attempt to improve the current state of IT Infrastructure surrounding national cancer performance data.	01.03.2026		Complete	Complete	closed down as out of PTHB's control.	**29/07/2025 update:** Following discussion at ARAC, further discussion to take place bewieen Board Sec and Audit Wales re this action. **January 2026 Update:** I don think the HB can make any further progress to close this. Discussion above needed to resolve. **May 2026 update: Closed down as out of PTHB's control.**	closed down as out of PTHB's control.				1	1515	apr-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R7	High	No central monitoring and reporting arrangements are in place. As highlighted under the previous objectives, there is currently no central register of all mattresses in place, and no process for recording compliance with cleaning requirements or the completion of monthly mattress audits. As a result, there is also no central monitoring or reporting of information relating to mattresses. The information that should be captured and reported would be expected to include the following: • Details of all mattresses on each ward; • Confirmation of compliance with cleaning and maintenance requirements; • The number of mattress audits undertaken; • The number of issues identified analysed by category; and • The length of time taken to resolve the issues identified analysed into appropriate time bands. Furthermore, the report should include previously reported results so that comparison and trends can be identified and drawn out. This information should be regularly reported to appropriate Groups within the Localities and Service Group.There should also be a clear mechanism for escalating any serious issues identified through the reports up to an appropriate Committee of the Board.	A system which captures the information suggested, will be put in place for mattresses along with appropriate reporting within the Localities. A clear mechanism for escalation of serious issues will also be established.	30.09.2025		Complete	Complete	Central monitoring and reporting arrangments now in place.	**22.8.2025 Update:** * Helen Kendrick to confirm the action of a central register - to be held on a SharePoint site for wide team access. * All CSM have received a copy of the PowerPoint update to come to every CSG QSPE meeting - inserted for records. This evidences the requirement for tracking and raising of issues. - Amendment, the document cannot be inserted due to editing rights so will share documents in an email. * We have also asked for a tracker of orders for replacement covers and mattresses and a review of cleaning practices & education provision. We are revieing whether we can add the mattress audits to MEG digital system to Ahava clear dashboard. **03.02.26 Update** - Process remains in place and is now embedded in Q&S reports for each area - Education in place with training delivery - awaiting % update from IP&C - Medical devices have confirmed that a mattress register has been developed and is awaiting validation - inventory available - to be mapped against E-quip and asset numbers. Timeframe for completion Q1 26/27 **05.03.26 Update:** -Validation has taken place – Risk mitigation completed and closed..	None	Central monitoring and reporting arrangments now in place.	Achieved	Central monitoring and reporting arrangments now in place.	7	1515	apr-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R1	High	Lack of awareness and specific training on the Health Board's Mattress Policy.Limited specific training on the Health Board's mattress policy has been provided and so most staff have limited awareness of its requirements.Furthermore, no register is maintained which records who has received specific training and how this compares with those staff undertaking the work	Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered.	30.07.2025		Complete	Complete	Training Programme in place and recorded on ESR	**28.08.2025 update:** * infection prevention and control emailed about training - there is some further discussion with drive about their offer under the contract. Awaiting an update from Gareth Thomas. * We have more substantive staff in post now with a reduction in 30 WTE vacancies and less agency use, so saturation of training is possible. * Lead for each ward to be identified by each CSM. 3.2.26 Update - Training program in place - Training Record held on ESR 15/5/26 Update As Previous - inreasing register of staff trained. IP&C confirmed local training provision with cascade training at ward level.	None	Training Programme in place and recorded on ESR	Achieved	Training Programme in place and recorded on ESR	9	1515	apr-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R2	Medium	No monthly confirmation of compliance with the Health Board's policy. There is currently no process in place whereby the ward leads confirm at the end of each month that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy.There is also no periodic review undertaken by the CSMs to check completion and follow up on any issues where necessary.	A system will be implemented to record monthly confirmation from the ward leads that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. The records will be reviewed by the Community Services Managers and followed up where necessary. A summary of these declarations will also be incorporated into the reporting arrangements under Finding 7.	31.08.2025		Complete	Complete	System in place for recording and monitoring.	**28.08.2025 update:** Audit channel in Teams confirms that each ward have undertaken a mattress check. * Confirmation from the North and Mid CSM that they have undertaken an oversight check of mattresses. * Plan in place for the South CSM to undertake oversight checks - to be confirmed end of September 2025. **Update 3.2.26** - confrimation that all CSM have oversight and Matress audits are being undertaken monthly. - This process remains centrally accessible for review in teams channel and is also reported through Q&S reports **15/5/26 Update** Updates on Mattress Audits are part of standing agenda for CSG Q&S Structure - compliance checks in place.	None	Monthly monitoring	Achieved	System in place for recording and monitoring.	7	1515	apr-26	

242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Linzi Shone	R3	High	Monthly mattress audits not completed by all wards. As detailed above, monthly mattress audits are not being completed by all wards.Furthermore, the audit templates in the mattress policy were not consistently used.	All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.	30.07.2025		Complete	Complete	Evidence of monthly compliance through Q&S minutes/recordings	**22.8.2025 Update:** * Email shared with all ward leaders by Head of Nursing (see email as unable to embed documents). * Mattress audits all undertaken for the months of July and August, with oversight of compliance of completeness by CSM team - due for reporting through QSPE on 6th October 2025 **3.2.26 Update** - reports have been recieved regularly through Q&S process - Evidence of monthly compliance through teams channel and Q&S minutes/recordings - Evidence of correct audit template being used. **Update 15.5.26** - prcoess BAU - Close	None	Monthly monitoring	Achieved	Evidence of monthly compliance through Q&S minutes/recordings	9	1515	apr-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R4	High	Confirmation that actions are taken to address issues identified: Where issues were identified in the mattress audits that we reviewed, there was generally no confirmation whether action had been taken to rectify the issues and if so, when it occurred. We also noted that there is currently no register in place that records the mattress audits and details any issues identified and the actions taken to address them.	A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.	30.07.2025		Complete	Complete	Actions and escalations captued in Ward level audits and reported through Q&S structure.	**22.8.2025 update:** This action requires completion - awaiting central resister to be shared by medical devices lead who is on leave. **3.2.26 Update** - Actions and escalations for ordering replacement covers/parts are captued in Ward level audits and reported through Q&S structure. **May 2026 Update** - Sustained process in place. Can be closed/completed	None	Monthly monitoring	Achieved	Actions and escalations captued in Ward level audits and reported through Q&S structure. 15.5.26 Update - sustained process in place close	9	1515	apr-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Paul Sussex	R6	High	Missing mattress audit information.Mattress identifier numbers and identifiable signatures were often missing on the mattress audits we reviewed.On some of the audits we also noted that there was no information recorded for a number of the mattresses, and the reasons for the omissions were not indicated.	Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.	30.08.2025		Complete	Complete	New process in place demonstrating complaince	**22.8.2025 update:** There was an issue that some of the identifiable information on mattresses was coming off during the process of cleaning - a request has been made to HK to ensure all information is attached to mattresses that has more permanence, this is under review. **Update 3.2.26** - Medical devices confirmed that a process is in place to secure asset numbers on devices. **Update May 2026:** No change - prcoess in place - recommend completion	None	Monthly monitoring	Achieved	New process in place demonstrating complaince	8	1515	apr-26	
242512	2024/2025	Partnership Governance Framework Final report		Director of Corporate Governance		R1		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.	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.	31.03.2026		Complete	Complete		**January 2026:** The mid year report was completed with the recommended action in mind. The end of year review will be undertaken as planned and a further update reported at the next reporting point. **May 2026 update:Framework has been reviewed, reporting developed and focus given to ensurting reports are succincvt and meaningful. Reporting to Executive and PPPH committees will continue.**				Yes - Framework reports		1515	apr-26	
242512	2024/2026	Partnership Governance Framework Final report		Director of Corporate Governance		R2		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.	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.	31.03.2026		Complete	Complete		**January 2026:** The action considers to be a kjey consideration and will form part of the annual review as scheduled. **May 2026 update: Review completed, Framework reporting will continue to be proportionate and take into consideration partnership building.**						1515	apr-26	
252611	2025/2026	Mental Health and Learning Disability Triage and Assessment Process	Reasonable	Director of Primary Care, Community and Mental Health	Merielle Restall	R2	Medium	The SPOA Service has a draft SOP that outlines in a clear, comprehensive and logical format the referral and triage criteria and processes, and these are underpinned by referral and triage pathways that explain the processes in detail. The SOP also includes a copy of the Colgate Triage Guidelines and Tool which are the formal requirements relating to the triage process undertaken by SPOA nurse assessors to determine further assessment and action. However, compliance timescales for each of the Colgate Triage Categories A to F are not directly stated within the SOP but are included within two Appendices. For ease of reference, it would be useful to include a summary of the Colgate Triage criteria and required triage timescales for each into the body of the SOP.	The SPOA Service draft SOP will be updated to reflect the Service's relationships with other Mental Health Service's respective SOPs as soon as is practicable. This action has been completed; SOP has been reviewed and updated to reflect current operational arrangements and is currently out to comments for wider service.A timescale for submission to the MH&LD Clincal Policy Advisory Group (CPAG) for approval will be confirmed once the SOP is updated.Following this, submission to SMT for approval.	20.01.2026		Complete	Complete		**January 2026:** The SOP has been reviewed and completed and is due to go back through the Clinical Policy Adivsory Group (CPAG) on 4/2/26. **May 2026 update:** Been back through CPAG nd through to SMT with April 2026 approval date						1515	apr-26	08.01.2026
252623	2025/2026	Decontamination	Reasonable	Director of Nursing, Quality, Women and Family Health	Gareth Thomas	R3	Medium	The Training Matrix included a number of unfilled cells highlighted in yellow, although this was partly due to training in progress or new starters.Similarly, Tristel and Trophon training records for annual refresher training in relation to ultrasound probes used in Radiology and Maternity indicated some outstanding training, although we were informed that this had been partly impacted by IT issues accessing online training	All staff training will be brought up to date and kept up to date going forward.	31.01.2026		Complete	Complete		**May 2026 update:** This was fully implemented, and staff training was brought up to date (excluding those currently on long-term sickness or maternity leave) by the end of January 2026. Ongoing monitoring will continue through the Decontamination Safety Group and up[ward to the IPC Committee					2	1515	apr-26	08.01.2026
252619	2025/2026	Digital System Uptake Final Report	Limited	Director of Allied Health Professions, Health Sciences and Digital	Head of Digital Programmes & Chief Nurse Informatics Lead	R2	Medium	Not all projects contained a defined training stage within the plan and have relied on early stakeholder engagement and ad hoc training sessions.	At the time of the Audit an interim arrangement was already in place with the recently recruited Training Function. To support this, training documentation will be prepared and will be incorporated into the project framework suite of templates, providing guidance for project managers during the implementation of new projects. Where training is deprioritised, this will be reported by the project board, in the Risks and Issues Logs. Training schedules will be added as a clearly defined milestone, against the project, and will record the method of training that will be provided based on each project requirements and workforce considerations. Some training will have to be cascade training due to the size of the training team and the demand and this will be the responsibility of the operations team.	28.02.2026		Complete	Complete		**January 2026 update:** A business case has been created to establish a permanent training function. It received endorsement from the IBG in December 2025, but needs resubmitted to the executive committee accompanied by a cost-saving proposal within 6 months, and so only a 6 month extension to the existing interim arrangement has been approved at Executive Committee. A training plan has been developed which encompass training approaches, activities, rollout strategies. Evaluation metrics are in development. Once approved, it will be incorporated into the suite of implementation framework templates available on the digital SharePoint page. **May 2026 update:** This is complete, the trainers are now in permanent positions and will support the training requirements for the organisation for digital clinical.	None	Digital trainers are currently in place to assist with several major projects, and the knowledge gained will be shared across further digial initiatives.	28.02.2026	Yes	2	1515	apr-26	08.01.2026
252619	2025/2026	Digital System Uptake Final Report	Limited	Director of Allied Health Professions, Health Sciences and Digital	Head of Digital Programmes and Chief Nurse Informatics Lead	R4	Medium	Tracking of system uptake is within individual project structures. There is no comprehensive, overall dashboard or proactive monitoring processes that provides an integrated view of adoption across the Health Board. We also note that there is a quarterly reporting which is provided to the Executive Committee, this includes reporting on digital system uptake, however reporting stops once the project is closed.	At the time of the audit, there was a Clinical Digital Systems group implemented, that has a focus for reviewing system uptake and usage. This will be an important governance hierarchy led by Clinicians and in collaboration with Finance and digital leads. There is currently not a project management system tracking tool in place to ensure that a method of tracking utilisation is embedded in all future projects. This will be reviewed to support the outcome for a dashboard reporting and performance.	31.03.2026		Complete	Complete		**January 2026 update:**In Development **May 2026 update:** We now have procedures in place to ensure live dashboards are available to monitor adoption and usage for the lifetime of the system, examples are Print Usage, Attend Anyware, Digital Maternity, Electronic Prescribing (in dev) and will be available for Connected Care. We intend to include those adoption/usage figures in our quarterly reports or where applicable.	None	Currently available on separate documents rather than 1 tracker	31.03.2026	yes	0	1515	apr-26	08.01.2026
252619	2025/2026	Digital System Uptake Final Report	Limited	Director of Allied Health Professions, Health Sciences and Digital	Head of Digital Programmes and Assistant Directors of Operational Services.	R5	Medium	The analysis of the causes of low uptake is not always rigorous. Adoption challenges are often explained vaguely without examining the underlying barriers, and in some cases services have been withdrawn without proper analysis and development of actions to overcome barriers. There is an awareness of cultural and organisational factors such as staff resistance, compliance issues, and geographical dispersion however these are not systematically addressed.	This will be tracked as part of the Lessons Learned log, which will commence at the start of every project, and complete within 3 months of Go Live, where there is an ongoing requirement to capture uptake and usage, this will transition to the benefits framework logs, and be reported to the Clinical Digital Improvement group and via the Digital First performance executive update reports	31.03.2026		Complete	Complete		**January 2026 update:** A FITT Framework has been created to facilitate adoption and now requires approval before being shared with the digital project managers. **May 2026 update:** Lessons Learned logs are embedded in the Programme template folders managed now in all projects. There is a post evaluation feedback from that has been developed and for example DMC was live early March, the post live evaluation is now with the Programme SRO and operational teams to complete and review.	None	Through comms and testomon	31.03.2026	yes	0	1515	apr-26	08.01.2026
252616	2025/2026	Staff Development Programme	Substantial	Director of People, Culture and Transformation	Head of Organisational Development	R1	Medium	Whilst we acknowledge that feedback is collected following the participation in the Managers Programme and CLIP there is currently no evidence that this feedback is formally shared or discussed at any governance forum. Although the Head of Organisational Development indicated that the feedback would be presented at team meetings and the People and Culture Committee, this has not yet occurred.There is no documented process to monitor or action issues raised through staff feedback. There are no formal plans in place to address recurring themes or issues, meaning thatopportunities for programme improvement may be missed	Management will agree on the forums through which staff feedback is presented. Management will establish a formal medium through which key concerns are captured with actions put in place to strengthen, improve the programme, and further aid staff's development.	31.03.2026		Complete	Complete		**January 2026:** Quarterly quality assurance meetings have been established for those delivering leadership and management programmes with the first formal meeting scheduled for March. Work is being undertaken to standardise participant feedback at the end of training sessions, as well as understand the longer-term evaluation methodology. **May 2026 update:** Quarterly QA meetings are now in place within the Organisational Development Team with the first taken place to establish the process and approach to be taken to gather Kirkpatrick Level 1 and Level 2 feedback, capture actions and adjust traning as required (meeting date 25 Feb 2026, next 03 Jun2 2026).					0	1515	apr-26	08.01.2026

252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services	Financial Accountant	R2	Medium	The testing we undertook on a sample of 15 balance sheet reconciliations completed identified the following issues with some of the payroll deductions reconciliations: • Incomplete information regarding outstanding transactions. In some cases, it was an amount with no breakdown of the individual amounts, staff payroll number and related financial period; • Balances brought forward from previous financial years; and • The reconciliations related to salary sacrifice schemes included balances for staff where there has been no activity this financial year.	For future reconciliations we will ensure that all outstanding transactions have appropriate supporting details noted. We will also ensure that such details are included where the reconciliation has a brought forward balance from a previous financial year. With regards to the reconciliations concerning salary sacrifice schemes we will undertake a review for those balances where there is no longer any activity and take the appropriate action to clear the balance.	31.03.2026		Complete	Complete		**January 2026 Update:** Initial discussions with Salary Sacrifice all wales team have taken place and this action is being taken forward. **May 2026 update:** This action has been completed					0	1515	apr-26	08.01.2026
252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services	Assistant Director of Finance	R3	Medium	Raising Invoices:Our testing on a sample of invoices raised from information recorded within the Periodic Income Register identified issues concerning: • The timeliness if invoices raised; • Difference in the value of the invoice to the value recorded within the Periodic Income Register; and • Delay in actioning an income accrual.	We will request that the Periodic Income Register is reviewed by Finance staff to ensure all invoice values are up to date and reflect any agreed annual uplift (where applicable). We will ensure that all invoices are raised in accordance with the frequency detailed in the register.We will also remind the Finance Support Team and Management Accounts Staff to update the Periodic Income Register as soon as any changes / updates are known for existing entries as well as any new 'recharges' that are identified.	31.01.2026	28.02.2026	Complete	Complete		**January 2026 Update:** Due to key staff absence this has been delayed by a month but is on track for completion by end of Feb 26 **May 2026 update: This has been actioned**					2	2	apr-26	08.01.2026
252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services	Assistant Director of Finance	R4	High	The processes in place within the Health Board for the management of long outstanding debts need to be improved. As at 30/09/25 the value of debts that had been outstanding for more than 60 days totalled over £882k of which £836k relates to previous financial years. We understand that during the Covid pandemic the Health Board stood down their debt management procedures and as a result when the debt management processes resumed many debtors when contacted assumed that the debt no longer applied as they had not been contacted for some time. We also note that the Health Board no longer makes use of a Debt Collection Agency to pursue their outstanding debts. Our review of the list of outstanding debts noted that some dated as far back as 2006 and have yet to be considered for write off.	We will review all longstanding debts to determine whether the debt should be pursued or considered for write off. We will ensure that all debts are pursued in a timely manner and consider whether to utilise the service of a debt collection agency.All overdue debts older than 6 months old are subject to a bad debt provision in the annual accounts. Following this review a summary of debts to be written off will be provided to the March 2026 Audit Risk and Assurance Committee to ensure enacted within the 25/26 financial year.	31.03.2026		Complete	Complete		**January 2026 Update:** Work on this is scheduled for February 2026 **May 2026 update: The debt write off review has been undertaken and actioned**					0	1515	apr-26	08.01.2026
252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services	Assistant Director of Finance	R5	Medium	From our fieldwork we noted that no debts have been proposed for write off this financial year. We also note that the Health Board has delegated authorisation of debt write off to the Audit, Risk & Assurance Committee regardless of the debt value. Good practice would be to delegate authorisation of lower value debt write off to Senior Finance staff subject to a suitable financial limit with the Committee continuing to authorise larger debt values. All debts authorised / proposed for write off should continue to be reported to the Audit, Risk & Assurance Committee for formal approval	We will undertake a review of all outstanding debts to determine whether any long outstanding debts should be proposed for write off. We will consider reviewing the delegated limits for write off. Following this review summary of debts to be written off will be provided to the March 2026 Audit Risk and Assurance Committee to ensure enacted within the 25/26 financial year.	31.03.2026		Complete	Complete		**January 2026 Update:** Work on this is scheduled for February 2026 **May 2026 update:** The debt write off review has been undertaken and actioned					0	1515	apr-26	08.01.2026
252617	2025/2026	Anti-Racism Action Plan	Reasonable	Director of People, Culture and Transformation	Service Lead for Welsh Language & Equalities	R1	Medium	The action plan contains 38 actions of which 13 are fully complete. 21 are shown as being on-track and four are delayed due to minor issues. Of the 25 actions therefore still to be completed, six were significantly overdue the date for completion shown in the plan, with five of these being identified as still on-track and one delayed for minor issues.	The Action Plan will be updated to either show these actions as delayed or to amend the dates for completion with justification provided for the revision.	01.03.2026		Complete	Complete		**May 2026 update:** The action plan was reviewed and updated in April to ensure it accurately reflects the current status of all actions. This is available via the health board's intranet pages Anti-Racism at Powys Teaching Health Board, this will be undertaken on a quarterly basis.			Complete	This is available via the health board's intranet pages Anti-Racism at Powys Teaching Health Board		1515	apr-26	
252617	2025/2026	Anti-Racism Action Plan	Reasonable	Director of People, Culture and Transformation	Service Lead for Welsh Language & Equalities / Director of People, Culture & Transformation	R2	Medium	Progress against the action plan is not being appropriately monitored on a sufficiently regular basis leading to a greater risk of actions not being achieved.	The Anti-Racist Action Plan will be reported to the People & Culture Committee on at least a six-monthly basis.	01.04.2026		Complete	Complete		**May 2026 update:** Committee updates are typically delivered in a presentation format. To strengthen assurance regarding the robustness and accuracy of the action plan, the full plan will be included as an addendum to future updates provided to the People and Culture Committee to ensure oversight of progress against the plan. These updates will be shared on a six-monthly basis, in line with the audit recommendation.				Not yet - Relates to future agenda items.		1515	apr-26	
252617	2025/2026	Anti-Racism Action Plan	Reasonable	Director of People, Culture and Transformation	Service Lead for Welsh Language & Equalities	R4	Medium	The Health Board did publicise the Anti-Racism Action Plan to all staff via the intranet when first launched. In addition, the Equality and Welsh Language SharePoint site has been used to publicise a number of events. However, these are almost exclusively being delivered by external parties – for example the links to Black History Month are to sessions being run by DHCW that are open to all NHS Wales staff. Whilst it is right to publicise the event and allow staff to be aware of, and take advantage of it, it does also clearly highlight the lack of something specific in this regard from the Health Board. The Equality and Welsh Language Newsletter for January 2026 highlights a number of successes for 2025, none of which relate to anti-racism.	In line with the stated action in the Anti-Racism Action Plan the Health Board will increase the amount and regularity of communication, supported by a programme of events delivered both internally and externally, to publicise and demonstrate commitment to an anti-racist culture and approach.	01.06.2026		Complete	Complete		**May 2026 update:** We will continue a programme of communication demonstrating a committment to an anti-racist culture and appraoch. Recongising that this will be ongoing, progress has been made to increase visibility and activity, including; - Delivery of internally commissioned hate crime training - Targeted promotion of unconscious bias trainin - Continued production of the quarterly Equality and Welsh Language bulletin. As part of our continued actions within the local ARAP, actions will continue to be developed to strengthen the Health Board's visible commitment as work progresses.				Yes		1515	apr-26	
252602	2025/2026	Policy Management	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R1	High	Our review of the policy database as at 15th January 2026 noted that there are currently 185 policies listed of which: • 107 policies are in date; • Four policies are due for review; • 74 policies are recorded as expired/overdue for review, of which 18 relate to All Wales policies which are regarded as extant leaving 56 policies expired. This equates to approximately 30% of the total policies recorded. With regards to the overdue policies, whilst the majority of them have become overdue since 2023, there are a small number that have been overdue for review as far back as 2012.	The accountable Executive Director will be contacted with a reminder that the relevant policy/ies is overdue for review and to request an update of when the review will take place.	31.03.2026		Complete	Complete		**April 2026 update**: All Executive Directors have been contacted and provided a detailed reminder regarding any overdue policies in their Directorates as of April 2026. Responses on progress have been requested and a position report is due to be presented to the Board in either May or July.						1515	apr-26	
252602	2025/2026	Policy Management	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R2	Medium	The internet page for policies and procedures included a link to access policies relating to the NHS Wales Joint Commissioning Committee. At the time of our field work this link did not work. • Our review of the documents saved on the clinical and 'non-clinical libraries' pages of the intranet identified occasions where documents were saved as WORD documents rather than PDF documents. There is a risk that staff accessing these documents could amend said documents in error. • As part of our testing we identified that one control document listed on the database could not be located on the intranet. A note on the database stated that the document was out of date and being reviewed. • Our testing also identified that two documents within our sample could only be accessed via a link to the department's intranet page that was saved within the clinical document library, meaning no copies of the documents were saved on the policies and procedures intranet pages.	We have undertaken a review of the information saved on the policies and procedures internet and intranet pages to ensure that links are working, documents are saved as PDF versions where applicable, and copies of all documents listed on the database are saved on the intranet and available to staff even if under review. Item listed on database has been confirmed by the service as archived and our database has been updated.			Complete	Complete		We have undertaken a review of the information saved on the policies and procedures internet and intranet pages to ensure that links are working, documents are saved as PDF versions where applicable, and copies of all documents listed on the database are saved on the intranet and available to staff even if under review. Item listed on database has been confirmed by the service as archived and our database has been updated.						1515	apr-26	
252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R1	Medium	There is an issue with the October 2022 review date for the Health Board's DoLS policy having passed. Although this was explained at the outset of the audit as initially being due to the UK Government delay and indecision with any potential implementation of the Liberty Protection Safeguards (LPS), which were effectively 'abandoned' in April 2023. Currently, the DoLS policy is unable to reflect updates within its policy until PTHB determine its Supervisory Body Role, following the Local Authority notice that they cannot continue their role of DoLS Co-ordination. This remains an identified gap within PTHB. The Policy should still be formally reviewed and updated where required. We also noted that there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen, and also note that the WG policy does not include reporting either.	Update DoLs Policy			Complete	Complete		**March 2026 update:** The DoLS Policy has been updated and converted into a practice guidance document entitled 'Deprivation of Liberty Safeguards. Guidance'. The Guidance was approved by the PTHB MCA Operational & Practice Improvement Group in January 2026. The Guidance is comprehensive and covers all elements of the DoLS process.						1515	apr-26	
252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R2	Medium	The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is noted under matter arising 4.	A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training put into place for the Managing Authority.	01.09.2026		Complete	Complete		**March 2026 update:** A Business case for the role of DoLS Co ordinator was developed and approved in May 2025. An analysis of required DoLS training was undertaken by a Task & Finish Group. All PTHB wards have been provided with a training session covering their managing authority responsibilities. A six-monthly rolling programme of training sessions to each ward started in February 2026.				Complete and evidence can be provided		1515	apr-26	
252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R3	Medium	Action First are contracted to the Health Board to provide BIA personnel when the demand rises above a level that can be managed by the Health Board Staff. The Health Board have been unable to confirm what/if any process exists to ensure the Action First staff are fully qualified and currently certified to fulfil the role.	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required.	01.02.2025		Complete	Complete		**March 2026 update:** Advice was received from the Procurement service and the qualifications and accreditation for all the current external assessors provided by Action First have been confirmed. A process has also been set-up to ensure that the same information is confirmed for any new external assessors. This will be managed by Safeguarding Administration. Procurement confirmed that the contract does not need to be amended at this stage, but this can be done when the contract is renewed.				Complete and evidence can be provided		1515	apr-26	

252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R4	High	The DoLS process previously failed to operate correctly when key personnel left the Health Board. The current interim measure has allowed additional administration for PCC to support the DoLS process using Welsh Government grant money. The MCA Senior Practitioner is also stepping outside of her role to undertake some responsibilities required in the DoLS Co-ordination responsibility. However, there remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team.	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	01.06.2025		Complete	Complete		**March 2026 update:** A Business case which included the roles of DoLS Co-ordinator and Best Interest Assessors, and the provision of administration was developed and approved in May 2025. The full title of the DoLS Co-ordinator role is the 'MCA DoLS Supervisory Body Authorised Signatory and Quality Assurance Practitioner'. There was a delay in recruiting to the role as the initial cycle did not have candidates with the necessary specialist knowledge. Interim arrangements were put in place from October 2025 until the permanent recruitment was completed and the Practitioner commenced in role in January 2025. The Best Interest Assessor posts have now also been recruited into and the individuals have commenced. A Service Level Agreement is now in place between the Health Board and Powys County Council for the provision of an administrative function				Complete and evidence can be provided		1515	apr-26	
252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R5	High	Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to the MCA Senior Practitioners normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications.	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	01.06.2025		Complete	Complete		**March 2026 update:** A Business case which included the role of DoLS Co-ordinator was developed and approved in May 2025. The job description for the permanent MCA DoLS Supervisory Body Authorised Signatory and Quality Assurance Practitioner confirms that the post includes undertaking the role of authorised signatory and also developing and expanding the capacity of DoLS signatories. The work to improve the DoLS signatories process has included increasing the number of signatories on the rota by five which has enabled reduced demand on other signatories and a robust sign-off process is now in place.				Complete and evidence can be provided		1515	apr-26	
252621	2025/2026	Deprivation of Liberties Safeguards Follow-up	Not Rated	Director of Nursing, Quality, Women and Family Health	Assistant Director of Nursing	R6	High	The DoLS applications have timescales for completion, being within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one. To date the Health Board has not monitored or reported whether or not the target dates have been achieved. The case tracking spreadsheet updated by the DoLS Admin team, is available to PTHB in real time since October 2024 and prior to this the spreadsheet was shared for the purpose of the audit from April 2024. This identifies within that time frame for the standard applications the target date was not achieved in 50% of cases. For urgent applications, 77% were not completed within the 7 day time limit and 68% were not completed within the 14-day extended. We were informed by the MCA Senior Practitioner that the current demand of application's are above what the Health Board can provide with the number of BIA's available and that the procurement of Action First is dependent on WG grant money being available for this.	The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A DoLs Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group.	01.06.2025		Complete	Complete		**March 2026 update:** The DoLS Case Tracker spreadsheet has been updated and now comprehensively covers all stages of the DoLS process including request, assessment and authorisation. Completion dates for the key stages of the process are also recorded and tracked. The Case Tracker is available to Health Board and Powys County Council in real time with required information governance in place. Review of a download form the live Case Tracker confirmed that the information recorded is complete and up to date. Information is extracted from the database through a BI report to provide monthly statistics on DoLS performance and this is reported into the Health Board's MCA Operational & Practice Improvement Group. The Group then reports into the Health Board's Safeguarding Strategic Group.				Complete and evidence can be provided		1515	apr-26	
252613	2025/2026	Primary Care - Clusters Project Management	Substantial	Director of Primary Care, Community and Mental Health	Head of Primary Care	R1	Medium	The terms of reference for the North Cluster state that: For decisions where there is a financial implication, no less than 75% of members will secure a decision (12 representatives). However, testing of a number of projects identified approvals being based on numbers that were frequently less than 12 and which were as low as eight approving members. The reason for this is due to the following: • The Cluster having less than 16 members: • Members being ineligible to vote due to declared conflicts of interest; and • Members not responding to the request to vote (which is done virtually).	The wording of the Terms of Reference for each of the Clusters will be amended to remove the reference to a specific number of representatives and to include the word eligible – i.e. therefore excluding any member with a declared conflict of interest but not excluding those that have just not responded to the request to vote.	31.01.2026		Complete	Complete		**May 2026 Update:** Action completed within 31st January deadline						1515	apr-26	
252607	2025/2026	North Powys Integrated Wellbeing Hub	Reasonable	Director of Improvement and Transformation		R2	Medium	The THB should seek clarity from Welsh Government as to the required deadline and process for demonstrating compliance. It may be that compliance should be demonstrated through the SOC/OBC submission or can be developed further during the FBC stage. Whilst we have rated this issue as a Medium Priority to resolve from a procedural perspective, we recognise that the THB has demonstrated during the audit the actions taken in relation to the conditions, and the more significant risk of funding withdrawal (for non-compliance with funding conditions) may be low. The THB	This has been resolved via Welsh Government approval of the SOC / OBC. The approval letter has not defined any further funding conditions.			Complete	Complete		**May 2026 Update:** This has been resolved via Welsh Government approval of the SOC / OBC. The approval letter has not defined any further funding conditions.						0		
252607	2025/2026	North Powys Integrated Wellbeing Hub	Reasonable	Director of Improvement and Transformation	Project Director	R3	Medium	The appointment of the multi-disciplinary advisory team was via framework Service Level Agreement (SLA). For appointments of this value and complexity, best practice would be to use the NEC Professional Services Contract. Application of the same should be considered at any relevantfuture appointments. The benefits of using the NEC PSC include: • Allows for execution as a deed with 12 years liability; • Provides consistency and alignment across the NEC suite with e.g. the Engineering & Construction Contract (ECC).	We will review the potential benefits, against costs, of applying NEC Professional Services Contracts at future appropriate projects. We will seek professional advice on this matter where appropriate.			Complete	Complete		**May 2026 Update:** This action is only required for consideration in relation to future projects and is therefore closed.						0		
252607	2025/2026	North Powys Integrated Wellbeing Hub	Reasonable	Director of Improvement and Transformation	Project Director	R4	Medium	We recognise the THB has set out a series of cost reduction opportunities to be explored during FBC development, which aim to bring the total capital cost down to circa £33m.Going forward, the THB should engage with Welsh Government in line with the specific requirements set out in the March 2026 funding letter (Schedule 1), including the submission of technical and commercial progress reports on the FBC development process, and of appropriate milestone information to satisfy Welsh Government that the programme scope and cost envelope remain within the award.	We will engage with Welsh Government in line with the specific requirements set out in the March 2026 funding letter (Schedule1), including the submission of technical and commercial progress reports on the FBC development process, and of appropriate milestone information to satisfy Welsh Government that the programme scope and cost envelope remain within the award.	Immediate		Complete	Complete		**May 2026 Update:** This is part of the IE project and programme governance structure with regular reporting to North Powys Wellbeing programme board and WG IRCF/Capital team. Governance and reporting structures are in place with regular progress reports and associated milestone information.						0		
252607	2025/2026	North Powys Integrated Wellbeing Hub	Reasonable	Director of Improvement and Transformation	SRO	R5	High	Whilst recognising that revenue costs for building operation had been robustly determined, including benchmarking to other projects, service revenue costs had not yet been determined, with the SOC/OBC stating "In respect of predicted revenue costs, the design at OBC stage does not include sufficient detail for the anticipated cost profile to be assessed".The business case does state the intent to deliver, as a minimum, a revenue neutral position for the Hub and its operation. The absence of revenue costs at this stage reduces the certainty of information available to the Board and Welsh Government when scrutinising the business case. It also does not benchmark well with the position typically confirmed in an OBC, where a revenue budget would have been included. We recognise the tight timeline for submission of the business case may have impacted this position.The emerging revenue position should be reported in a clear and timely manner, to relevant forums (which may include the Board), including any risk to the achievement of the revenue neutral target.	We will report any negative deviation from the revenue neutral target in a timely manner to appropriate forums within the THB			Complete	Complete		**May 2026 Update:** This is part of the IE project and programme governance structure with regular reporting to North Powys Wellbeing programme board and WG IRCF/Capital team. Governance and reporting structures are in place within both partner organisations to enable appropriate scrutiny of the FBC development including revenue position.						0		
252601	2025/2027	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R2	Medium	The delay in implementing Datix due to an issue with the software restricts the ability of the Corporate Governance Team to have effective oversight of all risks across the Health Board.	In 2026/27 the Health Board will review its approach to the recording and analysing of risks across the organisation to ensure an appropriate risk system is available to staff and provides sufficient value for money.	01.01.2027		Complete	Complete		**May 2026 Update:** The roll out of the Datix risk system will support the action, this has been paused due to a national system issue with Datix which has very recently been resolved. The development of the operational risk register and directorate risk reporting through directorate performance reviews has enhanced the sighteedness of risks. This action is recommended for closure as it sits within other recommendartions related to risk and risks dupication.	May 2026: the delay in the national Datix issue has caused delay	May 2026: Enhanced signtedness of risks through the ORR and directorate reviews.				0		
252601	2025/2028	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R3	Medium	The issues noted in review of both the Primary Care and Public Health Risk Registers highlight a potential lack of understanding in scoring the impact of risks, and for Public Health specifically there were a number of risks that were either incomplete or bore no evidence of recent review	Whilst the training to be delivered as part of the implementation of a system for risk will help to ensure that such issues are addressed across the whole Health Board, the Corporate Governance Team will ensure that both Public Health and Primary Care resolve the issues noted in the audit.	01.07.2026		Complete	Complete		**May 2026 Update:** Toolkit guidance updated with scoring guidance provided. The wider training for the Datix risk system is covered in other management responses, this recommendation is therefore recommended to be closed.				Yes, toolkit.		0		
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R3	Medium	While the November 2024 Asbestos Annual Report reported anasbestos risk of 10, this was linked to one current removal job rated at 10. Wider derivation of this score was not apparent.There was therefore scope for greater clarity as to the reporting and derivation of the overall asbestos risk within the Health Board estate.At the draft 2025 report (compiled during the audit) linkage to risk scoring of individual works had been removed.	We will clarify the derivation of the overall asbestos risk score e.g. being based on both works and wider factors such as training compliance, up to date procedures, and current surveys.	01.03.2027		Complete	Complete		**May 2026 Update:** the Auditor recognised that the Highlight Report, reflecting risk assessments for projects, had been updated during the audit.				Yes; refreshed Highlight Reporting adopted.	#NUM!	1515	apr-26	13.05.2026

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
252610	2025/2026	Continuing Healthcare	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	R2	Medium	The currently documented procedure describing the general CHC procedure was created in 2015 and last reviewed in 2018. This document was due to be reviewed in 2019, but no review has been documented, and our work has shown that the procedure described does not now accurately reflect the actual procedures employed. The CHC team are well represented at the All-Wales CHC Management Group and so are appropriately positioned to monitor and implement any change to the National Framework Guidance. Whilst this mitigates risk of actual process not aligning with current guidance, any changes are not reflected in procedural documentation. The CHC team have however drafted a new procedure document, and this is currently under review. We have reviewed this document and note that it does not contain reference to other related procedures, several of which are new. Whilst care must be taken to avoid duplication or repetition between procedural documentation, including references in a procedure to related guidance can help to ensure holistic capture of the full end to end process.	The procedure document currently in draft will be updated to include, where appropriate, references to other related and newly created CHC procedures. Review and approval of the draft will then be expedited and the final version circulated to all members of the CHC team for awareness.	30.11.2025	aug-26	Not yet due	Partially complete		**January 2026**: A revised deadline is proposed. Work is progressing; however, completion is dependent on the findings from the external review conducted by Grant Thornton toward the end of 2025. We are currently awaiting the release of the final report, which will inform and shape the transformational programme of work required within the Complex Care team. **May 2026 update**: External support in place with commencement of programme to develop and sign off procedures commenced in May 2026.					5	#NUM!	apr-26	08.01.2026
252617	2025/2026	Anti-Racism Action Plan	Reasonable	Director of People, Culture and Transformation	Service Lead for Welsh Language & Equalities	R3	Medium	The Black, Asian and Minority Ethnic Staff Network is not sufficiently effective due to insufficient membership and a lack of formality in the way that it operates.	The Health Board will continue to promote interest in the network across all staff and will ensure that internationally recruited nurses are particularly made aware of its existence. The remit and purpose of the network will be formalised, and a plan or framework of specific agenda items will be developed for the Network to consider, while still leaving room for emerging and/or immediate issues to be discussed as appropriate.	01.06.2026		Not yet due	Partially complete		**May 2026 update:** A meeting was held with current network members to explore future opportunities and clarify the purpose of the group. In agreement with attendees, the following actions were identified: -Review promotional materials (now complete) -Engage periodically with the Head of People: Business Partnering & EDI (quarterly or as required by the group) - Consider targeted communication approaches to promote network Targeting of communications was discussed, including whether ESR (Electronic Staff Record) could be used to enable direct communication with staff; however, it was agreed (with advice from IG) that this would not be an appropriate use of ESR data. As an alternative, agreement was reached to share communications promoting the network via line managers. This will be undertaken alongside a qualitative survey as part of the local Anti-Racism Action Plan, which is scheduled for circulation in June.	There was some reluctance among network members, particularly given the current small size of the group, to finalise a formal framework at this stage. It was agreed that this would be revisited at a later date, subject to an increase in membership.					1515	apr-26	
252601	2025/2026	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R1	Medium	Documented guidance has not been updated due to the delay in implementing Datix. Existing documentation is largely still relevant although it refers to the role of the Risk and Assurance Group which is no longer in existence. Testing of procedures within Primary Care and Public Health identified some misunderstandings in how to score risks and therefore the provision of training to support the roll-out of Datix would be beneficial in reinforcing consistent and good practice.	In 2026/27 the Health Board will review its approach to the recording and analysing of risks across the organisation to ensure an appropriate system for the reporting and recording of risk is available to staff. In conjunction with this the Risk Management Toolkit will be revised, and appropriate training will be made available to relevant staff. Due to timescales beyond the control of the organisation with regards to the Datix system the allocation of a target implementation date is difficult at this stage, hence a suggestion of March 2027.	01.03.2027		Not yet due	Partially complete		**May 2026 Update:** Risk guidance has been updated. The roll out of the Datix risk system will support the action, this has been paused due to a national system issue with Datix which has very recently been resolved.	May 2026: the delay in the national Datix issue has caused delay	May 2026: Guidance updated.	On target date			0		
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R1	Medium	Monitoring reports showed that 16% of buildings were not included within the original Management Survey. Management were subsequently able to demonstrate that this related to data anomalies of the external consultant which were being managed / addressed(e.g. 6 x-ray facilities reported as separate sites, disposed of premises etc). However, the asbestos issues identified within the (sampled) Brecon Roof works were not identified at the original Management Survey. The October 2024 Asbestos Highlight report, noting the elapsed time since the prior survey, commented that it was: "good practice to revisit surveys and possible rolling programme for individual sites in order to update." Re-inspections. The Asbestos Management Policy requires re-inspections to be undertaken of all premises on an annual basis as directed by risk assessments (e.g. as informed by the management survey and subsequent information). While subject to monitoring and discussion, compliance data and graphs were not included within reports. The effectiveness of reporting the associated risks has been considered at the Risk Management objective.	A decision has been made to introduce a rolling programme of Management Surveys starting with Llanidloes from 2026 alongside the continued programme of re-inspections. (b) In order to increase the resilience of the maximum annual cycle for asbestos re-inspections (which are currently commissioned every year and entailing potential procurement delays) a 5-year contract will be secured.	01.07.2026		Not yet due	Partially complete		**May 2026 Update:** item (a) has been progressed with Llanidloes management survey complete. Item (b) has a target date of December 2026 and is being progressed.					#NUM!	1515	apr-26	13.05.2026
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R2	Medium	While the audit did not find non-compliance with the CAR 2012regulations, procedures did not always fully specify expected administrative and record maintenance requirements, and in one instance did not fully record compliance (In the case of Bronllys, evidence of site induction relied upon the contractor's site diary, and only referenced induction the day prior to works completion). In the event of challenge that due process had been followed, procedures should therefore also include expectations as to administrative processes to evidence compliance e.g. • waste management (see finding 5); and• records of those discovering / disturbing asbestos and associated medical records (noting 40-year retentionrequirements and that at the time of the audit the asbestos officer(s) indicated that they did not have access to historical records of exposure to asbestos). Management advised that they were not aware of any such incidents.In review of minor works it was also found that refurbishment / demolition surveys had not been undertaken in these instances.in the case of Fire Alarms, works were required as part of a larger capital project (being embedded in an Artex roof of similar age to another with known asbestos).Workers were not exposed to undue risk due to the presumption of asbestos presence with associate precautions and practices.However, the Asbestos Management Procedures did not specify exemption from such survey by way of emergency or other exception.It is also possible that without such survey undue asbestos precautions may be undertaken. There was therefore a need to define the nature of works where such exceptions would be applied and the applicable exceptions. Reporting and closureReporting of approvals, costs, issues and completion of minor / emergency Permit jobs is presently as discussed at sub-group meetings. While a listing was available for "Permit" jobs (Table 1), this was not routinely utilised to inform monitoring by the Asbestos Sub-Group of minor works e.g. the February 2024 Asbestos Sub-Group meeting referred to 16 such jobs "mainly in Ystradgynlais and Bronllys" with no further detail.Formal closure was not identified for these jobs. However, there was no exception to standard handover and closure within procedures for minor works. A systematic report could perhaps be of benefit to ensure comprehensive coverage e.g. including authorisation, costing, survey exemptions and closure certification etc	The Asbestos Management Procedures will be reviewed and updated including to:(a) Recognise a process where the Asbestos / Deputy Asbestos Manager can authorise work without the need for samples where the knowledge of the material involved is well-established from similar appropriate prior sampling. (b) Reflect the process to capture the documentation on the closure of Permits.	01.07.2026		Not yet due	Partially complete		**May 2026 Update:** procedures being updated for items (a) and (b) with sign off to be scheduled with Asbestos Safety Group					#NUM!	1515	apr-26	13.05.2026
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R4	Medium	Action dates for all the full number of identified risks (several hundred) were not completed. While all site risks were monitored via Asbestos Management Plans for each site, these did not include monitoring against set risk action dates. There was therefore a need for management to confirm appropriate monitoring and reporting of identified risks.	An action tracker will be developed for the re-inspection survey recommendations (which will provide a pan-Powys tracking tool).	01.09.2026		Not yet due	Partially complete		**May 2026 Update: Pan-Powys tracker being developed.**					#NUM!	1515	apr-26	13.05.2026
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R5	Medium	The October 2025 Highlight Report further noted the need for: "Asbestos Management Plans to be set up for Primary care and leased buildings as well as sites where there are no asbestos containing materials present to provide a historical check" with the need to "gather information from Freeholder / landlord or survey site" and for "documents to be completed in conjunction with project team and use of Powys County Council database for sbestos", with a working group to be set up to progress.Accordingly, there was a corresponding need to ensure Management Plans were in place for Primary Care and leased premises.	A review will be undertaken of the effectiveness of the Duty of Care process related to the monitoring of asbestos management by Landlords of leased premises	01.12.2026		Not yet due	Partially complete		**May 2026 Update: Review ongoing**					#NUM!	1515	apr-26	13.05.2026
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R6	Medium	In accordance with legislation, the Asbestos Management Procedure states that Hazardous Waste: "must only be removed from site by a registered Waste Carrier and transferred to a suitably licensed Hazardous Waste facility with Hazardous Waste Consignment Note to be provided by the Waste Carrier". This was re-iterated at Plans of Work, including the waste carrier licence of the contractor (to permit advance vetting), procedures did not state these additional expectations. Management confirmed that operationally, asbestos waste is stored in red asbestos waste bins, held securely and collected periodically. However, similarly, these processes / requirements were not described within procedures. This also means that staff cannot reasonably be held to account for non-compliance.	The Asbestos Management Procedure will be updated to fully reflect required waste procedures.	01.07.2026		Not yet due	Partially complete		**May 2026 Update: precedures to be updated to reflect waste management process**					#NUM!	1515	apr-26	13.05.2026
252605	2025/2026	Asbestos Management	Reasonable	Director of Finance, Capital and Support Services	Associate Director of Capital, Estates and Property	R7	Medium	Detailed monitoring of asbestos training was undertaken for the Estates, Works and Capital teams.The Asbestos Management Policy requires the Asbestos Annual Report to report on training status.While this reported various tiers of training in place, from awareness to Duty to Manage, it did not report compliance (notably for the Responsible Person and supporting managers).	A narration will be added to the annual report in relation to levels of training compliance.	01.03.2027		Not yet due	Partially complete		**May 2026 Update:** next Annual Asbestos Report will reflect training status for Asbestos Manager					#NUM!	1515	apr-26	13.05.2026

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242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Amie Symes	R4	Medium	Data validation exercises are being undertaken but assurances cannot yet be made with respect to the completeness of data contained in the ALN App.	Data validation exercises will continue and regular compliance reports will be made to the Planning, Partnerships and Population Health Committee.	01.12.2025		Overdue	Partially complete		**August 2025 update:** Progress – PTHB digital tool for managing flow of information and compliance with the standards of the act is now embedded – data validation continues on a monthly basis and reported on through W&C IQPG. Recent Paper presented to PPP&P Committee **May 2026 update:** Remains in development - progress anticipated September 2026	Ongoing digital systems challenges	Services maintain spreadsheets to monitor open requests alongside the use of the digital system and enhanced monitpring arrangements are in place. There is positive engagement with Digital.	TBC pending discussion with Digital		4	1515	apr-26	
242520	2024/2025	Patient Flow and Discharge Managem ent Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Service Managers	R3	Medium	Compliance with D2RA module within ESR: A request for a list of staff who have completed the D2RA course revealed that only one individual had done so. The USC Senior Manager clarified that some staff completed the training before the D2RA module was launched on ESR. Consequently, a request has been sent to all staff to retake the course to ensure their records are updated in ESR. There is no specific deadline for retaking this module, but discharge remains a regular agenda item in their internal meetings. Furthermore, bi-monthly meetings are held with Ward Staff. Although this training is not formally structured, it includes updates on policies and encourages discussions about the impact of these changes on patient care.	Establish a specific timeframe for staff to retake the course, ensuring accountability and timely compliance.Monitor training progress and follow up with staff who have not yet completed the module. Consider using the existing bi-monthly meetings to emphasise the importance of the training, address questions, and provide support for those retaking the course.	01.12.2025		Overdue	Partially complete		**August 2025:** Whilst not a mandatory expectation of learning via ESR, it is acknowledged as part of the 6 Goals for urgent and emergency care workstreams, pathway of care delays and discharge to recover and assess processes, the importance for further education to support effective and proactive discharge planning. An intranet page is available to all ward teams with access to downloadable educational posters and how to access ESR training. Reminder of the training option via ESR sent out to all ward teams and also the flow team for completion 12/8/25. Team managers to monitor compliance. **January 2026** - Awareness of D2RA principles is supported through locally delivered training, refresher sessions and routine discussion within ward and flow team meetings, alongside access to guidance and learning materials via the intranet. Expectations for D2RA are also clearly set out across relevant Standard Operating Procedures. However, uptake of the D2RA module within ESR remains low and does not yet provide a reliable record of staff compliance, and D2RA principles are not yet fully embedded into day-to-day practice across all areas. Further work is planned throughout 2026/27 to reinforce consistent application in practice and to continue promoting completion of the ESR module alongside wider operational embedding. **May 2026 update:** Automated reporting in place for D2RA compliance which is demonstrating some improvement in recording and planning. Further Optimal Hospital Flow training sessions delivered to 8/9 Nov-Present, with 9th ward scheduled for early June. Further developments in place to support local campaign to further improve flow, address improvement in discharge culture and reduce length of stay, including metrics to support implementtion and monitoring.	Competing workloads on clinical teams	Line managers to monitor ESR compliance. Line managers to encourage staff completion	End of Q3		4	1515	apr-26	
242520	2024/2025	Patient Flow and Discharge Managem ent Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R6	Medium	Utilisation of DigiFLO whiteboards: The DigiFLO whiteboard app can be installed on phones, tablets, laptops, and large screens, with nine wards currently equipped. It replicates manual whiteboard processes but faces information governance challenges, particularly maintaining an audit trail to track changes. Currently, large screens are accessible to all staff, but generic accounts only allow display access. Modifications require logging in with individual identification on a computer. Future plans include tap-to-login or PIN systems to enable broader access, including bank and agency staff. The current utilisation of the DigiFLO whiteboards is mixed with some departments still relying on manual whiteboards, as observed during the audit of the two wards.	Conduct targeted training and engagement sessions for departments still relying on manual whiteboards to demonstrate the benefits of the electronic whiteboard and address barriers to adoption. Expedite the implementation of a secure tap-to-login or PIN-based system to ensure accurate tracking of user actions while improving accessibility for all staff, including temporary personnel.	01.12.2025		Overdue	Partially complete		**August 2025 -** Utilisation of DigiFLO whiteboards is supported by the Standard Operating Procedure (CSG 001, Sept 2024), alongside "How to Guides" and resources available on the intranet. These have been reinforced through the DigiFLO Information Roadshow (Nov 2024–Feb 2025), which provided targeted support for staff across all sites. Built-in audit functionality within Powys DigiFLO enables the tracking of user actions, ensuring information governance requirements are met. While a mixed approach remains in place with some reliance on manual whiteboards, utilisation of Powys DigiFLO as the digital option has increased. Options to improve accessibility for temporary personnel are being scoped, including the potential use of a PIN-based access system, though this remains exploratory rather than a confirmed development. **January 2026** - Utilisation of DigiFLO whiteboards has seen some improvement and is supported by established Standard Operating Procedure (CSG 001), user guides and previously delivered targeted engagement delivered through the DigiFLO Information Roadshow. Built-in audit functionality within DigiFLO continued to provide assurance where individual log-ins are used, and stable compliance is being maintained against relevant KPIs, although has not yet reached the desired level of compliance. Full operational embedding has not yet been achieved and a mixed manual and digital approach remains in place across some areas. Further work is planned during 2026/27 to address outstanding technical barriers and support consistent adoption. **May 2026 update:** Utilisation of DigiFLO whiteboards has remained broadly consistent overall, however, compliance against key measures has improved, demonstrating better utilisation of the system. A mixed manual and digital approach remains in place across some areas. Delays have been experienced in implementing a kiosk solution to support communal ward screens. However, most technical barriers have now been addressed and implementation across inpatient areas is expected throughout 2026/27. Access for temporary staff also remains an aspiration, although changes to the licensing model may require this approach to be reconsidered.	**August 2025** - Challenges remain around displaying DigiFLO on communal ward screens, licensing and cost implications, and establishing appropriate access arrangements for temporary staff (linked to licensing considerations). **January 2026** - Progress has been constrained by technical challenges, including infrastructure limitations, licensing requirements and cyber-security considerations, which have delayed the implementation of communal screen functionality with full update capability. **May 2026: Changes to licensing model may make temporary access prohibitively expensive to operate**	**August 2025 -** Ongoing scoping of access solutions, including communal display options and licensing models, is being progressed. **January 2026 -** As an interim measure, a "kiosk" solution providing a read-only communal screen view is planned for implementation in Q4 2025/26, improving visibility while technical solutions are progressed.	Increased utilisation - 2025/26 Temporary staff access - 2026/27		4	1515	apr-26	
242520	2024/2025	Patient Flow and Discharge Managem ent Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R7	Medium	Clinical Frailty Score: The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigiFLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigiFLO whiteboards will l be updated accordingly once this new score is implemented.	Utilise the DigiFLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack.	01.03.2026		Overdue	Partially complete		**August 2025** -Powys DigiFLO has the ability to record Clinical Frailty Scores (CFS), with guidance provided within the Standard Operating Procedure (CSG 001, Sept 2024) and accompanying "How to Guides." Training was delivered through the Powys DigiFLO Information Roadshow (Nov 2024–Feb 2025) to support staff in using this functionality. Recording of CFS is not yet consistent. The CEDAR Hospital-Acquired Deconditioning Tool is now in pilot across other Health Boards; however, as this is a manual recording tool, it cannot currently be integrated into Powys DigiFLO. **January 2026 -** Powys DigiFLO continues to provide functionality to record CFS, supported by the Standard Operating Procedure (CSG 001) and user guides, which have been updated to better align recording expectations with the evidence base of the CFS tool. Recording practice of CFS within Powys DigiFLO remains low and is not yet consistently embedded within admission processes. Wider developments are also underway nationally, with the CEDAR Hospital-Acquired Deconditioning Tool (DEWI) now progressing beyond pilot in some Health Boards; work is planned during 2026/27 to consider how this could be adopted or adapted into PTHB practices. Separately, the number of CGAs undertaken has increased, with further work required to align these separated elements into a more coherent and joined-up approach. **May 2026 update: Utilisation of CFS within Powys DigiFLO remains low and recording practice is not yet consistently embedded within admission processes. Work is planned during 2026/27 to take learning from other areas and utilise similar automated approaches to those developed for D2RA, with the aim of improving compliance and supporting more consistent recording practice. This work will be progressed through the Preventing Deconditioning Workstream alongside implementation of the DEWI tool.**	**August 2025** - Limited visibility of Powys DigiFLO on communal ward screens and the manual nature of the deconditioning tool, which increases time demands on staff.	**August 2025** - Continued embedding of Powys DigiFLO to improve awareness and consistent recording of CFS.	2026/27		1	1515	apr-26	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Luke Jones (DECLO)	R2	High	he DECLO has undertaken some training initiatives and offers individual assistance to colleagues who require guidance in relation to ALN issues but a formal or regular training programme is not currently in place.	Training initiatives will be revisited; a training schedule will be produced, informed by existing or refreshed data about staff knowledge and confidence, and details of training availability will be made available to relevant staff. Records will then be maintained of attendance at completed training.	01.09.2025		Overdue	Partially complete		**August 2025 update:** Due to the focus on clarity of data processes this has not been able to progress – there is slippage anticipate but a focus during the Autumn/Winter term. **March 2026:** Following a meeting with Powys County Council colleagues, it has been agreed that a training will be progressed targeting Children's Therapies professionals with leadership roles in the first instance, before cascading to wider staff. Initial training to be scheduled by end of April 2026, and plans for wider training to be established by end of April 2026. **May 2026 update:** Training for Therapies staff with leadership responsibilties has taken place. Training for wider Children's Therapies staff is scheduled for June 2026; the impact of this training will be evaluated. Awareness-raising training is also being delivered to CAMHS professionals in June 2026. No further training needs have been identified but this will continbue to be reviewed moving forward.	Staff capacity, need to resolve operational process issues prior to training delivery	DECLO is available to support staff as required. Activity completed to resolve operational process issues with Local Authority.	jun-26		7	1515	apr-26	
242519	2024/2025	Additional Learning Needs Final Internal Audit Report	Reasonable	Director of Nursing, Quality, Women and Family Health	Amie Symes	R3	High	A plan is in place, and whilst listed outcomes were appropriate, some were found to be unclear in terms of the means by which they are to be achieved. Target dates either have not been listed, are ambiguously defined, or have elapsed.	Monitoring procedures in relation to the partnership's Strategic Priorities Plan will be reviewed and it will be ensured that regular reports are made at an appropriately senior level, with reference to the reviewed governance arrangements specified in Key Finding 1.	01.09.2025		Overdue	Partially complete		**August 2025 update:** Clarity of arrangement have been agreed – monitoring through an embedding period now. Escalation reporting agreed and in place. **March 2026:** Strategic Plan is being updated iteratively and will be reviewed in Women and Children's Quality and Performance Meeting in March 2026, with ongoing monitoring to ensure satisfactory progress on a quarterly basis. **May 2026 update:** Strategic Plan continues to be updated iteratively but has not yet been reviewed by the the W&C Q&P Meeting. This has been scheduled for the June 2026 Q&P meeting	Competing priorities including digital issues	Review of plan through ALN Integrated Streering Group with oversight of Head of Children's Nursing	jun-26		7	1515	apr-26	

242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R11	Medium	'Planning your Discharge' Letter Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. The Welsh Government Hospital Discharge guidance includes a template for a 'Planning your Discharge' letter, which should be provided to patients. This letter emphasises that discharge planning should already be in progress and outlines the importance of facilitating a quick and safe discharge to enhance the patient's recovery. Powys Community Hospitals. Our sample testing identified only one instance out of twelve where the system recorded that this letter had been issued. The WG guidance does not specify the appropriate timing for issuing the letter. It is therefore important for the Health Board to decide whether the letter should be provided after the patient's initial MDT review or included as part of the admission pack. Additionally, it would be beneficial to document the issue of the discharge letter in the Discharge Discussions section of the WNCR. (Key Finding 9)	Ensure that a 'Planning your Discharge' Letter is issued to each patient. Establish clear guidance on when the letter should be issued. Ensure that the issue of the letter is documented within WNCR system, as highlighted in key finding 9.	01.09.2025	01.12.2025	Overdue	Partially complete		**August 2025:** Discussion underway to allocate a suitable lead for action and delivery. Recommend a revised delivery date of 1/12/2025 **January 2026** - Expectations for informing patients and their families or unpaid carers about discharge planning, including the use of the "Planning your Discharge" letter, are now clearly set out within the Community Hospital Discharge Policies and Procedures SOP. This includes a standard letter (Annexe A) intended to be issued to all patients to support early and safe discharge planning. However, this practice is not yet consistently embedded and evidence of routine issue and recording within WNCR remains limited. Further work is planned during 2026/27 to support practical implementation. **May 2026 update:** Further developments in place to support local campaign to further improve flow, address improvement in discharge culture and reduce length of stay, including metrics to support implementtion and monitoring.					7	4	apr-26	
242521	2024/2025	Business Continuity Planning Final Internal Audit Report	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	R1	Medium	Completeness of Service Area BCP's Review of the six Service Area BCP's identified that whilst all followed the toolkit template, the contact names and telephone numbers of key staff had not been included in three of the six plans. In addition, one 'document owner' and three other key contacts could not be found on Outlook which suggests they may have left the organisation, and several other key contacts had moved on to new job roles and no longer had any BCP responsibilities. Three document owners were recorded by job title but were not named.	The key contact names and telephone numbers will be updated for all 6 BCP's. A process will be developed to ensure all staff contact names and telephone numbers are kept up to date.	30.06.2025	nov-25	Overdue	Partially complete		**August 2025**: Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it's unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manger for Civil Contingencies. **January 2026:** The Directorate is still currently awaiting sight of the BCP to confirm and supply any outstanding information. As the audit documentation has not yet been received, it remains unclear what specific details are required from the service at this stage. **May 2026 update:** Expectation that any BCP reference positions not individuals, and where required on-call procedures. Further review of plans expected in coming months.					10	5	apr-26	
242521	2024/2025	Business Continuity Planning Final Internal Audit Report	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group/Assistant Director of Mental Health/Planning Manager for Civil Contingencies	R2	Medium	Testing of BCP's Service area BCP's should be tested annually in accordance with the Health Board's BCP guidance. The two Community Services Group BCP's had been tested during live incidents, but no planned testing exercises had been carried out. Information on testing for the four Mental Health BCP's was requested but no information was provided in relation to any completed or planned testing.	Annual tests of all service area BCPs will be scheduled and undertaken with subsequent completion of the debrief template and post incident report. Where testing is effectively undertaken via live incidents, full supporting documentation will be retained.	31.07.2025	nov-25	Overdue	Partially complete		**August 2025**: Directorate is awaiting sight of the BCP in order to identify and provide any missing information. The audit document has not been received, so it's unclear what details are required of the service currently. Recommend a revised deadline of Nov'25 to allow actions to be progressed between service and Planning Manger for Civil Contingencies. **January 2026:** Work is still ongoing with Planning Manager for Civil Contingencies to ensure this recommendation is fully completed, where by live testing of BCP's is completed but annually reviews of BCPs are now carried out and services requested to update. **May 2026 update:** Annual desktop reviews of BCPs are carried out as prompted by planning manager, and updates completed as identified.					8	5	apr-26	
252611	2025/2026	Mental Health and Learning Disability Triage and Assessment Process	Reasonable	Director of Primary Care, Community and Mental Health	Lauraine Hamer and Merielle Restall	R1	High	Currently there is no governance structure and arrangements in place that enables the SPOA Service to report governance related matters to the MH & LD Directorate Team meetings. Current reporting undertaken is only that of quality & safety related issues, and these appear to be reported on a very infrequent basis to the Adult Mental Health Putting Things Right (PTR) meeting. As such, the Directorate and wider Health Board governance apparatus may not have effective oversight of the service and may not be formally receiving any key governance issues arising that may require scrutiny and action at a higher level.	An Operational Delivery Group will be established for the SPOA which will formalise operational governance arrangements for the service. It will report into MH&LD SMT via the Service Quality Improvement and Development (SQID) workstream and align to the deliverables identified in the Transformation Workstreamreporting progress to the Better Together Project Board. The SPOA will also formalise the reporting of Quality & Safety related governance into the QUAILS meeting, which is an SMT workstream, this will be on a monthly basis.	01.02.2026		Overdue	Partially complete		**January 2026:** Work underway to put together a reporting template to report into QUAILS on a monthly basis, first meeting 20/1/26. **May 2026 update:** : Terms of reference for SQID updated to reflect new governance responsibility. New structure for SMT now in place to support the ooperational delivery groupo in target setting and for ongoing monitoring. SMT will report though to DMT on any exceptions or escalations as required. BCP for 111p2 SPOA complete						1515	apr-26	08.01.2026
252611	2025/2026	Mental Health and Learning Disability Triage and Assessment Process	Reasonable	Director of Primary Care, Community and Mental Health	Lauraine Hamer and Merielle Restall	R3	Medium	Whilst we can confirm that all sampled referrals were being triaged in accordance with the prescribed timescales, a number of referral to triage timescales stated on the Power BI report that was used for our sampling were erroneous.Initial investigations suggested that this is due to interface issues between WCCIS and Power BI whereby the triage form used by SPOA assessors is not shown as being closed down at the since time on the Power BI report as it was on WCCIS, despite the triage being undertaken in an efficient manner as documented on the WCCIS patient notes audit trail.Additionally, several referrals on the Power BI report stated incorrect Colgate Triage Categories, and this appears to be a glitch whereby they are correctly reflected on WCCIS patient notes but are not being pulled through via Power BI accurately. These issues will need to be addressed to ensure that future Power BI reporting accurately reflects content on WCCIS, as in due course Mental Health Directorate Management, as well as Health Board senior management may request the provision of reports, the content of which is at risk of being inaccurate	Liaison will be undertaken between SPOA management and the WCCIS Systems Team to ensure that future Power BI reporting accurately reflects content on WCCIS, and any interface reporting glitches are identified and remedied. Meeting with WCCIS and BI/IT staff has been scheduled to address discuss issues highlighted and to understand underlying reasons for the noted discrepancies. Based on these discussions an Action Plan will be put into place to rectify and improve data quality	01.03.2026		Overdue	Partially complete		**January 2026:** Digital have put a data quality section on the BI report. It shows: All open referrals (as of the previous evening), by default these are sorted to show those open for the longest first All open triage forms (as of the previous evening), by default these are sorted to show those open for the longest first All instances where a triage form was closed after the associated referral was discharged from SPOA. **May 2026 update:** Overall issues mainly addressed but noting transtion to new case management system will be ongoing work						1515	apr-26	08.01.2026
252611	2025/2026	Mental Health and Learning Disability Triage and Assessment Process	Reasonable	Director of Primary Care, Community and Mental Health	Lauraine Hamer and Merielle Restall	R4	High	At the time of our review there was no reporting of SPOA Service demand, capacity, triage call timescales and performance management data to Directorate senior management. We were informed by service management that no-one within the Health Board has requested any activity reports or any other performance information since the Service became operational in September 2024. SPOA Service management are also unclear what senior anagement would specifically want in the way of reports that could be provided by the Service. Additionally, no KPIs are in place for the SPOA Service, and we were informed that Health Board senior management have not to date asked for any to be introduced. Furthermore, there is no functionality within Power BI to produce reports on agency nursing activity, or the recording of data attributable to agency nursing usage as this information is held on the financial ledgers and not on WCCIS. There is no interface between Power BI to the financial ledgers that would facilitate production of reports/dashboard to show reduction of agency spend. As such, it is unclear if Health Board senior management and Health Board Groups/Committees are being formally appraised of the SPOA Service achieving the anticipated outcomes and benefits detailed within the	SPOA Service management will prepare for regular reporting of its demand, capacity, triage call timescales and performance management activity data to SQID which reports to MH & LD Directorate senior management. Improved data and reporting capacity has been highlighted as a service requirement as part of the WCCIS Replacement tendering process, it is recognised that additional work will need to be carried out to ensure that configuration of the new system delivers anticipated outcomes in terms of demand, capacity and activity reporting.	01.02.2026		Overdue	Partially complete		**January 2026:** Preparing a template for reporting at present with Quality and Safety. **May 2026 update:** Terms of reference for SQID updated to reflect new governance responsibility. New structure for SMT now in place to support the ooperational delivery group in target setting and for ongoing monitoring. SMT will report though to DMT on any exceptions or escalations as required. BCP for 111p2 SPOA complete						1515	apr-26	08.01.2026
252622	2025/2026	Duty of Candour	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R1	High	We note that whilst the Incident Management Framework (IMF) is current, it does not state which Health Board Group/Committee is responsible for its sign off. The IMF provides a high level overview of key staff and their responsibilities for the operation and management of Duty of Candour but does not specify which roles within the Health Board are accountable for this. In the absence of a dedicated Duty of Candour policy, it may be important to define clear responsibilities for relevant roles. Furthermore, the Framework lacks detail regarding lines of accountability within the Health Board and does not outline a formal organisational structure for the monitoring or reporting of Duty of Candour at the Clinical Service Group, Committee, and Board levels. We also identified discrepancies within the IMF regarding the specified timeframes for conducting Rapid Incident Review Meetings (RIRM) as references are made to both 72-hour and 48-hour intervals.	The Incident Management Framework will define and document the specific Health Board / Committee responsible for the signoff of the IMF. This will be included in the document to ensure accountability and clarity. The IMF will define and document clear responsibilities for relevant roles within the Health Board for identifying, investigating, and monitoring Duty of Candour cases. A detailed organisational structure will be developed and included within the Framework that outlines the lines of accountability for monitoring and reporting Duty of Candour. This will specify the roles and esponsibilities at the Clinical Service Group, Committee, and Board levels. The IMF will be amended to show the correct timeframe for conducting the RIRMs.	31.10.2025		Overdue	Partially complete		**January 2026:** Following the audit completed for DOC in October it was established that a DOC policy is required. This cannot be completed until the Listening to People Process and Procedure has been received in full from Welsh Government and this expected in Feb 26. A DOC policy is currently being drafted in anticipation of this. In the absence of a policy, individual roles with responsibilities include: Head of Service/Head of Quality and Safety - completing a rapid review with service to identify harm in order to trigger the duty. Assurance by Head of Service/Head of Q&S of the information contained within the outcome letter to the family and final sign off by the EDON. Roles and responsibilities are clearly described in the IMF. The IMF has been presented at Executive Committee and PEQS. Elements of the IMF are also reported to through these reporting structures through the Integrated Quality Report, IQPD and IQPG. This includes reporting and monitoring of DOC within the organisation. An exceptions report for DOC and Nationally Reportable Incidents is subitted to Executive Committee on a quarterly basis. Discrepancies in timeframes with regards to the rapid review process have been amended in the revised IMF, which was sent to the EDON for approval and sharing with the Executive Committee on 09/1/2026 . **May 2026 update:** The IMF is under review to align to LTP since the launch. This is anticipated to be completed by September 2026 due to competing pressures with embedding LTP and developing and establishing the LTP SoP in practice.	Capacity of the Quality & Safety Team	Oversight of the DoC cases, including a deep dive exercise for assurance	30.09.2026		5	1515	apr-26	08.01.2026

252622	2025/2026	Duty of Candour	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R2	Medium	Absence of Duty of Candour Awareness Exercises At the time of our review, the Duty of Candour SharePoint page had been viewed 452 times since its launch in March 2023. Additionally, no recent awareness exercises to promote Duty of Candour as a statutory requirement and also that of the SharePoint site have been undertaken within the Health Board during April 2024 to July 2025. Duty of Candour Training The Duty of Candour E-Learning course can be accessed through the ESR system. From March 2023 to July 2025, only 285 Health Board staff had completed the training. Additionally, we reviewed the attendance log for Health Board managers who completed Datix training, which covers Duty of Candour incident management. In 2024/25, only 44 managers attended including: • 29 from Nursing or Midwifery • 7 were Admin & Clerical • 5 Allied Health Professionals Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities. Agreed Action: Periodic exercises will be introduced to increase awareness and promotion of the Duty of Candour process and also signposting of the Duty of Candour SharePoint site.The Quality and Safety team will work with Clinical Education to review and enhance Duty of Candour training. Additional exercises may be implemented so all relevant staff gain the required statutory knowledge and understand reporting and investigation processes. The team will also identify staff who would benefit from this training. Monitoring of Duty of Candour training uptake within the Health Board Processes will be put in place to track and address gaps in Duty of Candour	Periodic exercises will be introduced to increase awareness and promotion of the Duty of Candour process and also signposting of the Duty of Candour SharePoint site. The Quality and Safety team will work with Clinical Education to review and enhance Duty of Candour training. Additional exercises may be implemented so all relevant staff gain the required statutory knowledge and understand reporting and investigation processes. The team will also identify staff who would benefit from this training. Monitoring of Duty of Candour training uptake within the Health Board. Processes will be put in place to track and address gaps in Duty of Candour training across all Clinical Service Groups.	30.11.2025		Overdue	Partially complete		**January 2026:** We are expecting a new e-learning package from Welsh Government this month (Feb 2026) regarding the introduction of the Listening to People P&P. This will be rolled out across the Health Board in March 2026 and will significantly overlap the training for DOC to be rolled out. There is currently a steering group for LTP/DOC in the Health Board which is adressing the training needs of staff. Awareness will be raised in the coming weeks of the changes to the regulations as the information is released from Welsh Government. An email has been sent (03/02/2026) requesting the ESR training is cascaded to all teams. Monitoring of this compliance will be reported on in the Q4 IQR report. **May 2026 update:** Capacity challenges in the Q&S team have resulted in a delay to implementing the recommendation in full. Additional training is in planning with support from NHSP&I and wil be extended to managers and executive colleagues. The item has been added to the Q&S Qaulity Improvement plan as a key action as this plan is being reported into Executive committee on a monthly basis and into PEQs committee on a quarterly basis. The IQR into PEQs is in change, with the first iteration having been delivered in Q4. Training compliance will be added to the next quarterly report. To ensure high compliance with DoC training a 6 month period is required hence December for full implementation.	Capacity of the Q&S Team		31.12.26		5	1515	apr-26	08.01.2026
252622	2025/2026	Duty of Candour	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R3	Medium	Changes to level of harm and Duty of Candour Rapid Review Meetings: Recording and retention of information on Datix A sample of 9 out of 27 DoC cases between January and June 2025 were selected. Our testing identified that: • All nine sampled cases had their severity ratings changed in Datix by appropriate staff; two were downgraded however during the final investigation stage with no documented justification or narrative. Rapid Incident Review Meeting (RIRM) Eight out of nine sampled cases had no documentary evidence retained within Datix to support the RIRM meetings. A questionnaire was distributed to CSG Governance Leads. The Mental Health CSG reported that rapid reviews are not routinely completed for all DoC incidents; however, they are conducted in cases involving a death. The Community CSG has implemented a process flow chart, which indicates that a RIRM should occur within 5 working days, though this is not consistent with the IMF timeframe. For Women and Children, a patient safety huddle may be convened between the governance lead, HoM, DoM, and Quality and Safety team as required. This indicates inconsistencies in the application of RIRM across all CSGs.	Ay changes to assessment severity levels will be recorded in Datix with an accompanying narrative explaining the reason for the change to the harm level. This documentation will be maintained for each phase. A copy of the Rapid Incident Review Meeting (RIRM) TOR will be distributed to relevant staff to emphasise the importance of conducting RIRM meetings within 72 hours of the initial report for incidents classified as moderate harm or above. Additionally, the TOR will be revised to highlight the equirement for documenting and recording of these meetings, ensuring that supporting evidence is maintained in Datix to confirm their completion.	30.11.2025		Overdue	Partially complete		**January 2026:** The process for the recording of rapid review meetings for DOC and harm has been updated for all governance leads. The Head of Q&S attends all rapid review meetings with the Head of service to ensure consistency in harm rating and triggering of the Duty. The process for rapid reviews has been made more robust through the recent revisions to the IMF and will be reinforced again with the implentation of a DOC policy, in line with the LTP P&P. All records of rapid review meetings are held in the process notes on all DOC incidents on Datix. This is the process for all services regardless of whether the patient has died following the incident or not. **May 2026 update: Regular meetings are in place with each care group and these are used to support and review progress and process. The next requirement is to re-audit internally to determine whether the learning / action take in the January update has been effective before this can be closed.**			31st October 2026		5	1515	apr-26	08.01.2026
252622	2025/2026	Duty of Candour	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R4	Medium	A Datix report was requested to incorporate the five working day key performance indicators, which showed that there had been 102 DOC-triggered incidents since its introduction in April 2023.The report found six cases with missing 'in person' notification dates in Datix with three dating back to 2024. Additionally, five cases all prior to 2025 had incident notification dates preceding their DoC trigger dates.Further detailed analysis was performed by selecting ten current DoC cases to assess the key processes in the Health Board's IMF. One case however had to be removed from our sample due to it being under external investigation and not subject to Duty of Candour requirements. Our findings highlighted: • All nine cases showed evidence that the service user/respondent was kept updated on the issue's progress. • The 'written notification' letter was not retained in Datix for three of the nine cases. (One respondent requested not to receive this correspondence or updates). • Although all nine cases had an initial date entered in the DoC section of Datix, five lacked documented narratives in the progress notes.	Key staff will be reminded of the importance of ensuring that • All 'in person' notification dates are recorded promptly in Datix. • All cases have documented narratives within the progress notes confirming the 'in person' initial date. • Copies of all 'written notification' letters are retained in the documents section of Datix. A review of the IMF will also be carried out to ensure that these requirements are documented within it for transparency. Periodic audits will be undertaken to verify compliance with these key stages and feedback will be provided to staff of any non¬compliance	31.10.2025		Overdue	Partially complete		**January 2026:** All incidents within the audit have been reviewed and updated. There are no current outstanding incient outside of 2025. The IMF has been reviewed and is awaiting ratification at Executive Committee. Monitoring will be completed in Q4 in the IQR report. **May 2026 update: Regular meetings are in place with each care group and these are used to support and review progress and process. The next requirement is to re-audit internally to determine whether the learning / action take in the January update has been effective before this can be closed.**			31.10.2026		5	1512	apr-26	08.01.2026
252610	2025/2026	Continuing Healthcare	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	R1	Medium	As part of our testing, we checked to ensure every recorded review could be substantiated with appropriate documentation. Whilst all records reviewed as part of our sample did have the appropriate documents, these were challenging and time consuming to identify, including for the CHC team as: • Files were named inconsistently, lacking convention and description of the document • Files lacked structure and order and were stored in folders containing sometimes dozens of documents. In addition, several of the files requested within the sample had not been typed in digital format and were only available in handwritten hard copy. This included several documents that had been originally created several weeks before the audit review commenced.	The CHC team will design and implement a file management process and ensure consistency of use across the team. The process will include: • A time target for typing up and storing documents electronically to patient files; • A file naming convention including: document title, patient reference and date; and • A file management structure within SharePoint for storing patient files.	31.03.2026		Overdue	Partially complete		**January 2026**: The action is not yet due; however, work is progressing, particularly in strengthening system management processes. This work is also contingent on the outcomes of the Grant Thornton external review conducted at the end of 2025. The service is currently awaiting the release of the final report, which will inform the next steps and any further required actions. **May 2026 update:** Ongoing internal strengthening of systems continues, but the organisation has now agreed the procurement of a dedicated digital system and this will be rolled out and adopted in 26/27.					0	1515	apr-26	08.01.2026
252604	2025/2026	Core Financials-General Ledger Managem ent and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services	Assistant Director of Finance	R6	Medium	The current version of the Financial Control Procedures (FCPs) for Debtors (FCP009) and General Ledger (FCP014) do not fully reflect the current practices/processes we noted as part of our audit fieldwork.We also noted that the current version of the Health Board's Procedure for the Recovery of Overpayments to Staff (HR101) has not been updated to reflect the All Wales Policy that was approved for Salary Overpayments.	We are reviewing and updating the FCPs for Debtors and General Ledger to reflect current practices and recommendations of this audit. Once the review has been completed, we will ensure that the documents are approved in accordance with Health Board guidance and made available for all staff to access.We will liaise with our Workforce colleagues to ensure that the current version of the Procedure for the Recovery of Overpayments of Staff is updated to reflect current practices outlined in the All Wales Policy for Overpayments of Salary.	31.03.2026		Overdue	No progress		**January 2026 Update:** Work on this is scheduled for February 2026 **May 2026 update:** Due to capacity within the team having to cover vacancies at extremely busy time or year end this has not progressed as intended and has been re-prioritised into Q32 26-27					0	1515	apr-26	08.01.2026
252618	2025/2026	Clinical Supervisio n	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Head of Psychology, Head of Therapies & Health Sciences	R1	High	Not all staff are receiving live supervision annually and clinical supervision quarterly as required by the Clinical Supervision Policy.	Awareness sessions for supervisors and supervisees to highlight the benefits of live supervision will be run to ensure all staff have live supervision annually in line with the clinical supervision policy.	01.04.2026		Overdue	Partially complete		**May 2026 update:** Psychology & Psychological Therapies. Awareness sessions delivered (or planned to be delivered in June/July) as part of LPMHSS Team Meeting, Adult Psychology Team Meeting, CEN Team Meeting, & OA Psychology Team Meetings, PIPIN Meetings, Mental Health Practitioner Forum, Counselling & Psychotherapy Forum, & via Managerial Supervision.	Psychology & Psychological Therapies. All clinical staff are acessing regular (at least monthly) clinical supervision Re: Live Observation barriers: (i) IG permission to record clinical sessions	*the potential risk only relates to the live observation of practice. Live observation is underway. All students / trainees / non-registrants are regularly observed and involved in joint sessions with	End of Q2 (Oct 2026)			1515	apr-26	
252618	2025/2026	Clinical Supervisio n	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Head of Psychology, Head of Therapies & Health Sciences	R2	Medium	Only 14/30 Psychology supervisees (47%) and 11/28 Therapies supervisees (40%) had signed the Clinical Supervision contract and completed the checklist as recommended by the Clinical Supervision Policy. • Supervision Notes were being kept by all Psychology supervisees but were not being kept by 8/28 Therapies supervisees (29%). • The recommended template from the clinical supervision policy was only being used by 5/30 Psychology supervisees (17%) and 6/22 Therapies supervisees that keep supervision notes (27%). • Supervision notes were only being signed off by 8/30 Psychology supervisees (27%) and 8/22 Therapies supervisees (36%).	Awareness sessions will be run for supervisors and staff receiving clinical supervision to help improve compliance with the clinical supervision policy.	01.04.2026		Overdue	Partially complete		**May 2026 update:** Psychology & Psychological Therapies Awareness sessions delivered (or planned to be delivered in June/July) as part of LPMHSS Team Meeting, Adult Psychology Team Meeting, CEN Team Meeting, & OA Psychology Team Meetings, PIPIN Meetings, Mental Health Practitioner Forum, Counselling & Psychotherapy Forum, & via Managerial Supervision.	Psychology & Psychological Therapies - Awareness of the supervision contract - All staff maintain notes of clinical supervision - The recommended clinical supervision template is not necessarily consistent with the structure of some clinical supervision in psychology (e.g. EMDR group supervision)	All clinical supervisors and supervisees maintain notes of their supervision, which is saved down to their personal folder on sharepoint.	End of Q2 (Oct 2026)			1515	apr-26	
252618	2025/2026	Clinical Supervisio n	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Head of Psychology, Head of Therapies & Health Sciences	R3	Medium	The Clinical Supervision Policy suggests supervisors can undertake four in-house training courses provided by the Health Board. For the sample of ten supervisors tested, only two had completed one of the four courses on offer. Some supervisors commented that they were not aware of the availability of PTHB training, and that they would find it useful to attend as the courses would provide helpful refresher training.	We will raise awareness of the PTHB training courses through a targeted campaign to encourage a greater take up by staff with clinical supervision responsibilities.	01.04.2026		Overdue	Partially complete		**May 2026 update:** Awareness sessions delivered (or planned to be delivered in June/July) as part of LPMHSS Team Meeting, Adult Psychology Team Meeting, CEN Team Meeting, & OA Psychology Team Meetings, PIPIN Meetings, Mental Health Practitioner Forum, Counselling & Psychotherapy Forum, & via Managerial Supervision	Lack of awareness	All clinicial supervisors access their own clinical and managerial supervision on a regular basis. Supervisors are also obliged to maintain a portfolio of CPD as part of their professional registration and many will have completed specialist training and/or qualifications in clinical supervision	End of Q2 (Oct 2026)			1515	apr-26	

252607	2025/2026	North Powys Integrated Wellbeing Hub	Reasonable	Director of Improvement and Transformation	Project Director	R1	Medium	During the audit, a number of opportunities for improved governance arrangements were identified. Whilst none individually posed any significant risk to programme/ project delivery, the next phase of the project (or future projects) may benefit from review and implementation of improved controls in the following areas: • The defined delegated authorities set out in the PEP and terms of reference could have more usefully identified key decision-making points aligned to the accelerated approach, e.g. those matters normally approved at SOC stage before progressing to OBC; • The Programme Board quoracy requirement should include representation from both PTHB and PCC; • The Programme Highlight Report should be fully populated to provide a summary of risks, issues and milestones as intended by the template; • Noting poor attendance from some parties, particularly PCC, Innovative Environment Project Board and Workstream attendance should be reviewed and commitment reinforced; • Advisers should be included in terms of reference as attendees not members, noting they should not have any decision-making authority; • The PEP should be updated to reflect Project Board arrangements; • Expenditure against capital budgets should be routinely reported to the Project Board.	We will review the audit findings and determine which actions can be taken to improve the governance arrangements at this project for the new phase.	31.05.2026		Overdue	Partially complete		**May 2026 Update:** At the time of update the actions from the audit in relation to programme governance are being addressed with a target date of 31st May 2026. An update was provided to the North Powys Wellbeing Programme Board on 28th May 2026 with the actions reported as on track for completion.						0		

PTHB Ref. No.	Audit Year	Report Title	Assurance Rating	Director	Responsible Officer	Reference	Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When is implementation expected to be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
242525	2024/2025	General Medical Services Unified Contract Assurance Framework	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	R1	Medium	Standard Operating Procedure: Practice Visit Report Assurance Ratings: Testing undertaken in Objective 4 identified that there is no SOP in place to clarify and formalise the process for the assessment and awarding of Practice Visit Report Assurance Ratings that underpin the potential invocation of the Framework Escalation Ladder, in absence of this approach being provided within the Framework Guidance.The Contract and Visit Governance Report includes twelve Assurance Ratings - one for each assessed Health & Care Quality Standard, and where there is an even or 'close call' split of ratings across the twelve Standards, as we identified in several of the five Reports, there is no current process to determine the final overall Assurance Rating	National guidance is due to be produced that will document and formalise the process for the assessment and awarding of Practice Contract and Visit Governance Report Assurance Ratings. Following production of the National Guidance, management will ensure that it is followed for future Practice Visits.	01.12.2025	01/04/2026 Revised deadline: April 2027	Deadline Revised	Partially complete		**August 2025:** Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therfore this deadline needs to be moved on to 01/04/26 **January 2026:** Due to revised timeline as awaiting national documentation, not yet due. **May 2026 update:** No national progress to update, however the national group are working through, therefore there is some progress happening. National timeline for updated framework is 01/04/27	National Work	National Contract Assurance review group meetings planned	01.04.2027		4	#VALUE!	apr-26	
242525	2024/2025	General Medical Services Unified Contract Assurance Framework	Substantial	Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	R2	Medium	Overall assurance rating for the Practice Visit Assessment reports: Our review of each of the five GMS Contract and Visit Governance Reports identified that, based upon the individual Standard Assurance Ratings stated within, all five Reports could have potentially contributed towards the justification of triggering the Framework Escalation Ladder on the basis of an 'averaged' Limited Assurance rating.The Framework guidance states that the Escalation Ladder should be used 'If a contractor receives a Governance Visit Report with Limited or no assurance AND the PCGFRP is either not accepted or monitoring shows non-compliance. However, as noted within Finding 1, there is currently no process for determining the overall assurance rating, and no overall rating was provided for any of the five GMS Contract and Visit Governance Reports produced during the current cycle.The introduction of an overall Assurance Rating and a brief summary to justify this Rating within the Contract and Visit Governance Report would also be of use to GMS Contractor Practice Management Teams as an overall position statement relating to the assessment undertaken	Following receipt of the national guidance referenced in Finding 1, the Primary Care Team will ensure that an overall assurance rating is determined and recorded for all future GMS Contract and Visit Governance Reports.	01.12.2025	01/04/2026 Revised deadline: April 2027	Deadline Revised	Partially complete		**August 2025:** Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therfore this deadline needs to be moved on to 01/04/26 **January 2026**: Due to revised timeline as awaiting national documentation, not yet due. **May 2026 update:** No national progress to update, however the national group are working through, therefore there is some progress happening. National timeline for updated framework is 01/04/27	National Work	National Contract Assurance review group meetings planned	01.04.2027		4	#VALUE!	apr-26	
242527	2024/2025	Risk Management & Assurance Final Internal Audit Report	Reasonable	Director of Corporate Governance	Stella Gwynne	R1	Medium	Directorate Risk Registers: Review of the Risk Register for People & Culture, and Mental Health & Learning Disabilities Service, identified that whilst both bore evidence of regular review and update, there were some minor errors and inconsistencies in completion. A number of these related to the calculation and rating of the score which should be addressed by the move to the Datix system. One recurring issue was that the column for actions already taken often included actions that appeared to be on-going.	The Health Board will ensure that appropriate guidance and training is provided to all relevant staff to accompany the revised risk management framework and the implementation of the DatixCloudIQ system. The Health Board will also review the "what has been done to manage the risk to date" field and instead consider "what existing measures are already in place to control the risk" to help to avoid the issue of partially completed actions being included in this field, which currently may give a false assurance that the risk is being effectively managed.	01.11.2025	01.12.2026	Deadline Revised	Partially complete		August 2025: Datix Risk Management Module continues to be rolled out, ORR template has ben updated to relfect suggested wording January 2026: for technical system related reasons, the roll out of the Datix risk management module within PTHB has been paused - the system is unable to record controls and no meaningful mitigations have been made available from Datix. The mitigating action is to return to excel in the interim while a new solution is investigated **April 2026 update**: A system update has yet to be released by Datix/Once for Wales Team to resolve the issue - the system remains on hold with the previously mitigations remaining in place. **May 2026 update:** Solution provided through the Once for Wales team, this is currently being tested and if practical, roll out of the Datix risk mopdule will resume. A training video and support materials have been produced. Roll out, once ready, will be slower than desired due to planned staff absences.	August 25: Work continues to onboard services to the Datix system, though uptake is slower than anticipated due to reduced cpacity due to long term absence in the corporate team. **January 2026:** the barrier is the system and its inability to record controls Jan 2026: the barrier is the system and its inability to record controls May 2026: Barrier remains the system and now planned staff absence.	The Once For Wales national team have offered to support in the transfer of risks on to the system where appropriate, this detail of this is currently being explored to potentially expediate the transfer. **Jan 2026:** the Once for Wales team are assisting but so far no workable solution available from Datix	Linked to full rollout of Datix System		5	#NUM!	apr-26	
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Finance, Capital and Support Services	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)	R3	Medium	Efforts should continue to ensure all FCPs with elapsed review dates are subject to an appropriate review process and submitted for the relevant approvals. Future review dates should then be defined, or an established review frequency should be determined and specified within each document.	Agreed - There is currently LHB review of policy process underway which is due to conclude during 24/25. All FCPs will be reviewed and where required approval undertaken and where required review frequency included within the document.	31.03.2025	31.07.2026	Deadline Revised	Partially complete		**August 2025 update**: Relevant procedures have been reviewed and are ready for approval. Just formulating approval stream for the policy documents. **January 2026 update:** The new corporate policy group framework has been implemented and the reviewed procedures will be directed through this group for consideration and approval prior to 31st March 2026 **May 2026 update:** Due to capacity issues with vacancies having to be covered this has not been progressed as intended. Movement has been made in that it has been agreed under the new framework that these can be internally approved and will progress on this basis in next Qtr		current procedures remain extant		Yes	12	#NUM!	apr-26	10.02.2025
252619	2025/2026	Digital System Uptake Final Report	Limited	Director of Allied Health Professions, Health Sciences and Digital	Head of Digital Programmes and Assistant Directors of Operational Services	R3	High	There is no Change Management Framework that sets out how business change is to be managed through a project lifecycle to enable successful delivery. As such change management is left to the project managers with the individual projects applying their own variants of change and training requirements. We also note that business cases do not always include specific resourcing for change management or identify the need for change leads or champions within the service.	A Change Management Framework was started in draft as part of the EPMA programme, where an interim Change Manager was appointed on a fixed term basis up until March 2025. This is a known area for improvement, and we accept this is a role that is essential, however due to how digital projects are funded, there is not a permanent Change Manager in post. The size of the organisation, the rurality of PTHB and the funding available is often a challenge to recruit the required change management roles with experience.	31.03.2026	31.07.2026	Deadline Revised	Partially complete		**January 2026 update:** The digital team have participated in change management training provided by workforce, and a change management framework is currently being developed. Workforce support has been made available to the digital team, offering guidance to staff on change management approaches to help ease the transition from any paper-based system to a digital solution and minimise any resistance to change. In the absence of a Change Manager, some operational teams (AD Community Services) have agreed to support with digital change and adoption. **May 2026 update:** The framework is near completion, which has been developed based on Kotters 8 steps methodology and best practice. This provides a step by step guide incorporating templates and checklists that forma part of our digital portfolio programme of work. This can then be used for evidence and assurance.	None	Comprehensive change management support is accessible, and the digital project team have received appropriate training to prepare them supporting users. The framework will represent the concluding phase.	31.07.2026	Partially Completed	0	#NUM!	apr-26	08.01.2026
252610	2025/2026	Continuing Healthcare	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	R3	Medium	The CHC team have a master improvement plan – the "Complex Care Improvement Plan 2024 – 2026". This plan effectively summarises activity and workstreams ongoing or complete across 16 different areas of focus. The planning document is maintained with narrative highlighting updates and key risks to achieving targeted objectives however, it is not presented in fulness to the Performance and Delivery Committee, and this may inhibit transparency over the full breadth and scope of work being undertaken by the team. Committee updates instead are formatted in such a way to provide a narrative update on key areas of focus within the plan. Whilst this narrative focus is appropriate for committee papers, the lack of summary provided on the full plan may inhibit the committee's view of the full scope and breadth of work being undertaken by the team and therefore limit the assurance being provided.	To provide perspective on the scale of improvement works undertaken, tighten governance and provide greater assurance, the Improvement Plan will be summarised with a dashboard presented at every committee meeting. The "Programme dashboard" will include the summary built into the plan illustrating: • Number of workstreams completed • Number of workstreams in progress • Number of workstreams at risk Narrative will then be provided on key achievements for the period and, where risks have been highlighted, what actions are being implemented to mitigate.	31.12.2025	01/08/2026 Sept 2026	Deadline Revised	Partially complete		**January 2026**: A revised deadline is proposed. Work is progressing; however, completion is dependent on the findings from the external review conducted by Grant Thornton toward the end of 2025. We are currently awaiting the release of the final report, which will inform and shape the transformational programme of work required within the Complex Care team. **May 2026 update:** Schedule of works in place with external contractor to develop and deliver improvement plan. Expectation that plan will deliver by end September 2026.					3	#VALUE!	apr-26	08.01.2026
252609	2025/2026	Catering Services – Food Safety Standards	Substantial	Director of Finance, Capital and Support Services	Head of Facilities	R1	Medium	Self-assessment audits are conducted by three tiers of management – supervisors, coordinators and operations managers. From review of departmental records between January and November 2025 we noted: • Monthly Management audits – 15 of 33 (45%) not complete • Weekly Supervisor/coordinator audits – 30 of 132 (23%) not complete. These audits provide value through providing assurance, ensuring standards and as a mechanism for identifying trends however, there is no mandate for the frequency these checks should be completed and recorded within the Food Safety Procedures.	Guidance on self-assessment audits will be documented within the Food Safety Procedures under the existing section 6 "Monitoring Compliance". This guidance will: • Describe the process for completing audits; • Define the frequency that audits will be undertaken by differing levels of management; and • Identify roles and responsibilities for completing audits and monitoring output actions to ensure these are completed.	01.04.2026	01.09.2026	Deadline Revised	Partially complete		**May 2026 Update:** There has been some resource challenges in the Facilities Management team have delayed overall completion but progress made.	Resource challenges in Facilities Management team with Head of Facilities and Operational Manager South anticipated to start in September but requiring some time to settle in before addressing the audit findings.	A reduced level of audit activity will be maintained and closely monitored if deficiencies are identified.	sep-26		0	#NUM!	apr-26	

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification
232401	2023/2024	Structured Assessment 2023	Director of Nursing, Quality, Women and Family Health		R3	Develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	mai-24		Complete	Complete	
242503	2024/2025	Review of Cost Saving Arrangements	Director of People, Culture and Transformation	Director of Finance, Capital and Support Services	R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potention costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	Agreed – The Health Board has established a programme of work around future sustainability with programme and workstream structure: - 'Task force' in place to examine three areas: • the future model (building on existing work) • options and decisions around when to achieve financial breakeven. • new opportunities based on analysis of data and benchmarking. Identified timeline in place with initial engagement planned for 24/25.	okt-24	mar-25	Complete	Complete	**April 2026 update**: Recommend closure. The Health Board has established a Financial Recovery Board and part of the remit and approach for this Board will include cost savings. The reporting, monitoring and Programme Management approach will be established and monitored by the FRB and this will include all savings delivery both in year and future years including the opportunities identified by the Grant Thornton consultancy work, GIRFT and the Better Together Programme.
242503	2024/2025	Review of Cost Saving Arrangements	Director of People, Culture and Transformation	Director of Improvement and Transformation	R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the Accelerated Sustainable Model.	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	okt-24	mar-25	Complete	Complete	**April 2026 update:** Recommend closure - actions identified in column H complete. Additional capacity & capability approved to support Better Together portfolio. This will be subject to ongoing review as part of the portfolio structure.

252601	2025/2026	Tackling the Planned Care Challenges	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Assistant Director Community Services/Assistant Director Performance Commissioning	R1	**Longer term planning and costing** Over and above the commitments signalled in the Integrated Plan 2024-29 and Annual Plan 2024-25, the Health Board should develop a Planned Care improvement plan which aims to both design and deliver financially sustainable local services and affordable commissioning approaches in the medium to longer term. The plan should be costed, with realistic but challenging milestones within it	The 2025/26 Annual Plan contains more detailed Planned Care objectives with broader stakeholder nvolvement in the Plan development. A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. “Better Together” is PTHB promise to work together with citizens to review how and where we provide services, to ensure safety, to improve quality, and to make best use of resources that we can. We want to talk to patients and service users, people and communities, health and care staff, and our partner organisations.	jun-26	mar-26	Complete	Complete	
252601	2025/2026	Tackling the Planned Care Challenges	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Assistant Director Community Services/Assistant Director Performance Commissioning	R2	**Demand and capacity planning** The Health Board should ensure that its demand and capacity modelling approach informs short-term service capacity planning and longer-term service design. This should fully consider continued growth or expected changes in population demand for planned care services	A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. Links Better Together Case for Change referenced in under R1 response.	mar-26		Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Deputy Board Secretary	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	The Standards of Behaviour Policy was updated to include relevant staff and was approved by the Board on the 26 March 2025.			Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Director of Nursing, quality, Women and Family Health	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	The Integrated Quality and Performance Framework was reviewed and approved by the Board on the 21 May 2025. Bi monthly reporting will continue to take place to the Boards Finance & Performance Committee and Board alongside the other requirements set out in the revised framework.			Complete	Complete	May 2026 Update: Action is marked as closed. The Integrated Quality and Performance Framework was reviewed and approved by the Board on the 21 May 2025.
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Deputy Board Secretary	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.	The audit tracking tool and process will be updated to reflect the action.	nov-25		Complete	Complete	

242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Director of Planning, Performance and Commissioning	R4	4.1- Ensure annual reviews of its well-being objectives are clearly communicated 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	4.1 – It is noted that the WB Objectives are part of the Joint Health and Care Strategy (agreed with Powys County Council). Overall review undertaken via RPB workplan. The Health Board will review them each year as part of the annual and medium term planning cycle and communicate to the PPPH Committee and Board as part of the IMTP process. 4.2 – The current Joint Health and Care Strategy is agreed up until 2027. The Health Board reviews the strategic priorities to deliver the Strategy each year as part of the annual planning cycle and will continue to do so. The review and development of the refreshed Strategy will be planned ensuring it is completed by 2027 and will be reported to both the Planning, Partnerships and Population Health Committee and Board. Note that due to the joint nature of the Strategy the RPB coordinates this work.	March 2026 April 2027		Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Director of Planning, Performance and Commissioning	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 5.2. strategic performance measures to accompany its well-being objectives that capture the long-term impact it is seeking to achieve	5.1 - Due to the joint nature of the Strategy this is monitored by the RPB and for the Health Board will also form part of the annual and medium term planning cycle. 5.2 - Due to the joint nature of the Strategy this will be coordinated by the RPB as part of the refreshed Strategy review and development.	mar-27		Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Deputy Board Secretary	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	Reports will include strengthened information articulating where delivery is off track.	mar-26		Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Executive Director Planning, Performance & Commissioning	R7	The Health Board should identify, monitor, and manage any immediate quality and performance risks that may arise because of the ongoing financial challenges	This forms part of the assessment of financial improvement options as part of the planning process. The monitoring is undertaken via the Integrated Quality and Performance Framework. Bi-monthly Integrated Quality and Performance Reports will continue to be presented to the Finance & Performance Committee and Board alongside the other requirements set out in the revised framework.			Complete	Complete	
242504	2024/2025	Structured Assessment 2024	Director of Corporate Governance	Executive Director of Finance, Estates and Support Services	R8	The Health Board should provide greater assurances within finance reports on the impact of mitigating actions to address key financial risks	Further assurances will be included in the finance report for both the Boards Finance & Performance Committee and Board as well as the assurance of financial control reporting made to the Audit and Risk Assurance Committee.	sep-25		Complete	Complete	
252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Deputy Board Secretary	R1	The Health Board's committee action logs should clearly set out which group actions have been referred to and what they expect the group to do because of the referral	Action logs will be adapted to ensure the purpose of referral and any follow up action/reporting is clearly articulated.	apr-26		Complete	Complete	
252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Executive Director of Nursing, Quality, Women and Family Health	R3	The Health Board should review and update the structure of the Integrated Quality Report to ensure that areas which require further attention are clearly identified	A revisited report has been presented to Executive Committee and will be presented to our PEQS committee in April 2026. The report is structured to separate three key elements: intelligence, triangulation, and assurance. A dedicated compliance section then provides assurance against key regulatory and national standards. This approach is intended to improve the visibility of learning, support a more integrated understanding of risk, and strengthen the Health Board's ability to drive argeted improvement.	apr-26		Complete	Complete	

252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Executive Director of Planning, Performance and Commissioning	R4	The Health Board should make it clearer how the priorities set out in the Annual Plan supports the priorities in the Integrated Plan.	The Strategic Priorities in the Integrated Plan flow from the Joint Health and Care Strategy, which include the statutory Wellbeing Objectives. The strategic priorities in each successive Annual Plan cycle also flow from the Joint Health and Care trategy (and thereby the Integrated Plan) however we refresh them in each annual planning cycle in line with best practice in strategy deployment; to ensure we respond to the changing external context and WG's annual Planning Framework. We will keep this under .review			Complete	Complete	
252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Executive Director of Finance, Estates and Support Services	R5	The Health Board should ensure its finance reports contain information on actual savings delivered to date. This should include where savings delivery is off track, and any mitigating actions.	The finance report to Board will be modified to contain information on actual savings delivered to date. Appropriate commentary will be included.	jul-26		Complete	Complete	
252602	2025/2026	Quality Governance follow up review	Executive Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health & Executive Director of Planning, Performance and Commissioning	R1	**Commissioned provider performance measures:** The Health Board should develop performance and quality measures for each commissioned provider which it can monitor and measure in line with the Strategic Commissioning Framework. This will provide oversight and assurance on commissioned services and patient care.	The Health Board has established baseline performance metrics for commissioned providers through NHS Wales and NHS England standard contract arrangements. In addition, work is underway to develop a comprehensive suite of quality and patient safety metrics for commissioned services. These measures will be embedded within the Integrated Quality and Performance Framework (IQPF) and aligned to the Strategic Commissioning Framework (SCF) to strengthen oversight, ssurance, and early identification of quality or performance concerns in commissioned services. Detailed Commissioning Intentions have been issued to the three main NHS England providers and to NHS Wales providers to support timely data submission and strengthen contractual oversight arrangements.	mar-26		Complete	Complete	
252602	2025/2026	Quality Governance follow up review	Executive Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R2	**Complaints about commissioned services:** The Health Board should set out a mechanism in the Strategic Commissioning Framework about how it will provide assurance on complaints about commissioned services. This should include the mechanism for recording complaints and reporting them to the Patient Experience, Quality and Safety Committee	The operational mechanisms for the recording, management, and reporting of concerns and complaints relating to commissioned services sit within the Integrated Quality and Performance Framework (IQPF) and wider Quality Management System (QMS) arrangements. The Strategic Commissioning Framework references the PTHB QMS in providing a focus on quality domains and enabling actions as per the PTHB QMS; references requirement as per Duty of Quality to actively monitoring progress in quality mprovement efforts; and cross references to the IQPF through which PTHB discharges its duty to scrutinise and assure the performance of PTHB and the delivery and commissioning of quality, patient centred services. The Executive Director of Nursing, Quality and Family Health and Deputy Director teams have reviewed current processes to strengthen mechanisms through Datix. Concerns and complaints relating to commissioned services are reported through established Integrated Quality Framework reporting arrangements to the Patient Experience, Quality and Safety Committee.			Complete	Complete	

252602	2025/2026	Quality Governance follow up review	Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health & Executive Director of People, Culture and Transformation	R6	**Duty of Quality e-learning oversight :** The Health Board should strengthen its arrangements for duty of quality e-learning training by routinely monitoring and reporting on staff completion rates	Our improvement approach includes a joint strategic responsibility between the Executive Director of Nursing, Quality and Family Health, and the Executive Director for People, Culture and Transformation. The Executive Director of Nursing, Quality and Family Health is responsible for promoting and building compliance and the Executive Director of People, Culture and Transformation will ensure that regular monitoring reports are provided, highlighting areas of concern in compliance rates. Improvements in training compliance will be done through the consideration of adding the E-Learning course to the all-staff Statutory and Mandatory Training list and adding performance reporting to the Workforce Performance Report, which is monitored through People and Culture Committee, Patient, Experience and Quality Committee as well as Executive Committee. This report will also be included as part of the Directorate Performance Review approach for both People and Culture, and Nursing.	30/09/2026 31/12/2026		Complete	Complete	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Chief Digital Data Officer	R1	The Health Board should clearly set out responsibilities, milestones, and measures for each project in the Digital Roadmap so progress and outcomes can be properly monitored	We agree that the Digital Strategic Framework will be reviewed and refreshed ahead of 2027. This intention is reflected in our Integrated Planning cycle and will be made explicit in future digital reporting. A new “Digital Roadmap on a Page” is in development, setting out strategic alignment, priority programmes, ownership, milestones, dependencies, risks and expected outcomes.	aug-26		Complete	Complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
Jan 25 The People's Exeperience Framework is awaited from Welsh Government. Funds are available to develop a Patient Experience Lead. JD being written. **Feb 25** Peoples Experience Framework still awaited **August 25** - CR to discuss with HB, this action is not aligned to the peoples experience framework and is aligned to board member site visits and feedback. **May 2026 Update: Board walkabout guidelines in place and implemented.**				Yes, walk around guidelines			31/04/2026	mar-24
New directorate stood up October 2024 under new Director of Improvement & Transformation post. The Route Map to Sustainability work has been progressed to a new programme delivery structure with associated Finance team representation. Case for Change, Journey to Consultation, Clinical service redesign and Estate implications in development. As options are developed these will be costed and included in financial planning. Partially complete as work accelerated however full qualtification of potential costs and savings will not come through until later in FY25/26. **Feb 2025 -** No further update - recommend extention of deadline to Q4 2025/26 in line with Better Together timeline. **Aug 2025 -** Recommendation in Feb was for deadline to be extended to Q4 2025/26 in line with Better Together timeline. Work ongoing to confirm options for board approval to consult on future model and configuration of services for adult physical and mental health community services. Board decision on progression to consultation anticipated October 2025. Further phases of work across 2026/2027 will address planned care and women & childrens services. Recommend deadline is extended to reflect this. **Feb 2026 -** Recommendation remains to extend timeline to align with Better Together timeline. The timeline to Consultation for Phase 1 has now been extended until Q2 2026/27. Phase 2 work has started with strategic assessment of planned care underway and due to conclude end O4 FY25/26. WCF scope approved Feb 2026 and programme board to be initiated from Q1 2026/27. **April 2026 update:** The Health Board has established a Financial Recovery Board and part of the remit and approach for this Board will include cost savings. The reporting, monitoring and Programme Management approach will be established and monitored by the FRB and this will include all savings delivery both in year and future years including the opportunities identified by the Grant Thornton consultancy work, GIRFT and the Better Together Programme.	Capacity in key roles/teams to work at pace on options development.	Ongoing mitigation through existing operational measures.					31/04/2026	nov-24
New directorate stood up October 2024 under new Director of Improvement & Transformation post. Resource plan for delivery of Improvement & Transformation activity will be included in Better Together programme and wider Improvement activity. Feb 2025 - No further update - recommend extention of deadline to Q1 2025/26. **Aug 2025 -** Better Together portfolio structure fully operational with some additional capacity and capability identified to support portfolio. Ongoing gaps in clinical specialty support to planned care and mental health, discussions with national programmes to secure support in these areas. Capacity challenges across corporate and operational services to deliver to timelines during period of increased pressure and scrutiny in other areas such as financial savings and national returns. **Feb 2026 -** As above organisational capacity and capability constraints have continued to be rate limiting factors. Resource plan agreed by Executive Commitee Dec 2025 to support an improved position from Q1 2026/27 subject to recruitment. Suggest agreement on measure of success to be set for this action to support timely closure. **April 2026 update:** Recommend closure - actions identified in column H complete. Additional capacity & capability approved to support Better Together portfolio. This will be subject to ongoing review as part of the portfolio structure.	Capacity in key roles/teams to identify additional resource requirements	Ongoing mitigation through existing team deployment to areas of highest priority					31/04/2026	nov-24

Feb 2026 Update: GIRFT commissioned by Better Together programme to produce an evidence-based diagnostic across planned care services that combines provider activity data with commissioned activity, highlighting the top ten spend areas and top opportunities for population health, patient outcomes, cost, quality, outsourcing possibilities and access improvements. Initial scoping complete, including first workshop delivery, with further workshop scheduled for 24th February 2026. **May 2026 Update:** External review complete and reporting provided. Report transitioning through organisational governance, alongside prioritisation and delivery planning. Initial actions taken, including strengthening of clinical leadership roles.	None identified.		mar-26	Yes			31/04/2026	13.02.2026
Feb 2026 update: As above strategic assessment is underway. Incorporated is a review of den=mand & capacity. Seperately, refreshed planning framework tools are now available, which will inform an options appraisal for the 26/27 elective care provider delivery model due to be considered by the Health Board in March 26. **May 2026 Update:** As above, external review complete and reporting provided. Report transitioning through organisational governance, including clear modelling of expected demand, capacity and opportunities for repatriation. Initial actions taken, including strengthening of clinical leadership roles.	None identified.		mar-26	Yes			31/04/2026	13.02.2026
May 2026 Update: The Standards of Behaviour Policy was updated to include relevant staff and was approved by the Board on the 26 March 2025.				Yes, Board minutes and revised policy			31/04/2026	mar-26
May 2026 Update: Action is marked as closed. The Integrated Quality and Performance Framework was reviewed and approved by the Board on the 21 May 2025. Bi monthly reporting will continue to take place to the Boards Finance & Performance Committee and Board alongside the other requirements set out in the revised framework.							31/04/2026	mar-26
May 2026 Update: Audit tracking strengthened and reported to ARAC				Yes, audit tracking report and ARAC minutes			31/04/2026	mar-26

May 2026 Update: 4.1 – It is noted that the WB Objectives are part of the Joint Health and Care Strategy (agreed with Powys County Council). Overall review undertaken via RPB workplan. The Health Board will review them each year as part of the annual and medium term planning cycle and communicate to the PPPH Committee and Board as part of the IMTP process. 4.2 – The current Joint Health and Care Strategy is agreed up until 2027. The Health Board reviews the strategic priorities to deliver the Strategy each year as part of the annual planning cycle and will continue to do so. The review and development of the refreshed Strategy will be planned ensuring it is completed by 2027 and will be reported to both the Planning, Partnerships and Population Health Committee and Board. Note that due to the joint nature of the Strategy the RPB coordinates this work.							31/04/2026	mar-26
May 2026 Update: This has been reviewed and agreement made across all partners to extend to 2029, this was co-ordinated via the RPB and also separately reported via PPPH and PTHB Board							31/04/2026	mar-26
May 2026 Update:							31/04/2026	mar-26
May 2026 Update: Completed – as forms part of the revised Integrated Quality and Performance Framework approved by the Board in May 2025							31/04/2026	mar-26
May 2026 Update: The monthly Finance report contains summary level information on the financial position and forecast of the organisation, including the impact of remedial actions.				Finance reports			31/04/2026	mar-26
April 2026 Update: Strengthended process developed and implemented by the Corproate Governance Team and enacted for all Committees of the Board				Committee and Board action logs			31/04/2026	mar-26
May 2026 Update: Action is marked as complete revisited report has been presented to Executive Committee and will be presented to our PEQS committee in April 2026. The Areport is structured to separate three key elements: intelligence, triangulation, and assurance. A dedicated compliance section then provides assurance against key regulatory and national standards. This approach is intended to improve the visibility of learning, support a more integrated understanding of risk, and strengthen the Health Board's ability to drive argeted improvement.				IQR report and PEQS minutes (April 2026)			31/04/2026	mar-26

May 2026 Update: Additional explanatory guidance was included in the Annual Plan 2026 – 2027, as discussed with the Internal Auditors, to clarify the relationship between the Health and Care Strategy, Wellbeing Objectives and Strategic Priorities and the associated scheduling cycles.							31/04/2026	mar-26
May 2026 Update: Action integratred into M1 reports to F&P, Executive Committee and Board				Finance reports			31/04/2026	mar-26
May 2026 Update: There is ongoing work through the Digital and performance teams to continue to develop interactive dashboards. Grant Thornton and Partners are supporting the development of a Commissiong Dashboard by end Q1 as the priority area.							31/04/2026	mai-26
May 2026 Update: The operational mechanisms for the recording, management, and reporting of concerns and complaints relating to commissioned services sit within the Integrated Quality and Performance Framework (IQPF) and wider Quality Management System (QMS) arrangements. The Strategic Commissioning Framework references the PTHB QMS in providing a focus on quality domains and enabling actions as per the PTHB QMS; references requirement as per Duty of Quality to actively monitoring progress in quality mprovement efforts; and cross references to the IQPF through which PTHB discharges its duty to scrutinise and assure the performance of PTHB and the delivery and commissioning of quality, patient centred services. The Executive Director of Nursing, Quality and Family Health and Deputy Director teams have reviewed current processes to strengthen mechanisms through Datix. Concerns and complaints relating to commissioned services are reported through established Integrated Quality Framework reporting arrangements to the Patient Experience, Quality and Safety Committee.							31/04/2026	mai-26

May 2026 Update: DoQ Elearning Training mandated to all staff as a one off training package. All manditory training compliance is reported monthly to managers via directorate performace review.				yes, added to ESR as mandatory training			31/04/2026	mai-26
May 2026 Update: This is complete the reporting template has been revised to include the milestones and forms part of the regualar reporting cycle				yes			31/04/2026	mai-26

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PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification
232401	2023/2024	Structured Assessment 2023	Director of Corporate Governance /Director of Nursing, Quality, Women and Family Health		R5	The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	jul-25	jan-26	Overdue	Partially complete	
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health	Director of Primary Care, Community and Mental Health	R1	The Health Board should review the relative maturity of clusters, to reflect on the existing arrangements, address any potential gaps and strengthen Health Board support where necessary.	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects at cluster level through 'start well', 'live well', 'age well' programmes – a bottom-up approach to increase cluster maturity. Progress will be monitored via the ACD readiness checklist and assurance provided through the RPB Executive Group	mar-25	mar-26	Overdue	Partially complete	
252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Deputy Board Secretary	R2	The Health Board should further refine the management of its strategic and organisational risk registers. The Health Board should review what is a strategic risk and what is an organisational risk. Organisational risks should then be allocated to a relevant committee for scrutiny and monitoring	The Risk Management Framework and Board Assurance Framework will be reviewed and aligned to ensure consistency and clarity.	mai-26		Overdue	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
April 2024 - plans in place and on target June 2024 - plans continue to progress with 12 teams/service areas now included within Datix. Work will continue over the summer to move more areas into the system. Full roll out may be slightly later than target but progress is positive. **Dec 24** The Health Board continue to roll out the requirement that all risks for all directorates to be captured in the RL Datix system. **Jan 25 -** The Health Board will record all risks on RL Datix by Summer 2025. Request extenstion to July 2025 **August 2025 update-** Implementation plan reviewed and roll out of moving risks to Datix system continues during Q2 & Q3 Work continues to onboard services to the Datix system, though uptake is slower than anticipated due to reduced capcity due to long term absence in the corporate team. The Once For Wales national team have offered to support in the transfer of risks on to the system where appropriate, this detail of this is currently being explored to potentially expediate the transfer. Request extension to January 2026. **January 2026:** for technical system related reasons, the roll out of the Datix risk management module within PTHB has been paused - the system is unable to record controls and no meaningful mitigations have been made available from Datix. The mitigating action is to return to excel in the interim while a new solution is investigated. **April 2026 update:** A system update has yet to be released by Datix/Once for Wales Team to resolve the issue - the system remains on hold with the previously mitigations remaining in place. **May 2026 update**: Solution provided through the Once for Wales team, this is currently being tested and if practical, roll out of the Datix risk mopdule will resume. A training video and support materials have been produced. Roll out, once ready, will be slower than desired due to planned staff absences. Date change requested to align with similar recommendations from internal audit.	National issues surrounding the once for Wales Datix system **Jan 2026:** the barrier is the system and its inability to record controls	**Jan 2026:** the Once for Wales team are assisting but so far no workable solution available from Datix **May 2026 update:** a solution has been identified and now being tested for roll out.					31/04/2026	mar-24
August 2025: Delays with establishment of Professional Nursing Collaborative. Unlikley to be implemented this financial year. Strengthing cluster voice in RPB Exective Group - meeting being arranged to include DPCCMH input. progressing the merging of the mid and south cluster - T&F group set up and engagement with stakeholders will shorty be commencing. Proposed Revised Deadline of Mar-26 due to delays mentioned above. **January 2026:** The action is not yet due; however, work is partially completed. Primary Care has undertaken development work within clusters to support improved maturity. In addition, the DPCCMH restructure has contributed to strengthening and expanding cluster team capacity, further supporting progress toward maturity. **May 2026 Update:**							31/04/2026	jul-24
April 2026 update : The Strategic Risk Regsiter is due to be reviewed by the Board following approval of the 2026/27 Integrated plan in line with annual process, this will in turn inform a review of Strategic/Operational risks with the intention to integrate Organisational Risks into Committee Risk Registers when the Organisational Risk Register is of an apprioriate level of maturity.							31/04/2026	mar-26

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification
252601	2025/2026	Tackling the Planned Care Challenges	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Assistant Director Community Services/Assistant Director Performance Commissioning	R3	**Efficiency and productivity** To further improve efficiency and productivity, the Health Board should: • 3.1 Produce a progress report providing an update on the completion of recommendations arising from the Getting It Right First Time (GIRFT) reviews to be presented at Board. (Exhibit 6). • 3.2 Reduce the numbers of short notice surgical cancellations due to clinician unavailability (Exhibit 6). • 3.3 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85%	The Getting It Right First-Time actions now form part of the CIN Optimisation Frameworks and key transformation priorities reported/assured via the PTHB lanned Care Board. PTHB has agreed with NHS Executive that PTHB will focus on ophthalmology and orthopaedics as key priority areas identified in the PTHB. Key to progressing recommendations is speciality medical leadership and supporting clinical infrastructure which require investment proposals to resource Progress on key priority areas are provided to the Board as part of Transformation, Integrated Performance and Annual Plan Reporting. The HB is currently awaiting feedback from NHS Wales Planned Care Programme in terms of optimisation framework maturity matrix returns submitted in Q1 2025/26. Transformation Fund Bids were developed to support GIRFT progress within PTHB including speciality leadership, MDT infrastructure and Programme management. A successful internal investment bid for MSK/Orthopaedics has provided funding to appoint a speciality consultant lead for orthopaedics and supporting MSK infrastructure a similar investment proposal is being developed in 25/26 for ophthalmology. Progress report on Optimisation Frameworks including GIRFT to be provided as part of Performance & Finance Committee update. 3.2 SLAs with all providers are under significant challenge due to DGH pressures. The Planned Care Team continues to develop an MDT approach to support service sustainability shift left from reliance on consultant led model with digital healthcare underpinning wherever possible this is a long-term goal focus is currently on ophthalmology and orthopaedics. As part of Better Together workstream review of PTHB commissioning across Planned Care will be undertaken to review opportunities to mitigate in reach fragilities. 3.3 Theatre Transformation Plan in place as part of key priorities within PTHB community context no DGH, medical model. Working with regional partners to explore opportunities for mutual maximising utilisation of PTHB theatre estate at regional level.	des-25	01/03/2026 01/08/2026	Deadline Revised	Partially complete	
252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Executive Director of Finance, Estates and Support Services	R7	The Health Board should arrange for more training on finance for Independent Members to allow them to enhance scrutiny further in line with the developing financial pressures challenges.	The Health Board will arrange a specific training session on finance for Independent Members.	jun-26	jul-26	Deadline Revised	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
February 2026 update: 3.1 As outlined, the Getting It Right First-Time actions now form part of the CIN Optimisation Frameworks, with this and key transformation priorities reported/assured via the PTHB planned Care Board. Increased capacity for clinical leadership in agreed key areas (ortho / Ophthalmology) remains priority, with Orthopaedic lead in post. Further expansion of actions co-dependent on the outcome of strategic review programme. 3.2 SLA fragility remains a key risk to reduction of cancellations. No risk seen to RTT delivery through timely reframing of available clinical capacity and effective pathway management. Again, further benefits to be realised from strategic review. 3.3 Theatre Transformation Plan remains key priority within PTHB, and further efficiency seen in ophthalmology pathways. Further benefits to be realised from strategic review. **May 2026 Update:** All actions now wrapped up into external review. Clinical priority areas for clinical optimisation agreed with WG (Ophthalmology and Orthopaedics). Further rogress demonstrated in improved productivity within ophthalmology through increased numbers of cataract surgery per list, though fragility of SLA arrangements remains a risk factor. Further clinical engagement planned with team to support developments. Clinical leadership[roles appointed to (including orthopaedics) with programme of improvement expected to fall under monitoring of Better Together implementation programme.			aug-26				31/04/2026	13.02.2026
May 2026 Update: Schedule for July Board Development.			jul-26				31/04/2026	mar-26

PTHB Ref. No.	Audit Year	Report Title	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	Status	If closed and not complete, please provide justification
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Director of Primary Care, Community and Mental Health	R5	The Health Board should improve oversight at Board and committee level of performance within primary care by: 5.1. increasing the coverage of primary care performance within its Integrated Performance Report. 5.2. increasing the focus on outcomes and experience	Progress the development of a Primary Care Dashboard as part of Integrated Performance Report presented to Executive and Board Committees. Frequency to be agreed	des-24	01/05/2025 August 2026	Not yet due	Partially complete	
242502	2024/2025	Primary Care Follow-up Review	Director of Primary Care, Community and Mental Health	Director of Primary Care, Community and Mental Health	R6	The Health Board should strengthen its Primary Care Services Team by: 6.1. Reviewing the resources available to ensure it has the necessary capacity to deliver local and national priorities, alongside meeting day-to-day operational and business need. 6.2. Ensure that training and development opportunities extend to all members of the team and develop a succession plan.	in conjunction with ongoing operational requirements, including contract reform. Review resources available to increase capacity in the Primary Care Services Team. Develop a training plan for the Primary Care Services team to support succession planning and ongoing resilience.	jun-24	01/06/2025 August 2026	Not yet due	Partially complete	
252601	2025/2026	Tackling the Planned Care Challenges	Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Assistant Director Community Services/Assistant Director Performance Commissioning	R4	**Managing clinical risks associated with long waits** The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks resulting from long waits. • 4.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties (Exhibit 7). • 4.2 Routinely report harm resulting from delays in access to treatment to the Quality and Safety Committee. This should include data for all Powys residents i.e. whether they are treated in Powys or receiving care commissioned by the Health Board	PTHB Planned Care appointed a Senior Nurse Quality & Safety lead in October 2023 to further develop and strengthened Quality & Safety Framework and reporting within Planned Care Powys Provider. Clinical governance and oversight arrangements were further strengthened in October 2024 with the appointment of an Assistant Medical Director for Planned Care. Planned Care has a weekly Incident Panel Reporting Panel chaired by Senior Nurse Quality & Safety to review incidents, actions and learning (reported via Datix as part of All Wales Incident Reporting). There is a formal Planned Care Quality & Safety Meeting which reports into the Community Services Quality & Safety and health board Quality & Safety Committees. Risk, harm incidents are reported via this Framework. Commissioning, quality, performance meetings are held with each in reach provider which including standing agenda item for Quality & Safety. Clinical governance is being further strengthened with the appointment of speciality lead consultant for orthopaedics Sept 2025 and general surgery/endoscopy June 2025. 4.2 PTHB commissioned waits are discussed as part of PTHB commissioning assurance process with Quality & Safety as a standing agenda item at formal HB meetings with LTA providers and reported to Board as part of PTHB Integrated Performance Framework. Enhanced Quality and Safety waiting times report is under development	mar-26	mai-26	Not yet due	Partially complete	

252601	2025/2026	Structured Assessment 2025	Director of Corporate Governance	Executive Director of Finance, Estates and Support Services	R6	The Health Board should ensure it regularly reports more explicitly on the activity and impact of working groups which have been established to mitigate financial pressures. This includes the Variable Pay Working Group, Commissioning Working Group and Mental Health Working Group which should be formalised within governance reporting structures. This would enhance the assurance at Finance and Performance Committee and Board about the difference the groups are making	The Health Board undertakes a series of Deep Dive reviews into areas of concern. These are presented to the Finance and Performance committee. The Health Board will ensure that all working groups are covered within the schedule.	mar-27		Not yet due	Partially complete	
252602	2025/2026	Quality Governance follow up review	Executive Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R3	**DATIX training:** The Health Board should ensure, record and report that all relevant corporate staff have received training and support on how to use the DATIX system to report concerns and near misses	The Health Board is currently reviewing DATIX training provision to improve content, accessibility, and uptake across relevant corporate staff groups.. The updated programme will be rolled out within the next four weeks. Completion rates will be monitored and recorded, with compliance and uptake reported through established governance structures. This work aims to improve reporting culture, enhance the quality of incident reporting, and strengthen organisational learning from oncerns and near misses.	jun-26		Not yet due	No progress	
252602	2025/2026	Quality Governance follow up review	Executive Director of Nursing, Quality, Women and Family Health	Executive Director of Allied Health Professions, Health Science and Digital & Executive Director of Planning, Performance and Commissioning	R4	**Data analytics and dashboards:** The Health Board should explore opportunities within existing capacity to develop interactive digital dashboards to present performance indicators and help the reader to understand and evaluate success and challenges	There is ongoing work through the Digital and performance teams to continue to develop interactive dashboards. Grant Thornton and Partners are supporting the development of a Commissiong Dashboard by end Q1 as the priority area.	jul-26		Not yet due	No progress	
252602	2025/2026	Quality Governance follow up review	Executive Director of Nursing, Quality, Women and Family Health	Executive Director of Planning, Performance and Commissioning	R5	**Commissioned Services Performance Report:** The Health Board should develop and present the monthly Commissioned Services Performance Report as outlined in the Integrated Quality and Performance Framework. This will develop oversight and scrutiny of the quality and safety of commissioned services as intended	The Health Board is developing a Commissioned Services Performance Report as part of its broader commissioned services oversight model. The report will incorporate quality, patient safety, and performance indicators arising from Recommendation 1 and will form part of the Integrated Quality and Performance Framework (IQPF). Reporting will be provided on a regular basis, aligned to data availability and provider reporting timelines, to ensure meaningful oversight and scrutiny of commissioned services. The report will be presented through relevant governance and committee structures. Development of the Commissioning Dashboard referenced in Recommendation 4 will further support the maturity and presentation of commissioned services reporting. The ability to regularly produce the report is contingent on the development of the Commissioning Dashboard referenced in R4.	sep-26		Not yet due	No progress	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Chief Digital Data Officer	R2	The Health Board should strengthen its Strategic Risk Register by clearly identifying and articulating risks associated with digital transformation, including risks related to delivery, capacity and resources	We agree that digital risks require clearer articulation at corporate level. These risks have been reviewed with Executive colleagues and submitted into the Corporate Risk Register, with clear ownership, mitigations and reporting through ARAC and the Board alongside operational directorate risks.	jul-26		Not yet due	Partially complete	

262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Assistant Director of Digital, Data and Technology and Senior Cyber Security Specialist	R3	The Health Board should produce an annual Cyber Security Delivery Plan that states how they intend to comply with the Network and Information Systems Regulations 2018 Cyber Assessment Framework	The Health Board will develop a proportionate annual Cyber Security Delivery Plan aligned to the Network and Information Systems (NIS) Regulations and Cyber Assessment Framework. The plan will set out priority actions, controls, assurance activity, dependencies and deadlines, recognising the Health Board's scale, risk profile and available specialist capacity.	okt-26		Not yet due	Partially complete	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Assistant Director of Digital and Data Operations Head of Information Governance	R4	The Health Board should strengthen its arrangements for managing risks relating to Artificial Intelligence by: R4.1 developing a clear organisational plan for the safe and effective use of AI; R4.2 strengthening arrangements for identifying, assessing, and managing AI-related risks; and R4.3 ensuring appropriate governance arrangements are in place so that AI is deployed and used safely, appropriately, and in line with agreed policies	We recognise that AI governance is underdeveloped. In response to: R4.1, there is a draft AI policy that is ready for submission to approve. Once approved this will be supported by a SOP R4.2 there is already a process in place via the Digital Initiatives Group, this can only monitor those that we are aware of. R4.3 This will be supported by a SOP and a communication to all staff to follow the process. A method of auditing proper use of AI in context will be investigated.	mar-27		Not yet due	No progress	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Chief Digital Data Officer	R5	The Trust should strengthen its approach to understanding and developing digital skills in the workforce by: R5.1 increasing participation in the HEIW Digital Capability Framework self-assessment; R5.2 creating a clear plan for measuring digital confidence and monitoring progress over time; and R5.3 assessing the technical digital capabilities within the core digital team	The Health Board will request HEIW to support with a clear plan to strengthen our approach to understanding and developing the digital skills in the workforce In response to R5.1, We will promote the HEIW Digital Capability Framework self-assessment through staff engagement and staff briefings. In response to R5.2, we will develop an iterative plan for measuring Digital.confidence using surveys as part of each digital implementation/evaluation in our IMTP. In response to R5.3, Digital will assess technical capability and capacity risks within the core Digital Team and agree development actions, which will be reported through established governance. This will be proportionate to organisational capacity and financial constraints.	mar-28		Not yet due	Partially complete	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Chief Digital Data Officer, CNIO, Business Manager Powys Living Well Service	R6	The Health Board should strengthen leadership for digital inclusion and develop a digital inclusion plan	We accept this recommendation and will look to have support from our Boards Independent members. We do already have Executive oversight with the Exec Director of AHP, Health Science and Digital. A plan will be developed in collaboration with HEIW, Workforce and Organisational Development, the Living Well Service and the Clinical Informatics Team	mar-28		Not yet due	Partially complete	
262701	2026/2027	Digital Transformation	Director of Allied Health Professions, Health Science and Digital	Chief Digital Data Officer/ Head of Digital Programmes	R7	The Health Board should introduce a consistent post-implementation review process to assess whether digital projects deliver their intended benefits	We accept and recognise the need to apply the Benefits Framework more consistently as projects go live and come to an end. The Benefits Framework will be adapted to include user experience to regularly assess and measure if the digital projects deliver the intended benefits.	mar-27		Not yet due	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identifed being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
August 2025: DPCCMH commenced conversations to develop dashboard. Wealth of information available from various departments i.e information; finance, commissioning and primary care. Requires pulling into a central repository/dashboard.Ongoing assurance via relevant papers to executive committees, including Board development and Board briefing sessions. **06/08/2025** - Integrated Quality and Performance Framework refreshed for 2025/26. Continuation of Directorate Integrated Quality and Performance Group meetings including Primary, Community Care and Mental Health. The Integrated Quality and Performance Report (IQPR) does include and report on a limited number of primary care measures and will reflect detail from the Primary Care Dashboard once completed. **January 2026:** As per Augsut update: work continues, but is delaye due to other organisational priorities. Suggest deadline is revised to August 2026. **May 2026 Update:**							31/04/2026	jul-24
August 2025: Team resource reviewed and revised structure proposed. Work being led under the direction of DPCCMH as part of a wider Directorate workforce review. 'grow your own' approach to increas team resilience under way. Formal and informal training opportunities underway, developing the team. **January 2026:** As per August update, Suggest deadline is revised to August 2026. **May 2026 Update:**							31/04/2026	jul-24
February 2026 update: Planned Care has a weekly Incident Panel Reporting Panel chaired by Senior Nurse Quality & Safety to review incidents, actions and learning (reported via Datix as part of All Wales Incident Reporting). There is a formal Planned Care Quality & Safety Meeting which reports into the Community Services Quality & Safety and upwards to the Health Board Quality & Safety Committees. Risk, harm incidents are reported via this Framework. Commissioning, quality, performance meetings are held with each in reach provider which including standing agenda item for Quality & Safety. Further work is needed to develop a fully compliant reporting tool include data for all Powys residents which would include both patients treated in Powys or receiving care commissioned by the Health Board. **May 2026 Update:** we are updating the Integrated Quality and Performance Framework for 26/27 within which we will update the Integrated Quality and Performance Report and looking to include more detail on quality metrics. We are also developing a Commissioned Services Performance Report which will include detail on quality metrics including reporting on risks associated with long waits.			Timescale to be confirmed once Commissioning Dashboard (currently in development) has been received.				31/04/2026	13.02.2026

May 2026 Update: As per management response.							31/04/2026	mar-26
May 2026 Update: Training plan in development.							31/04/2026	mai-26
May 2026 Update: There is ongoing work through the Digital and performance teams to continue to develop interactive dashboards. Grant Thornton and Partners are supporting the development of a Commissiong Dashboard by end Q1 as the priority area.							31/04/2026	mai-26
May 2026 Update: Strategic group established; linking with Grant Thornton work							31/04/2026	mai-26
May 2026 Update: The 2 corporate risks have been shared with the Corporate Governament team and Board Secretary for inclusion, This is a Cyber Risk and a National Programme Risk and whilst not yet available via ARAC once approved for the corp register they will be.							31/04/2026	mai-26

May 2026 Update: The Cyber Improvement Plan is on track for delivery							31/04/2026	mai-26
May 2026 Update: R4.1 There is an AI policy that is submitted to corporate govenance and so will be live for the organisation, R4.3 there is a plan to launch awareness of the policy in collaboration with Digital and IG. A funding bid for an AI lead has been submitted to DPIF WG. R4.2 is complete this is part of our process 'Where Known' meaning if Digital and IG are involved with AI opportunities there is a governance process.							31/04/2026	mai-26
May 2026 Update: R5.1 Digital, Workforce colleagues, HEIW, the clinical informatics team and the PLWS are collaborating to strenthen the HEIW Capability, there is a poster developed and will be signposting via staff briefings. R5.2 Complete - we will replicate the survey used for the EPMA confidence and will form part of the programme pack. R5.3 We have completed the Demand and Capacity for Data Core teams, in 2025, we will continue information gathering to asses current capacity and capability, which will inform whether there are specific gaps to address, and this will be presented via a report with recommendations							31/04/2026	mai-26
May 2026 Update: A bid for funding support has been submitted for consideration of DPIF for a digital inclusion lead. An application to the Bevan Commission to support Digital inclusion has been submitted. Capacity to lead this is a constraint at the moment. Engaging with Digital Inclusion Wales to complete new self-assessment (following on from membership of the now-dissolved Digital Inclusion Alliance Wales). Undertaken self-assessment with Digital Poverty Alliance as part of their Digital Inclusion Charter campaign (outcome pending).	Capacity and specialist knowledge to lead this		mar-28				31/04/2026	mai-26
May 2026 Update: Project Timeframes and formal Project boards now continue for six months beyond implementation. This additional project closure window is to accommodate the completion and analysis of beneits framework, user experience feedback and tracking of adoption, and change framework success measures.			mar-27				31/04/2026	mai-26

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.6

Audit, Risk and Assurance Committee	**Date: 07 July 2026**
Subject:	**Information Governance & Records Management Annual Report 2025-2026**
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Head of Information Governance, Records and Data Protection Officer
Other Committees and meetings considered at:	Executive Committee -

PURPOSE:

To provide assurance on the arrangements in place to support the Health Board's compliance with statutory obligations, national frameworks, records management requirements, and good practice in information governance.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the 2025-2026 Information Governance and Records Management Annual Report
- Take **ASSURANCE** from the reported activities undertaken and performance in maintaining compliance with legislation, standards and regulator guidance.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	1. IG ensures that patient data is used effectively by securely sharing accurate information, healthcare providers can offer personalised and effective care, enhancing patients' overall wellbeing. 2. Reliable IG practices enable timely access to data, supporting early intervention and proactive care. 3. IG embeds processes ensuring data is accurate and accessible, enabling healthcare professionals to develop and implement targeted interventions. 4. Good IG practices promote seamless information sharing across different care
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	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

		providers and sectors ensuring patients receive coordinated care, improving their treatment outcomes and experiences. 5. IG plays a role in training and supporting the healthcare workforce in IG and Records Management responsibilities. 6. Effective IG supports the adoption of new technologies and innovative practices ensuring data is managed securely and compliantly. 7. IG is fundamental to the digital transformation of healthcare ensuring digital solutions are implemented securely, protecting patient information while improving efficiency and accessibility. 8. IG facilitates the safe and secure sharing of information between different organisations, enabling effective partnerships and joint initiatives to improve patient care.

EXECUTIVE SUMMARY:

Overall, the report provides reasonable assurance that the Health Board maintained effective information governance and records management arrangements during 2025–2026, despite sustained growth in demand, increasing complexity, and continued pressure on team capacity.

This report covers the full-year position from 1 April 2025 to 31 March 2026, including Quarter 4. Detailed performance information is set out in the Background and Assessment section, with key highlights summarised below.

- **514** Freedom of Information (FOI) requests were received, up from **477** in the previous year. Complexity also increased. Compliance improved from 86% to 92.22%, exceeding the ICO target of 90%. In addition, **5** requests were considered under the Environmental Information Regulations (EIR), and **4** internal reviews were undertaken.

- Requests for personal information continued to increase, with **856** received compared with **814** in the previous year. Compliance remained high at 98%, although requests are becoming broader in scope and more resource intensive. **Six** requests were extended due to complexity; **five** were completed within the extended timescale and one remains ongoing. **Four** internal reviews were also undertaken.

- AI-generated requests under UK GDPR and FOIA have increased. This has resulted in more clarification activity, follow-up correspondence and repeat contact where clarification is not provided. The ICO has issued guidance on managing these requests.

- The team is reviewing guidance issued in response to the Data Use and Access Act 2025 to identify any changes required to local processes, guidance and public information. Draft wording for the public webpage on data protection complaints is in development, and work is underway with the Concerns function to reflect relevant requirements in any updated Listening to People guidance.

- Mandatory IG e-learning compliance as of 31 March 2026 was **81.61%**, an improvement on the previous year's position of 77.30%. This however remains below the NHS Wales benchmark of 85%.

- The team delivered **31** bespoke training sessions to services, compared with **27** in the previous year. Topics included information governance, records appraisal, subject access requests, SharePoint, confidential information handling and CCTV. Regular sessions also covered the Information Asset Register, UK GDPR and data breach reporting.

- A total of **232** IG and records management incidents were reported through Datix, compared with **172** in the previous year. Of these, **77** were not reported to the IG team within the UK GDPR 72-hour timeframe; all related to delays in reporting by Health Board services.

- The team undertook **17** independent data protection and records management investigations or access audits and managed **3** public complaints relating to data handling, 2 of which were reported to the ICO. The ICO issued recommendations in both cases and took no further action.

- National Intelligent Integrated Audit Solution (NIIAS) notifications increased from **43** in 2024–2025 to **72** in 2025–2026, representing a 67.44% increase. Many were subsequently confirmed as appropriate work-related access following investigation.

- The team received **21** archive storage requests. **One** was cancelled following non-response from the service, and one was approved but remains on hold pending service action.

- The NHS Wales Information Governance Toolkit annual audit for 2025–2026 has been completed and submitted. A full out-turn report was presented to the Committee in April. Readiness work will continue during 2026-2027 for next submission and progressing outstanding actions.

- **One** new procedure was developed during the year: IGP 025 Archiving of Paper Records Procedure.

- The team reviewed **36** policies, procedures and guidance documents from other services, providing records management and information governance advice where required.

- A continued review and complete update to service intranet pages has been undertaken to reflect current guidance, advice and news, with a refresh and relaunch in December 2025.

- In line with the communication plan, the team issued the following guidance and news updates during the year:
  - Posting Prescriptions via royal mail
  - Records Management – Records Storage Security Checklist
  - How to prevent some common personal data breaches
  - Draft AI Governance Policy – out for consultation
  - Immediate Embargo on Destruction of Clinical Records
  - National Intelligent Integrated Audit Solution (NIIAS)
  - Managing your downloads
  - Postal service and sensitive information

- The IG team reviewed and supported **80** Data Protection Impact Assessments (DPIAs), covering both local and national programmes.

- The team reviewed and supported **65** contracts and information sharing agreements across local and national programmes to support compliance with legislative requirements.

- The team reviewed **19** research and service evaluation proposals, compared with **24** in the previous financial year. The reduction reflects the absence of any proposals requiring review by the Research, Innovation and Improvement Panel during Quarter 3.

- The Information Asset Register currently contains **238** registered assets; however, approvals remain labour-intensive and a backlog continues.

Key challenges remain in relation to the increasing volume and complexity of requests under FOIA and UK GDPR, growing demand to support local and national programmes, mandatory training compliance remaining below the NHS Wales benchmark, and delays by services in reporting incidents.

DETAILED BACKGROUND AND ASSESSMENT:

Compliance with Legal and Regulatory Framework

The Health Board maintains an Information Governance Framework to support compliance with data protection, freedom of information, confidentiality and records management requirements, informed by relevant legislation, national guidance and codes of practice including the Surveillance Camera Code of Practice 2021, the Caldicott Principles and the Records Management Code of Practice for Health and Social Care 2022.

Under UK GDPR Article 37, The Health Board has an appointed Data Protection Officer in line with UK GDPR requirements. The role provides advice, oversight, training support and independent assurance on data protection compliance across the organisation.

Information governance and cyber-related risks are considered through regular engagement between key leads, including the SIRO, Digital, Corporate Governance, the DPO and the Caldicott Guardian.

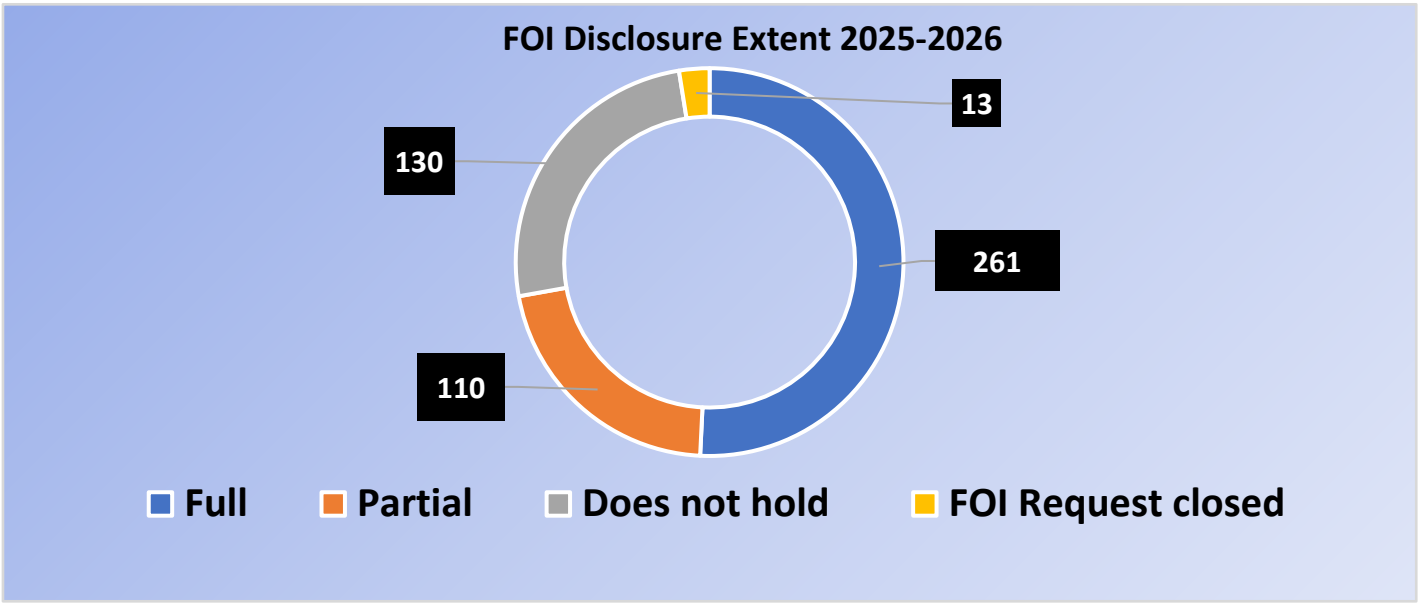
Since March 2026, the DPO has also served as Vice-Chair of the All-Wales Information Governance Management Advisory Group, supporting shared learning and coordination of common information governance issues across Wales.

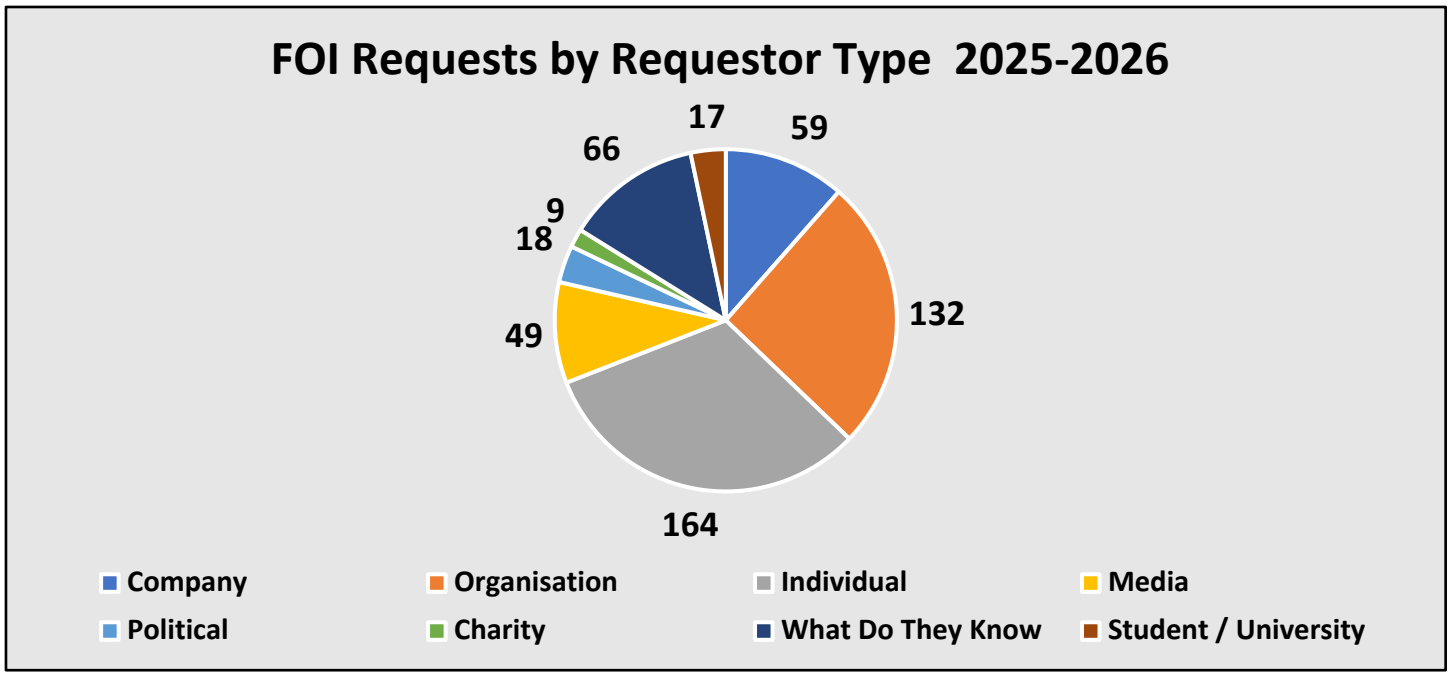
Key developments during 2025–2026 included:

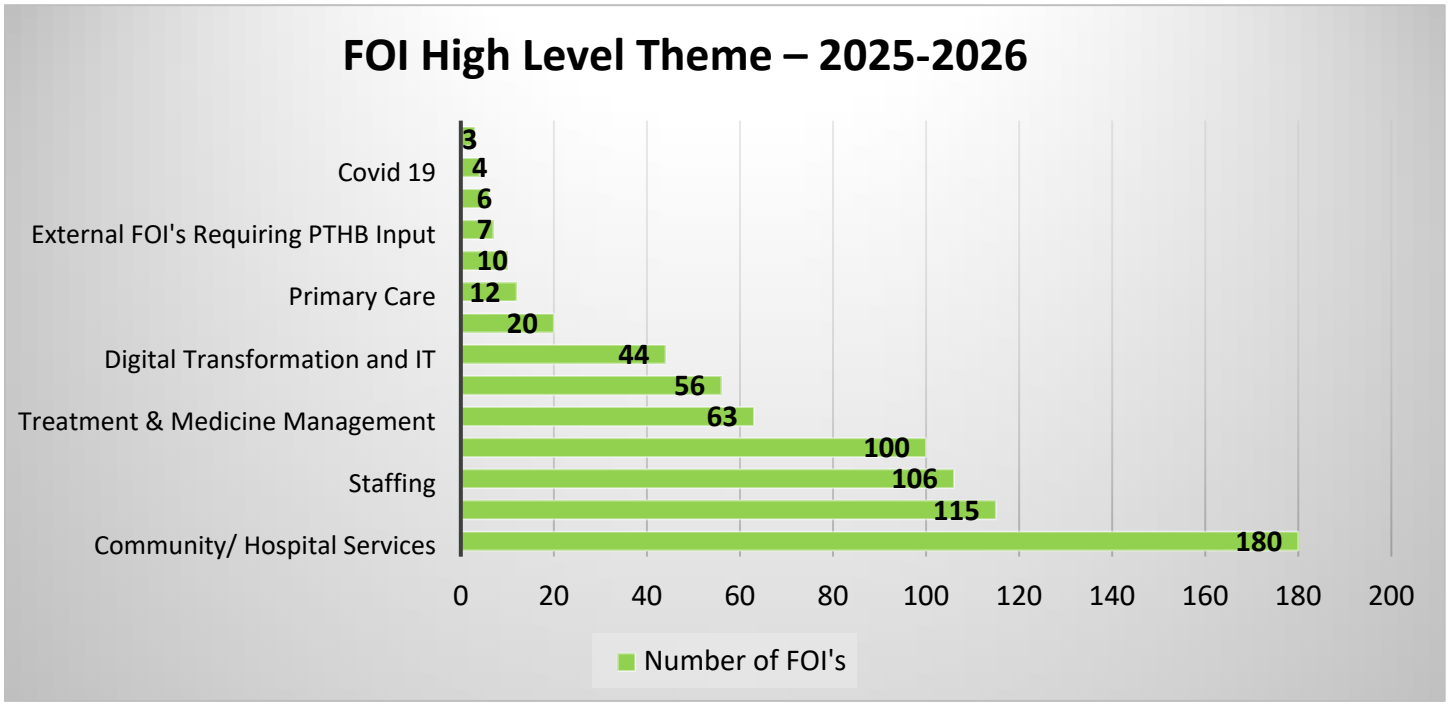
- Adoption of all-Wales IG and digital policy approaches for local implementation in 2026–2027.
- Replacement of local data sharing and processing templates with all-Wales/WASPI-aligned templates.
- Update of the DPIA screening process to strengthen consideration of cloud processing and artificial intelligence.
- Contribution to development of an all-Wales DPIA template for projects involving AI.

Performance Reporting

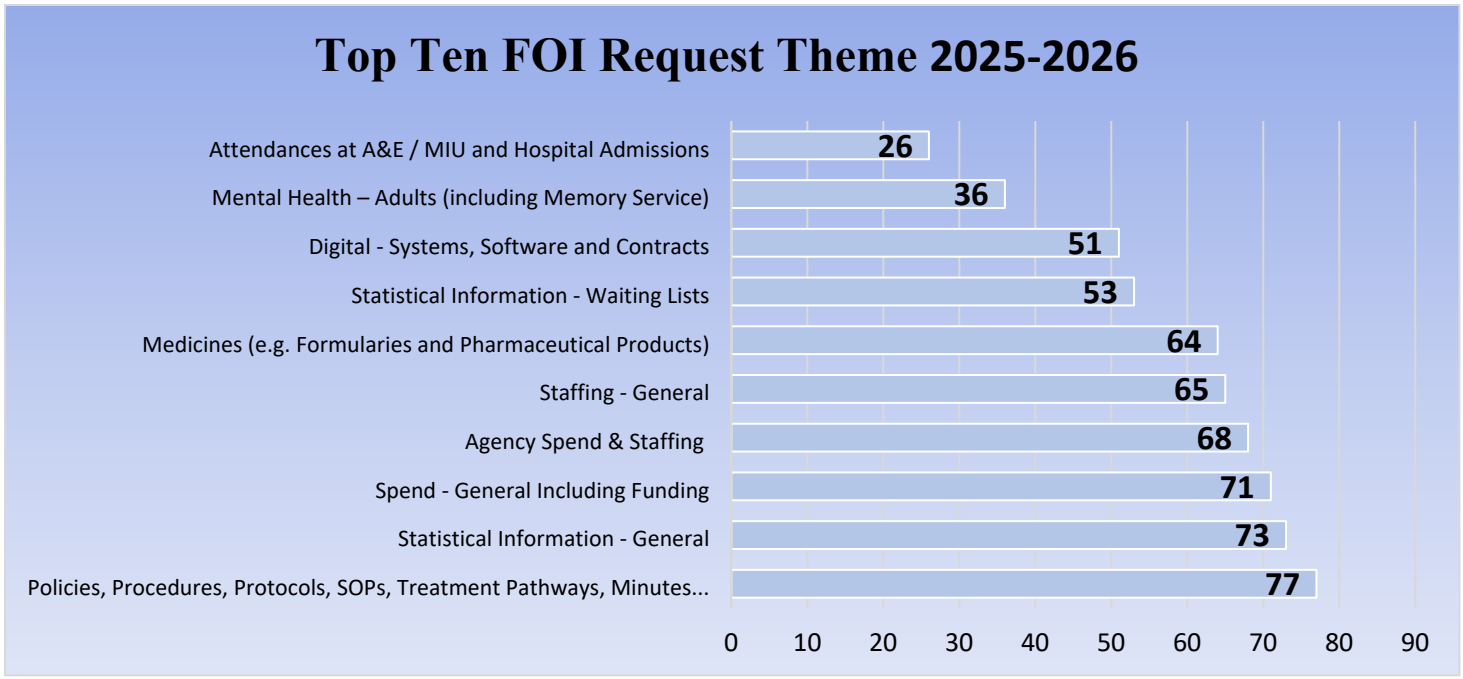
Freedom of Information performance remained strong during 2025–2026 despite increased request volume and complexity. The charts below summarise request sources, outcomes and themes.



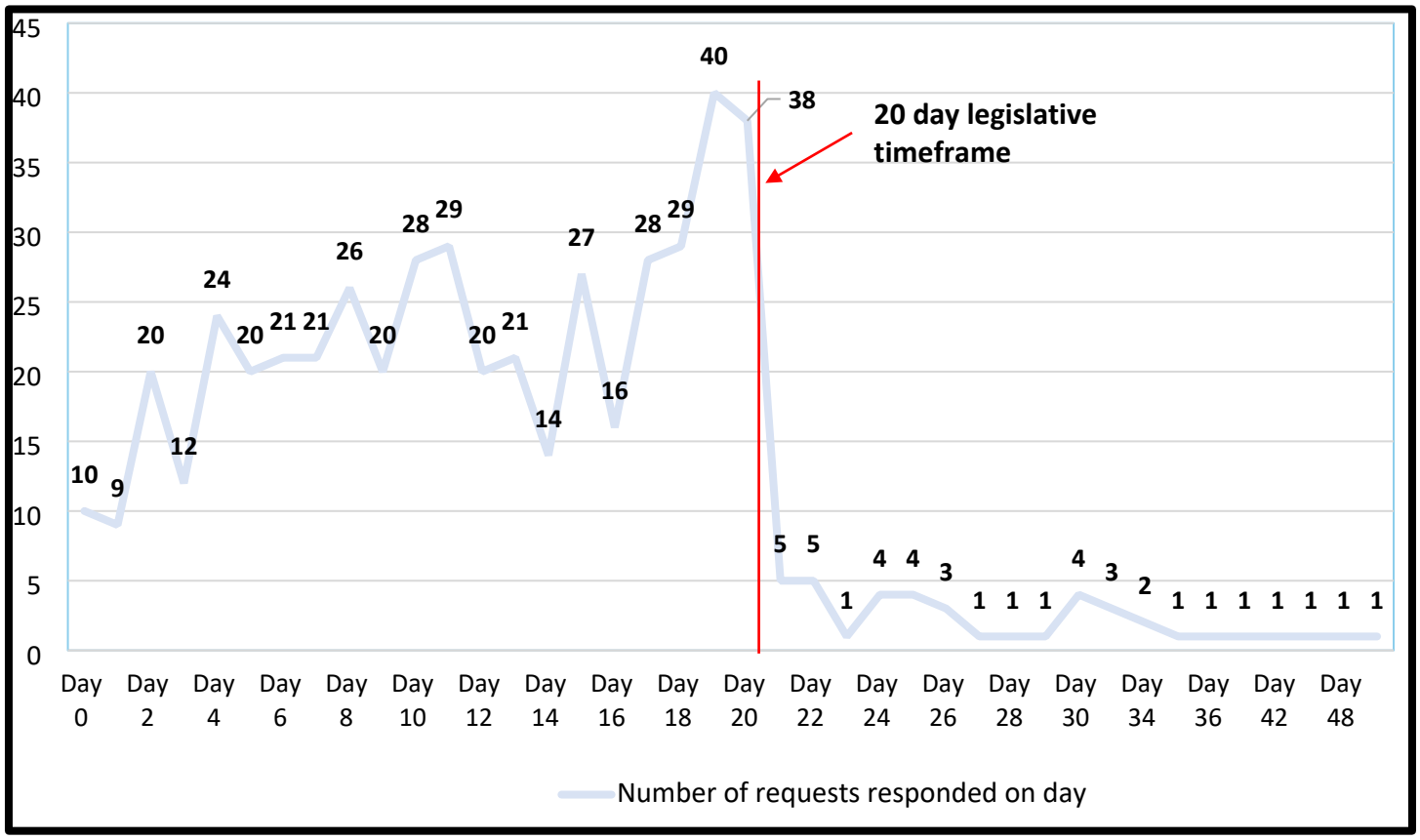




Note: Where multiple high-level categories apply to the same record, the visual counts each category individually. As a result, totals may exceed the number of unique records.



Note: Where multiple themes apply to the same record, the visual counts each category individually. As a result, totals may exceed the number of unique records.



Publication Scheme

Work continued to strengthen the FOI Publication Scheme and support development of a contract register with Digital.

From Quarter 3, request themes were recorded differently to support better reporting and publication scheme development. The team has also seen an increase in AI-generated FOI requests, often requiring additional clarification and follow-up.

Requests for personal information

Requests for personal information continued to increase during 2025–2026 and remained a significant demand on team capacity. Total requests rose to 856, compared with 447 in 2021–2022, with increasing breadth and complexity. The table below sets out the volume of personal information requests received during 2025–2026, including compliance against the relevant statutory timescales:

	Q1 2025-2026			Q2 2025-2026			Q3 2025-2026			Q4 2025-2026			
Type of request by legislation and timeframe	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Annual**
SARs (UK GDPR/DPA 2018 – 30 days)	24	40	39	45	39	53	37	48	42	58	58	64	547
Rectification (UK GDPR/DPA 2018 – 30 days)	0	0	0	0	0	0	0	0	0	0	0	0	0
Erasure (UK GDPR/DPA 2018 – 30 days)	0	0	0	0	1	1	0	1	0	0	0	1	4
SARs Breached (UK GDPR/DPA – 30 days)	0	0	0	2	1	2	0	0	1	0	4	0	9
Deceased (AHRA) 40 days	1	0	2	1	1	7	1	0	0	4	0	2	19
AHRA Breaches (40 days)	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Examiner Service (72 hrs)	21	14	9	20	15	18	22	14	18	15	14	17	197
Medical Examiner Service (72 hrs) Breaches	1	1	0	2	1	0	0	0	0	0	0	1	6
3rd party DPA requests – no timescale	8	5	5	13	7	5	3	3	3	5	6	6	69
Other: Medical Reports etc	0	1	2	0	0	4	1	0	2	5	2	2	19
Internal Reviews	0	0	0	0	1	0	2	0	0	0	0	1	4
Total requests for all legislation	54	60	57	79	63	88	64	66	65	87	80	89	856
% Of compliance for all requests	98%	98%	100%	95%	97%	98%	100%	100%	98%	100%	95%	99%	98%

In Quarter 4, SAR work accounted for 78% of available records management capacity. This included review, preparation, quality assurance and disclosure of 474 sets of records totalling 37,423 pages.

The team began using the IEP platform in Quarter 3 to send digital radiology images and reports directly to requestors. This reduces use of discs, lowers cost and information governance risk, and supports compliance. Further sites are planned for 2026–2027.

Review and redaction remain resource-intensive, particularly for lengthy or complex records requiring detailed line-by-line consideration.

Measures introduced to improve handling included updated guidance and templates, greater use of clarification where requests were unclear or disproportionate, regular drop-in sessions with service representatives, and implementation planning for a new SAR application in 2026–2027.

Datix Incidents (Breach Reporting)
All incidents with an information governance theme are reviewed and risk assessed by the team, with ICO notification considered where the reporting threshold is met. The table below summarises Quarter 4 and annual activity.

	Financial Year 2025-2026				
	Q1	**Q2**	**Q3**	**Q4**	**Annual Total**
Number of PTHB IG Incidents reported	63	57	53	59	**232**
Number of IG incidents NOT reported within 72 hours (including non PTHB)	17	13	23	24	**77**
Non PTHB incidents	11	7	5	13	**36**
Number of incidents reported to the ICO	1	2	0	2	**5**

Incident volumes increased during the year, with 232 incidents reported compared with 172 in 2024–2025. A continuing concern is delayed reporting by services, with 77 incidents not notified to the IG team within 72 hours.

Datix Theme	Q4	Annual
Records Management		
Wrong attachment/data (containing patient data) sent to external recipient	6	20
Wrong attachment /data (containing patient data) sent to internal recipient	0	4
Missing records/ documentation	0	5
Documentation Lost	0	3
Wrong information recorded	6	23
Wrong attachment uploaded	0	6
Wrong patient record updated	0	1
Lack of availability of information for clinical care	2	8
Patient record misfiled	0	3
Incorrect/inappropriate storage of documents	4	6
Potential delay in records being updated / delay in treatment	0	2
Missing Prescription	0	2
Records damaged due to flooding/ fire	0	1
Wrong documentation/ record provided	0	2
Information Governance		
Lost in post	0	3
Unintended recipient external (letter, email)	8	24
Unintended recipient - medication	0	3
Breach of sensitive data	5	19
Printer documentation	0	1
Inappropriate disclosure (verbal) external	1	4

Unintended recipient internal (letter, email)	0	4
Patient record accessed inappropriately	0	1
Communication issues	0	6
PTHB service SOP/ Process not followed correctly	0	2
NIIAS	0	2
IT/System Security or Function		
Missing laptop / Device	0	2
Photocopier / printer issue	0	1
Telecommunications	3	3
System not functioning as expected	6	13
No access to Internet/server issues	0	3
Physical Security		
Insecure premises	5	15
Access door codes	0	1
Non-PTHB		
Records Management - Wrong information recorded	5	12
Records Management - Lack of availability of information for clinical care	0	1
Records Management - Wrong attachment/data (containing patient data) sent to external recipient	0	1
Medication/ Prescription errors	3	3
IG - Unintended recipient external (letter, email)	2	5
IG - Breach of sensitive data	3	10
Postal issue / delivered to the wrong address	0	1
Damage during transit/ Post	0	3
Records shared on social media	0	2
Physical Security - Insecure Premises	0	1
Total	**59**	**232**

Data Protection Investigations
The team undertook 17 independent investigations or access audits relating to records management or data protection concerns. These arose from public complaints, service concerns and Datix notifications and exclude NIIAS audit notifications.

Data Protection Complaints
Three public complaints were received about the handling of data by PTHB staff or services. All were upheld as legitimate concerns. Datix incidents were raised in each case, with two reported to the ICO. The ICO took no formal action but issued recommendations in both cases

NHS Wales Mandatory e-Learning for IG, Records Management and Cyber security:
Mandatory IG, records management and cyber security training compliance at 31 March 2026 was 81.61%, up from 77.30% in the previous year, but still below the NHS Wales benchmark of 85%. The tables below show quarterly and directorate-level performance

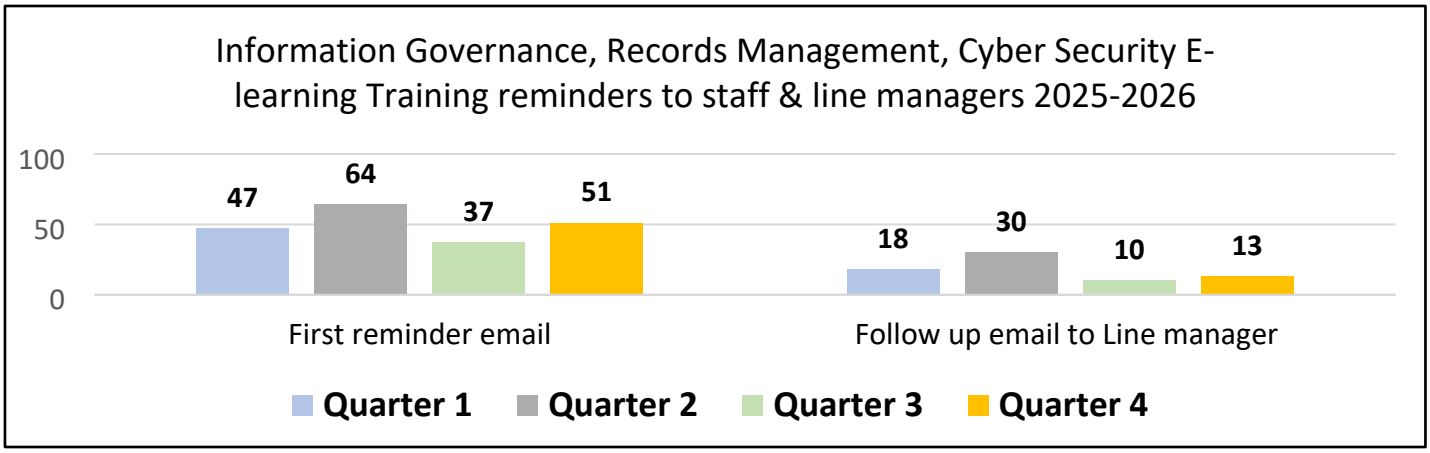
Mandatory IG Module Completion	Q1	Q2	Q3	Q4
Prior to joining	16	10	11	8
Not completed	**74**	**95**	**67**	**75**
Completed within 6 weeks	7	25	16	20
Completed after 6 weeks	2	4	2	6
Grand Total	99	134	96	109
Percentage compliance	**25%**	**29%**	**30%**	**31%**

The table below shows a detailed breakdown of mandatory IG training compliance for each directorate as of 31 March 2026:

Directorate	Assignment Count	Required	Achieved	Compliance %
Bank Staff	1658	1658	1118	67.43%
Chief Executive Office	24	24	19	79.17%
Community Care & Therapies	1140	1140	1049	92.02%
Community Dental Service	74	74	64	86.49%
Corporate Governance	24	24	21	87.50%
Estates & Works	51	51	46	90.20%
Finance Directorate	37	37	33	89.19%
Facilities & Support Services	196	196	165	84.18%
HCRW	83	83	76	91.57%
Medical Directorate	6	6	5	83.33%
Mental Health	489	489	422	86.30%
Medicines Management	38	38	36	94.74%
Nursing Directorate	34	34	33	97.06%
Public Health Directorate	84	84	80	95.24%
Planning Directorate	17	17	16	94.12%
People & Culture Directorate	70	70	62	88.57%
Primary Care	16	16	13	81.25%
Therapies & Health Sciences Directorate	71	71	70	98.59%
Transformation Directorate	22	22	17	77.27%
Women &Children Directorate	195	195	184	94.36%
Grand Total	**4329**	**4329**	**3529**	**81.61%**

The team continues to follow up non-compliant staff and target new starters who have not completed training within six weeks. From 2026–2027, IG and Digital will also have a regular slot in Health Board induction to reinforce responsibilities from the outset.

The graph below shows the number of first time and follow-up reminder emails issued Quarter 1 - 4 2025-2026:



Advice, Training and Assurance
The team continued to provide assurance and practical support across DPIAs, information sharing and contracts, incident investigation, bespoke training, service queries, support to IAOs and IAAs, and participation in local and all-Wales governance groups.

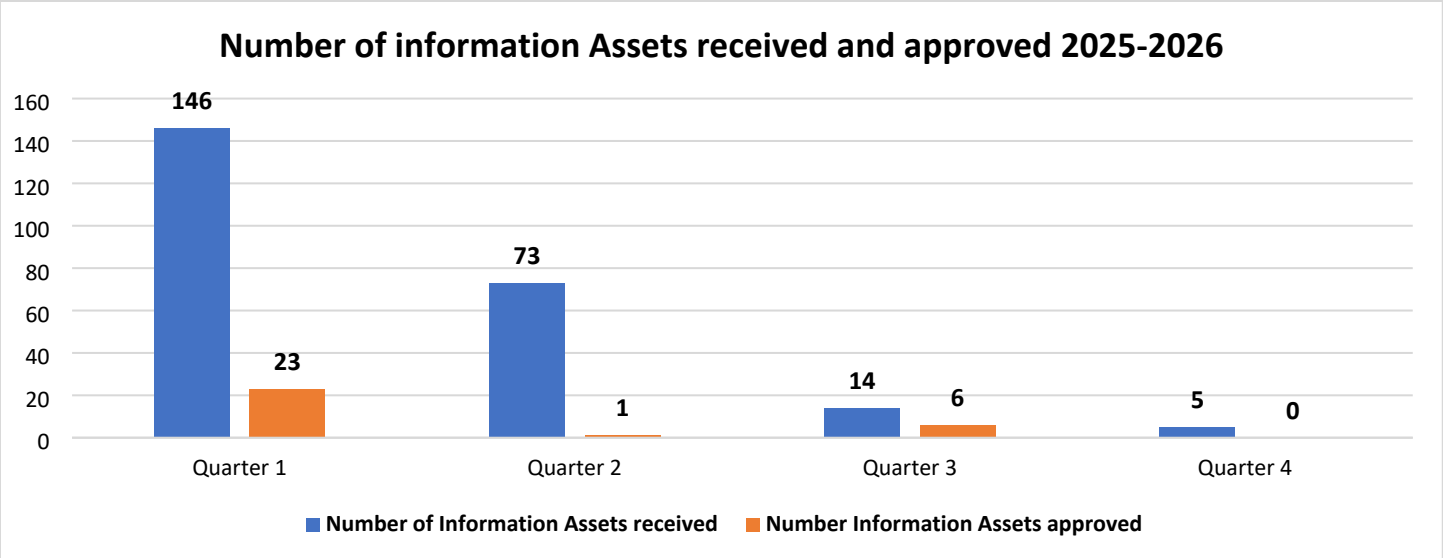
Information Security Assurance
The Digital Governance Board was replaced by the Digital Initiatives Governance Group (DIGG), bringing together digital and clinical expertise to review local digital procurements. This has strengthened accountability and supported compliance with data protection, cyber and wider regulatory requirements. The team supported **35** digital initiatives through this route during the year.

Risk Management Assurance
The SIRO oversees information risk across the Health Board, supported by the IG team. This includes maintaining the Information Asset Register, supporting the Record of Processing Activities, and advising services on information risk, data flows, continuity and related controls

Information Assets/Information Asset Register
The Information Asset Register contains 238 assets, with 5 added in Quarter 4. Review and approval remain labour-intensive and a backlog continues. Work is ongoing to promote the register and support services to identify and submit assets.

Information Asset Register (IAR) Review

2025-26	IAR Received	IAR Approved
Q1	146	23
Q2	73	1
Q3	14	6
Q4	5	0



Risk Register

The SIRO and IG team monitor and report information governance risks through the Audit, Risk and Assurance Committee. There is currently one risk on the Organisation Risk Register relating to the National Data Architecture and the requirement to ensure appropriate governance and legal assurance arrangements are in place to support lawful processing of personal data.

Data Protection Impact Assessments (DPIAs)

During the year, the team reviewed and supported 80 DPIAs across local and national programmes, advising on privacy risks, mitigations and compliance requirements. This represents a 52.5% increase on the previous year. By comparison, 42 DPIAs were reviewed in total during 2024–2025.

Information Sharing Agreements and Contracts

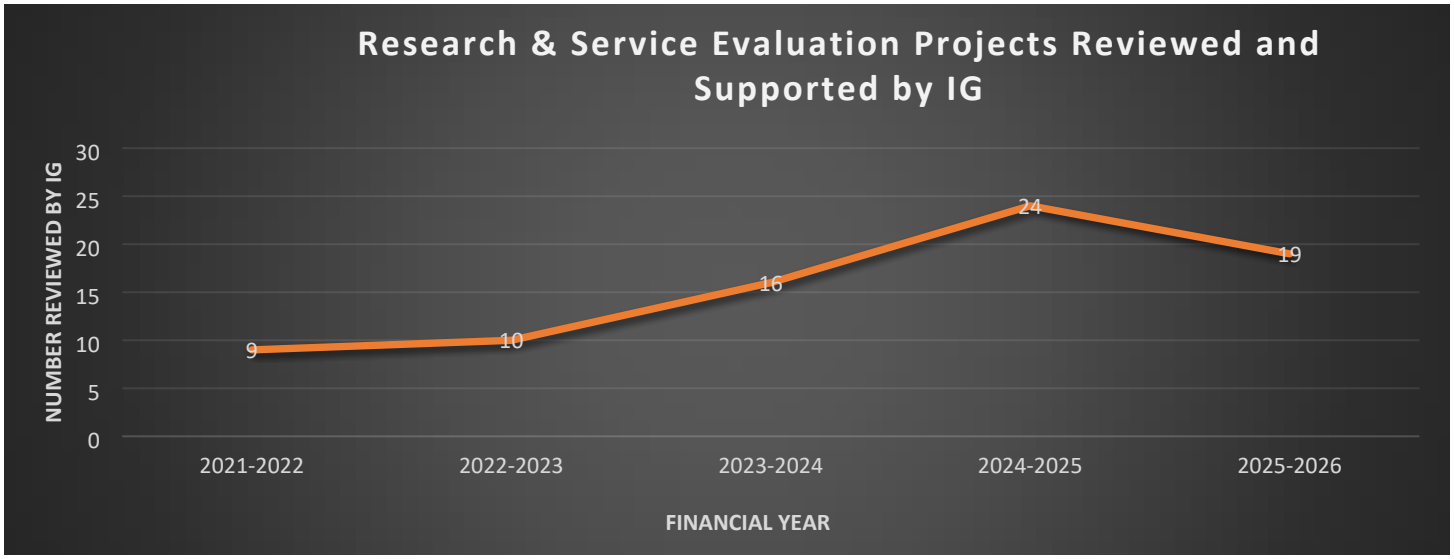
The team continued to support services with information sharing arrangements and contractual documentation required to support lawful information use. During the year this included:

- Data Sharing Agreements (National) **- 15**
- Data Sharing Agreements (Local) **- 16**
- Data Disclosure Agreements **- 9**
- Data Processing Agreements **– 8**
- Information Sharing Protocol (ISP) (National) **– 1**
- Information Sharing Protocol (ISP) (Local) **- 4**
- Information Sharing Protocol (ISP) (Regional) **- 2**
- Service Level Agreements **– 7**
- Joint Controller Agreements **- 3**

Research and Service Evaluations

Fewer research and service evaluation proposals were reviewed in 2025–2026 than in the previous year, reflecting a temporary pause in Quarter 3. However, proposals remain

detailed and resource-intensive to assess. The table below shows the position over the last five years:



Audit and Monitoring Assurance

The NHS Wales Information Governance Toolkit assessment for 2025–2026 was completed with support from relevant services, and the out-turn report and action plan submitted. During Quarter 4, the Health Board also published its first DPIA for FOI and EIR requests on the Publication Scheme.

National Intelligent Integrated Audit Solution (NIIAS)

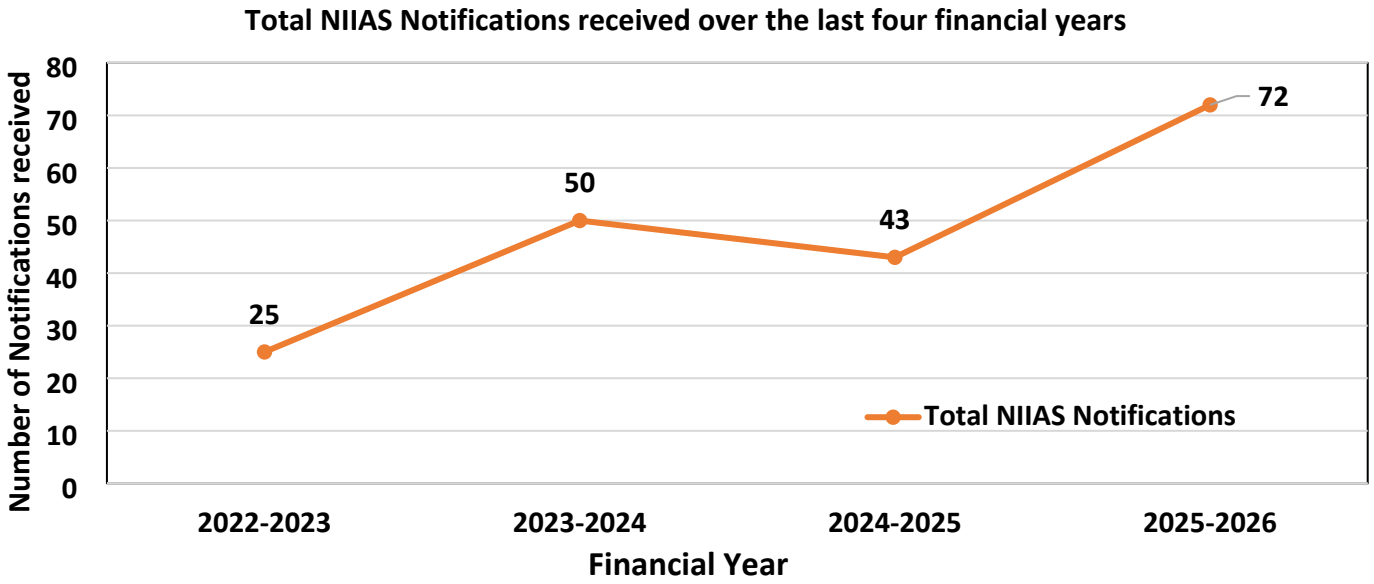
The IG team undertakes weekly review of NIIAS notifications relating to potential inappropriate access to staff members' own records or those of family members. Notifications increased from 43 to 72 during the year. Most were found to be work-related and appropriate following investigation; where inappropriate access was substantiated, action was taken and staff were required to repeat mandatory IG training.

Type of incident	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Own Record - 1st offence	0	2	2	3	7
Own Record - repeated	1	1	2	0	4
Home Relations (Family) Record - 1st offence	3	2	27	25	57
Home Relations (Family) Record - repeated	4	0	0	0	4
Both home relations and own record accessed	0	0	0	0	0
Notification for Non-PTHB member of staff	0	0	0	0	0
Grand Total	**8**	**5**	**31**	**28**	**72**

The table below shows the outcomes of the notifications following investigation:

NIIAS - Potential Breach Outcome	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Confirmed appropriate - work related (not family member)	5	1	27	20	53

Confirmed inappropriate own record first offence.	0	2	1	3	6
Confirmed inappropriate - line manager reiterated obligations. Mandatory IG training to be retaken.	1	1	27	5	9
Confirmed as part of work - no other staff available	1	1	0	0	2
Confirmed appropriate work related. Accessed in error due to same name	0	0	0	0	0
Confirmed appropriate - work related (family member - legitimate reason)	1	0	0	0	1
Confirmed appropriate - work related (Patient numbers and viewed own account)	0	0	1	0	1
Grand Total	**8**	**5**	**31**	**28**	**72**



Records Management Strategy

To support digital ways of working and management of legacy paper records, the team will begin development of a five-year Records Management Strategy aligned to digital transformation and wider organisational priorities.

National inquiries

National inquiry requirements continued to affect records management during the year. The embargo on destruction of clinical records was reissued in December 2025, with further preservation considerations arising from additional inquiry activity. Actions included updated guidance, internal communications and reminders to services on preservation responsibilities. In Quarter 3, an addendum was also issued to IGP 017 to remind staff of the embargo on destruction of all clinical records.

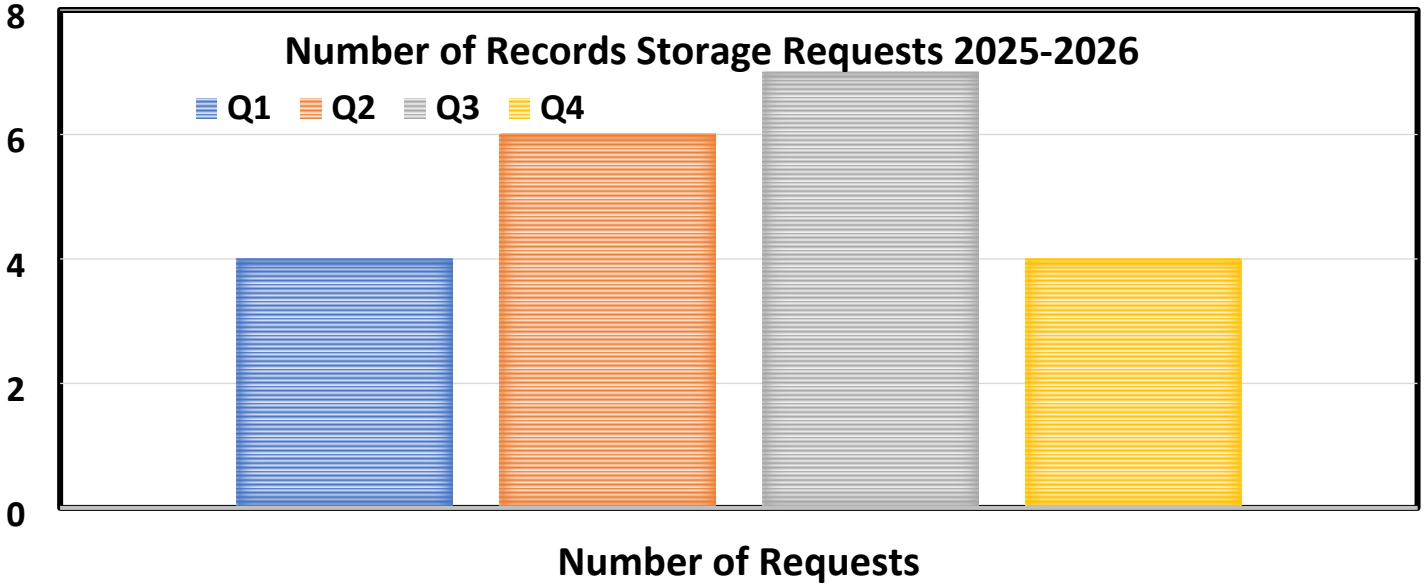
Records Storage

Refurbishment works to O Ward commenced in Quarter 2 and are nearing completion. Digital locking is planned for O Ward and Spa Road in Quarter 1 2026–2027 to strengthen security, support compliance with records management requirements and improve management of archived records by:

- Complying with legislative requirements for records storage
- reducing risk of unauthorised access, loss and breach
- Improving environmental controls to preserve the condition and integrity of records.
- strengthening centralised archive storage

In Q4, services were reminded that all records storage solutions require a completed Records Storage Security Checklist.

Archive Records Storage Requests:



Other Updates

The Data Use and Access Act 2025 has introduced phased changes affecting digital information and data protection practice. The team is reviewing ICO and other relevant guidance as it is issued to identify any changes required to local processes, guidance and public information. Work has commenced on drafting wording for the public webpage on data protection complaints, and the team is working with the Concerns function to reflect relevant requirements in any updated Listening to People guidance.

NEXT STEPS:

Work will continue in the following areas:

- Progress AI governance arrangements to include Policy, intranet page and supporting tools for staff
- Progress work identified within the Teams' development plan.
- Commence drafting of a five-year Records Management Strategy working with Digital Transformation.
- Continue to issue guidance and support in line with communications plan
- Monitor and support progress against the NHS Wales Information Governance Toolkit improvement plan and readiness for 2026-2027 submission.
- Continue and support with WASPI and Information Sharing across the Health Board.
- Continue to identify opportunities to improve information governance and records management compliance across the organisation.

- Continue to monitor IG-related incidents, work with services to reduce incident numbers, and improve reporting timescales
- Support Digital Transformation through the implementation of the Connecting Care Programme
- Work collaboratively both internally and externally with stakeholders

Provide continued assurance reporting through Executive Committee and Audit, Risk and Assurance Committee.

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		Strengthens confidentiality, integrity, and availability of records Good compliance around processing access to information requests Standardised processes supports staff in IG and Records Management and ensure compliance with legislation. Consistent handling of requests and access support legislative obligations Ensure Trust is embedded and open and transparency Increase in access requests, embargo and other legislative requirements means addition input requirement from operational staff Dependences across services and systems (digital transformation, archiving of records, estates) can impact consistency.
Timely			x		
Effective			x		
Efficient			x		
Equitable			x		
Person Centred			x		
Workforce		x			
Leadership					
Culture	x				
Information				x	
Learn, Improve, Research					
Whole Systems Approach				x	

EQUALITY:

	No impact	Negative	Positive	Both	
Age	x				Standardised Accessibility of information and formats; reduced barriers to request processing
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				Potential of fines if breach or lack of compliance with Uk GPDR. Also recent embargo on destruction of records could result in additional financial requirements.
Financial			x		

Corporate			x		
Operational			x		
Reputational		x			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.7

Audit, Risk and Assurance Committee	**7th July 2026**
Subject:	**Counter Fraud Update Report and Counter Fraud Work Plan 26/27**
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services
Prepared by:	R Neil Jones, Head of Counter Fraud (Interim)
Other Committees and meetings considered at:	

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 2026/27.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
Y		Y

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

EXECUTIVE SUMMARY:
The Counter Fraud Update Report updates the committee on key activity and developments in relation to the Counter Fraud Work Plan 2026/27. Please see appendices for further information.
HEADING:

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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

Item 5.7

Counter Fraud Update Report

7 July 2026

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 24 June 2026
Strategic Governance	**45**	**7**
Inform and Involve	**60**	**3**
Prevent and Deter	**103**	**4**
Hold to Account	**100**	**16**
TOTAL	**308**	**30**

4. STRATEGIC GOVERNANCE

The Counter Fraud Functional Standard Report 2025 – 2026 has been signed off by both the ACC and Director of Finance and submitted to the NHS Counter Fraud Authority.

5. INFORM AND INVOLVE

The Counter Fraud Team have been engaging with the Health Board Managers to drive participation with face-to-face fraud awareness training. The Team are continuing to utilise the use of the Employee Engagement Platform – Viva Engage to build a fraud awareness culture within the Health Board, via issuing weekly Blogs. In addition, the use of AI is being enhanced to develop counter fraud literature to raise staff awareness of current scams, which are effecting organisations, staff and members of the public.

6. PREVENT AND DETER

Work on the Health Board's matched data sets released by the National Fraud Initiative has commenced. The initial emphasis is on issues which identify dual employment between the Health Board and other public sector organisations. This work is currently ongoing.

7. HOLD TO ACCOUNT

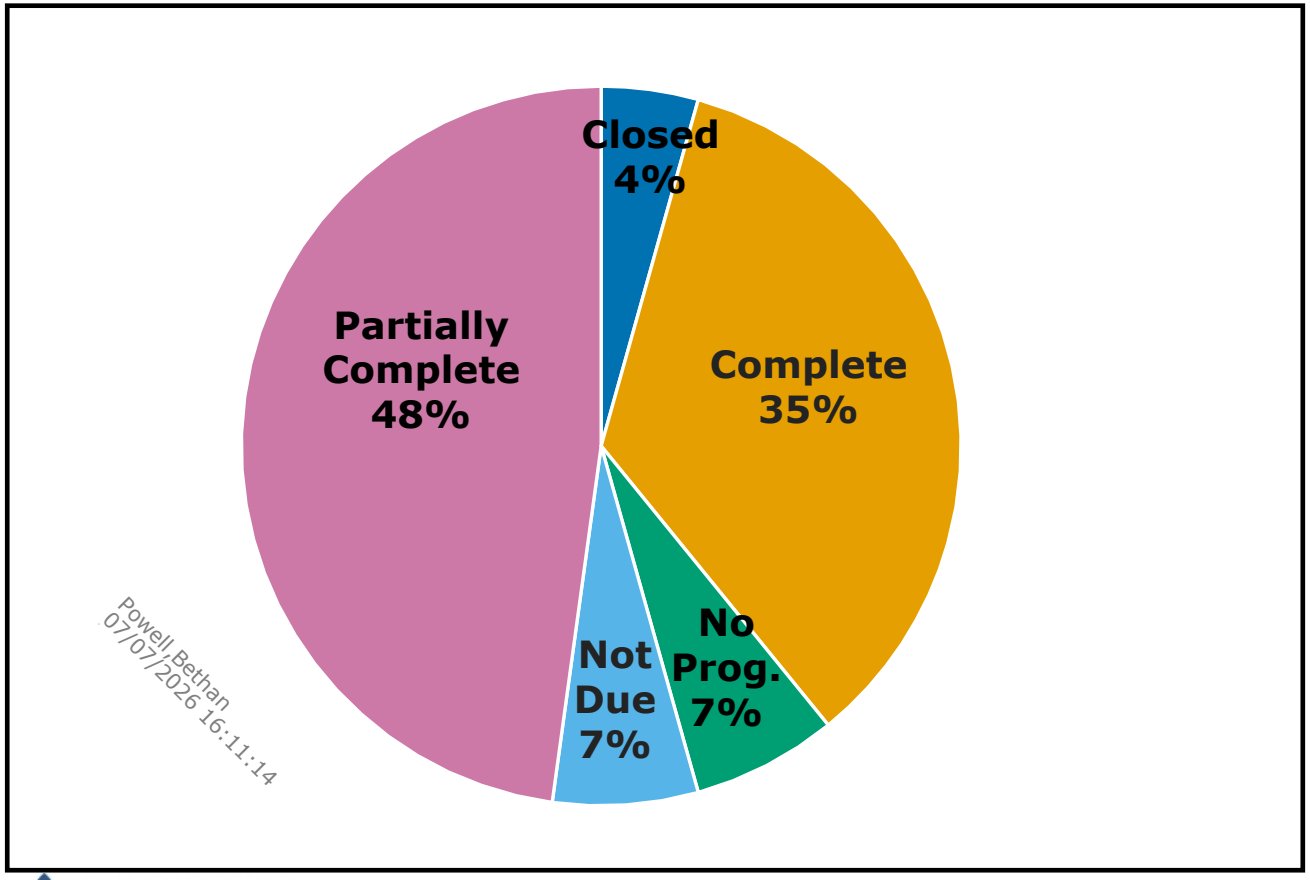
The status of the LCFS investigative caseload is provided to Committee Members in anonymised data via Background papers.

Subject:	Welsh Health Circulars and Ministerial Directions Tracking Report (WHCs and MDs)
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Officer
Purpose:	The purpose of this paper is to provide the Executive Committee with an overview of the position relating to the implementation of Welsh Health Circulars and Ministerial Directions.
Recommendations:	The Committee are asked to: • **RECEIVE** the contents of the report; and • **CONSIDER** and **REVIEW** those WHCs and MDs reported on slide 2 of this report as No Progress, in recognition that this position will be reported to Audit Wales, Internal Audit and Welsh Government for scrutiny and review as part of the Annual Report 2025/26.
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 10 June 2026 is as follows: • For those WHCs received in 2022 there are 31 complete and 1 recommended for closure • For those WHCs received in 2023 there are 40 complete and 1 partially complete • For those WHCs received in 2024 there are 47 complete, 6 partially complete, 1 not yet due and 1 recommended for closure. • For those WHCs received in 2025 there are 29 complete, 7 partially complete and 2 not yet due. • For those WHCs received in 2026 there are 9 complete, 7 partially complete, and 1 with no progress • All Ministerial Directions received 2022-2023 are complete • For those Ministerial Directions received in 2024 there are 22 complete and 1 partially complete. • For those Ministerial Directions received in 2025 there are 22 complete and 2 with no progress. • No Ministerial Directions have been received to date in 2026. 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 –** Ministerial Directions currently outstanding (not yet due, partially complete and no progress) and the progress made to action them **Appendix 4 -** Ministerial Directions completed since the last report (n/a as none completed since last report)

SUMMARY POSITION – Welsh Health Circulars and Ministerial Directions

Narrative of position: The pie chart below shows the overall position of Welsh Health Circulars and Ministerial Directions. There has been an improvement in the number findings marked as fully complete for this period. The Corporate Governance team has increased their focus working with directorates to ensure that all leads are reviewing and updating actions regularly. As evidenced in the pie chart, ongoing increased efforts of the teams to close overdue actions.

WHC and MD
July 2026 position



Summary of WHCs and MDs current Position:

- 2 actions have been closed since the last report; (4%)
- 16 actions have been completed (35%)
- 22 actions have been partially completed; (48%)
- 3 actions are Not Yet Due for implementation (7%) and;
- 3 actions have made no progress. (7%)
- There are 46 Welsh Health Circulars and Ministerial Directions in total on the live tracker as of July 2026.

SUMMARY POSITION – Welsh Health Circulars and Ministerial Directions which remain outstanding with No Progress made.

Summary since the last report in: March 2026

The Table provides the committee with an overview of the Welsh Health Circulars and Ministerial Directions that remain outstanding with no progress made at the date of writing this report. Updates will continue to be sought against these WHCs and MDs and will be verbally reported to the Executive Committee and Audit, Risk and Assurance Committee.

Welsh Health Circulars and Ministerial Direction – No Progress

Status	Executive Lead	WHC/MD Ref	WHC/MD	Position
No Progress	Executive Director of Primary Care, Community and Mental Health	Ministerial Direction WG-25-28	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services) (Wales) Directions 2025	Jan 26 - delay in PSR regulation and L&R advice has delayed implementation of this DSS. L&R advice confirmed mid-January. All practices currently participating in old DES and LES have been served notice for PTHB to withdraw on 31/03/26. Currently laying with practices for signup to new DSS specification for implementation from 01/04/26 May 2026 – verbal update to be given during meeting
	Executive Director of Primary Care, Community and Mental Health	Ministerial Direction WG-25-72	The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	Jan 26 - delay in PSR regulation and L&R advice has delayed implementation. L&R advice confirmed mid-January. Patient lists prepared and Expressions of interest being sought from practices. Planned go-live date 01/02/26 May 2026 - verbal update to be given during meeting
	Executive Director of Primary Care, Community and Mental Health	WHC-2026-013	Quality Statement Mental Health	May 2026 - verbal update to be given during meeting

SUMMARY POSITION – Implementation of Welsh Health Circulars

Summary

The following table provides an overview of the progress made against the implementation of WHCs received since the last report presented to the Audit, Risk and Assurance Committee in March 2026. 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.

WHC's position as of March 2026

WHC Status	2022	2023	2024	2025
Not Yet Due	0	0	2	2
No Progress	0	0	0	3
Partially Complete	1	2	8	6
Completed since the last report	2	0	2	22

WHC's progress position as of July 2026

WHC Status	2022	2023	2024	2025	2026
Not Yet Due	0	0	1	2	0
No Progress	0	0	0	0	1
Partially Complete	0	1	6	7	7
Completed since the last report	0	0	3	3	8

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 March 2027.

SUMMARY POSITION – Implementation of Ministerial Directions

Summary

The following table provides an overview of the progress made against the implementation of Ministerial Directions received since the last report to the Audit, Risk and Assurance Committee in March 2026. All Ministerial Directions received in 2022 and 2023 are complete and no Ministerial Directions have been received to date in 2026.

Ministerial Directions March 2026 position

MD Status	2024	2025
Not Yet Due	0	0
No Progress	0	0
Partially Complete	1	2
Completed since the last report	3	18

Ministerial Directions July 2026 position

MD Status	2024	2025
Not Yet Due	0	0
No Progress	0	2
Partially Complete	1	0
Completed since the last report	0	0

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 March 2027.

NEXT STEPS

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.

The Corporate Governance Team will be moving into the next phase of engaging with leads to understand the position of all those Welsh Health Circulars and Ministerial Directions that have made no progress and/or are overdue.

Discussions are ongoing with leads to enhance the user friendliness of internal tracking processes for the management of WHCs and MDs going forwards to ensure visibility of actions across their directorates.

An updated position will continue to be reported on a bi-annual basis to the Audit, Risk and Assurance Committee. The next update will be presented in March 2027.

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.
- 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 (n/a as none completed since last report)

WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	Expected Target date of completion	What Evidence can be provided to ensure closure of WHC/MD	WHC/MD
WHC 2026 004	Refreshed Intellectual Property (IP) guidance and policies for NHS Wales Organisations	27/03/2026	26/03/2026	Board or Executive level, with a supporting organisational and/or team structure. This structure will oversee production of a refreshed IP policy in line with the attached IP guidance and template, and should include membership from Research, Development, and Innovation teams. By 17.07.2026 Develop and internally agree a refreshed IP Policy, based on the IP guidance and IP policy template attached at Appendix 1 and Appendix 2, respectively. By 20.12.2026 Specify metrics that will track usage and implementation of the IP policy; to include IP creation, usage of the IP policy, numbers of projects, income generation and IP protection. This should include the effectiveness of the process in meeting the needs of staff undertaking research, innovation, or other activities with the potential of creating IP. By 20.12.2026 Provide initial feedback on the IP policy and guidance to WG Innovation and Research and Development teams, to inform a definitive version of the guidance and policy template. By 20.12.2026 Set out a regular organisational process for undertaking regular reviews of the effectiveness of the IP Policy and Guidance within their organisation. This should include gaining feedback from staff on the extent to which the process and the IP Policy has enabled or been a barrier to research and innovation activities and/or	Director of Improvement and Transformation	17.07.2026 20.12.2026 November 2027 and annually thereafter	Partially Complete	**May Update:** IP Policy template is being completed for consideration by Medical Director / Board Secretary before approval.			
WHC 2026 011	Maternity Reporting Data Set (MRds) – Data Requirements	01/04/2026	01/04/2026	implementation aligned to national maternity system deployment from April 2026, with first data flowing from June/July 2026 for April and May data	Executive Director of Nursing, Quality, Women & Family Health	Immediate	Partially Complete	**May 2026 update** - Badgernet fully implemted since 2nd March. Progress being made and overarching monitoring of data underway.			
WHC 2023 003	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	04/04/2023		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.	Director of Nursing, Quality, Women and Family Health	30/04/2023	Partially Complete	**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. **26.01.26 update** - It has been confirmed that PTHB Community Paediatricians are using EDI guideline in terms of assessment and first line investigations although North Powys patients genetics go to the Birmingham lab so get WGS rather than SNP array and fragile X which is what is still offered in Wales (this will change when the Welsh lab has capacity to catch up with English labs). The very small number of children requiring 2nd line investigations will be referred tertiary neurology or paediatricians with a special interest in the area of concern and they will organise these investigations which include some, such as fasting bloods, which cannot be taken routinely in the community but need to be done in a DGH. **May 2026 update** ,no further update			
WHC 2024 005	Private obesity surgery and the Welsh NHS	N/A		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."	Director of Planning, Performance and Commissioning	N/A	Partially Complete	**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. **Agreement from VBHC Programme Board on 24.05.2022 to link and track through VBHC Programme Plan.** **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. **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. **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. **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 engagge in the relevant National PROMs sub groups. **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) **January 2026 update:** As previsouly updated this sits under VBHC Programme for updating not DPCCMH. May 2026 update ,no further update			
WHC 2024 012	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	N/A		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.	Director of Nursing, Quality, Women and Family Health	01/10/2025	Partially Complete	**30/01/2025 -** Restorative supervision is in place within Ditrsict nursing in PTHB. Time is being builth into ward rosters for clinical supervision in readiness for the change with similar taking place in DN services. February 2025 - Preceptorship programme in place. Restortive Supervision - model being worked through with a plan to recruit and increase supervisiors, use a train the trainer model to train supervisors while building a support network, this will enble the offer of restoritve supervison to be operationalised later in the year. **01.04.25** Clinical lead identified, 'train the trainer' dates booked. **15.01.26 update** - Preceptorship update, an annual rolling program is mandated for all newly qualified nurses and is offered to all new starters in PTHB including AHP's. Attendance can be a challenge based on clinical need, but overall is good. Feedback on the sessions is positive and the ability to understand the wider network across PTHB is welcomed. Attendance by our 'grow your own' staff/students has increased and is being demonstrated as beneficial for their IPE/APL ePAD proficiences across all fields of Nursing. We await the All Wales Perceptorship policy and workbook from the Education Leads group, based on PTHB's workbook described as an exemplary version. The offer of quarterly Restorative supervision is included in the Preceptorship program. Restorative Clinical Supervision update, regular RCS sessions continue within District Nursing service. 2 group sessions offered to all nursing preceptees (49 in total) with 22% uptake in November and 10% in December. Excellent feedback from those who attended. To date - 4 RCS facilitators, 2 PNA + RESTORE and 2 RESTORE only trained staff = 8 on total. Issues identified for staff accessing RCS train the trainer course in Cardiff due to location, particularly those in mind and north Powys prevents wide uptake. Limited resources to offer in house training by those who have attended train the trainer to grow our numbers. Focus on ensuring appropriate individuals with qualities and experience to be effective restorative supervisors. Developing business case for the PNA role to ensure restorative supervision sessions are timely, responsive and delivered by a suitable person. **May 2026 update:** RCS steering group reviewing how supervisors will escalate themes and to whom, how they record numbers of attendees, and setting up peer support for facilitators. No additional supervisors traied. RCS is embedded into the preceptorship program. Awaiting all-Wales Preceptorship policy and workbook, current program well-received.		nd north Powys prevents wide uptake. Limited resources	WHC_2024_012 - ptorship and CS W

WHC 2024 016	Healthy Child Wales Programme: for school aged children	11/04/2024		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.	Director of Nursing, Quality, Women and Family Health	Immediate	Partially Complete	**Feb 2025 -** Action Plan in place to support implementation across 44actions. 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 momnent 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. **28.01.26 update** - PTHB continue to participate in the national work supporting the delivery of the framework. Workforce requirements remain a challenge as there remains an absence of consensus across Wales with regards to caseload numbers. PTHB continue their development programme of supporting more nurses to become Specialist Community Public Health Nurses, School Age Children. Continue actions to increase resilience of a programme for children educated other than school. **May 2026 update:** PTHB continues to progress towards implementation of the Healthy Child Wales Programme for School-Aged Children and is engaged in national work to support this implementation. Supporting training of registrants to become Specialist Community Public Health Nurses continues with a plan to reach optimum qualified School Nurses by September 2028.		026 update PTHB continues to progress towards implementation	
WHC 2024 035	Standardising the management of acute deterioration	17/09/2024	18/09/2024	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 numberof 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.	Director of Nursing, Quality, Women and Family Health	n/a	Partially Complete	**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. **12.01.2026 update** - NEWS2 has been fully implemented in physical health inpatient wards. Training has been completed to 93% with local plans to reach 95% in place for Q4. The local policy has been reviewed for a second time with the implementation of NEWS2 across NHS Wales to ensure that the policy is aligned. It is included in the mandatory HCSW Induction. Implemented an audit for NEWS2 with evidence of good compliance with implementation. It has been updated on the MEG digital audit platform and due to go live in Q4. In addition, NEWS2 will be implemented in District Nursing in Q4, training is at 90% for this area. **13/05/26 Update:** NEWS2 has been implemented in all Physical health areas - audit data shows 97% compliance. DN to commence Audit in Q1 26/27. Where escalation is required - audits suggest that escalation has been timely.NEWS2 has been implemented in Mental health inpatient wards - pending update and Audit outcomes. NEWTT2 - fully implemented and embedded. Training fully implemented in relation to NEWTT2	ACTION: Awaiting assurance audit outcome before closure		
WHC 2024 042	Introduction of the 'Dictionary of medicines and devices	04.11.2024	05.11.2024	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.	Medical Director	With Immediate Effect	Partially Complete	**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. **Jan 2026:** Welsh Government has mandated the use of the Dictionary of Medicines and Devices (dm+d) as the foundational interoperablity standard for medicines data across NHS Wales. For secondary care, PTHB will meet these requirements through procurement and implementation of the BetterMeds ePMA system, which is built natively on dm+d and therefore enforces compliance by design. The BetterMeds rollout is scheduled to commence in March 2026, with phased implementation and full completion by July 2026. This will ensure that medicines recorded and transferred between digital systems use dm+d codes at the appropriate structural level and that systems can process ongoing weekly dm+d updates in line with national requirements. **21/05/2026 Update:** PTHB continues to work with digital, pharmacy and supplier teams to ensure systems can appropriately receive and process ongoing weekly dm+d updates in line with national expectations. evidence of dm+d compliance within system specification/procurement documentation; ePMA rollout plans and governance reporting; supplier assurance regarding native dm+d functionality and update processes			
WHC 2024 030	Published Weight Management Medication Pathway	Unknown	05.11.2024	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	Director of Primary Care, Community and Mental Health	Jul-25	Partially Complete	**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 Service. **January 2026 update:** Weight Management Medications now available through the Powys Living Well Service to people who meet phase 1 or 2 of the priority guidance. People also need to engage with behaviour change (reduced calorie intake and increased activity) throuout the course of treatment. This is supported by the lifestyle management programmes run by the Powys Living Well Service **May 2026 Update:** End of year report due to Executive committee with view to consider next steps.			
WHC 2025 005	Climate Emergency Leadership day and adaption	12/03/2025	12/03/2025	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,	Director of Finance, Capital and Support Services	07/03/2025	Partially Complete	**April 2025** - Note progress and actions in relation to the environment and climate. Ongoing area of focus that is reported and monitored. **January 2026** – Work programme being led by Environment Team who have developed in conjunction with other health boards a common overarching Risk Register. Department-level risk assessments will sit underneath and are being completed through bespoke workshop sessions to be run across 2026 by the Environment Team. Climate Response Plan, Decarbonisation Delivery Plan and Climate Adaptation Plan are presently being drafted and will undergo internal governance before submission to National Climate Emergency Programme Board. **May 2026 Update** – The Climate Adaptation Assessment and Plan (2026–2030) has been developed and is progressing through internal approval. It provides PTHB's first organisation wide assessment of climate risk and sets a clear framework for strengthening resilience across the estate, services, workforce and partnerships. The Decarbonisation Delivery Plan (2026-2030) has been drafted and delivery is being progressed through the established tracking and assurance framework used during the first phase of decarbonisation. This approach provides consistent performance management, clear ownership of actions and routine reporting to Executive and Board, ensuring alignment with the refreshed NHS Wales Decarbonisation Strategic Delivery Plan. In parallel, the Environment Team is developing an overarching Climate Response Plan to integrate decarbonisation, adaptation and wider climate risks into a single, coherent organisational framework.	Dec-26		
WHC 2025 002	Timelines and responsibilities for Early Warning Scores (EWS)	04/03/2025	04/03/2025	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.	Director of Nursing, Quality, Women and Family Health		Partially Complete	**28.02.25** - Email sent with the WHC 2025 002 Timeline and Responsibities 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 **12.01.26 update** - NEWS2 has been full implemented in physical health inpatient wards. Training has been completed to 93% with local plans to reach 95% in place for Q4. In addition, NEWS2 will be implemented in District Nursing in Q4, training is at 90% for this area. **May 2026 Update:** - Update NEWS 2 implemented in all physical health areas - Audit in place since October 2026 NEWTT2 was implemented in July 2025 with ongoing audit for assurance which will be completed now in May post implementation of Badgernet. Neonatal risk assessments remains paper based on a national level for now. MEWS - MEWS escalation for community settings was ratified by the network in April 26 and plan to be fully implemented by September 2026 (the timeline for the recommendation was for acute settings).			

WHC 2025 037	Infected Blood Enquiry, Implementation of Recommendation 7e. Implementing SHOT reports.	25/09/2025	25/09/2025	I would be grateful if the following were actioned by Health Boards and NHS organisations: • Establish a governance framework ensuring integration of the Hospital Transfusion Committee (HTC) for board-level oversight of the review and implementation of SHOT Safety Standards. • Appoint an Executive Director with designated responsibility for the delivery and oversight of SHOT Safety Standards within the organisation. • Undertake a comprehensive analysis of the SHOT Transfusion Safety Standards, utilising the baseline assessment tool. Due to the broad nature of the recommendations, this must be performed by the responsible personnel across the clinical, laboratory and managerial domains to ensure accuracy and accountability. • Ensure submission of initial findings and proposed actions from the baseline assessment to the BHNOG Transfusion Risk Group by 31st December 2025. • Identify a responsible committee within your governance structure to oversee ongoing improvement and barriers to implementation (this could be the Board level. committee to whom the Transfusion/Blood Safety Group reports). • Regular compliance review should occur to ensure ongoing improvement and identify any barriers to implementation. Outcomes and process measures that demonstrate improvements should be reported to the BHNOG Transfusion Risk Group on a six-monthly basis, and NHS Performance & Improvement as part of your regular reporting.	Medical Director	N/A	Partially Complete	May 2026: No update received **June 2026**, actions have been taken, review has been completed and submitted. Temporary reorganisation of provision made as a result of review. CSG governance to be defined more clearly before being complete.			
WHC 2025 051	Safety netting discharge leaflets for adults and children	08/12/2025	08/12/2025	Action: Distribtion of Patient Safety netting discharge leaflets for adults and children.	Director of Nursing, Quality, Women and Family Health		Partially Complete	**15.01.25 update -** No update as yet. **May 2026 update :** the Children's safety netting information sheet has been shared with MIU's and Primary Care. There is a need to make this fit for Powys in particular the MIU's which is being worked through and anticipate to be ready to move forward in Q2. The Communications team have been engaged and will add the Powys Branding and ensure fit for purpose, and support digital and printed versions, for distribution across settings			
WHC 2025 052	COVID-19 spring vaccination programme 2026	15/01/2026	15/01/2026	Health boards are expected to continue to maximise vaccine uptake, minimise vaccine waste and retain their focus on reaching the most vulnerable. It is important that health boards understand and address inequity by ensuring access for all eligible people. For older people, the expectation is that health boards provide clear information on the vaccine and ensure local access to receive a vaccination at a convenient time and place. Taking up a vaccination should be as accessible as possible and health boards should be ambitious in undertaking activity that minimises patient burden (including travel burden) as much as possible.	Director of Public Health	30/06/2026	Partially Complete	**07/05/2026 Update:** This programme is currently underway and runs alogside the Routine RSV programme (75 years), RSV expansion (80+ and Residents of a Care Home) and the RSV catch up (76-79 years) All residents in a Care Home have been offered Covid-19 vaccination in the first 2 weeks of April 2026. The remaining eligible cohorts will be invited to their nearset community based setting.	30/06/2025	07/05/2026 Once the Campaign is completed evidence of delivery plans, uptake rates and invite letters can be proivided as evidence.	
WHC 2025 053	Expansion of RSV vaccine eligibility to adults aged 80+ and residents in a care home for older adults	02/02/2026	02/02/2026	Health boards should continue the ongoing work to increase vaccine uptake, reduce waste, and ensure fair access for everyone eligible. There is a need for a coordinated, equity-focused approach to vaccination, which addresses barriers and the diverse needs of underserved communities to ensure we achieve maximum reach. There has been some progress made across Wales in embedding equity into vaccination policy and practice, reflecting the ambitions of the National Immunisation Framework. However, inequalities in uptake persist and, in some areas, are worsening. Equity needs to be built into the design and delivery of services, to promote universal accessibility, but with tailored interventions to understand and overcome the specific barriers faced by different population groups. Given this is an older cohort, health boards should ensure that RSV vaccination is made as easy and convenient as possible. with access offered close to home and through familiar local services.	Director of Public Health	30/06/2026	Partially Complete	**07/05/2026 Update:** This programme commenced early April and s currently underway alongside the Covid-19 Spring campaign. All residents in a Care Home have been offered a vaccination in the first 2 weeks of April. Any outstanding vaccinations will be undertaken as part of a mop-up programme alongside delivery to the remaining eligible cohorts. Where possible, co-administration has taken place with Covid-19. The remaining eligible cohort will be offered a vaccination at their nearest local venue before 30 June 2026.	30/06/2025 - anyone that has missed a vaccination after this date remains eligible and will be invited as part of the catch up campaigns.	07/05/2026 Once the Campaign is completed evidence of delivery plans, uptake rates and invite letters can be proivided as evidence.	
WHC 2025 044	Directions to apply the Code of Practice on Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services - February 2026	05/02/2026	05/02/2026	Local Health Boards and NHS trusts in Wales are asked to note the coming into force of the Code of Practice on 31 March 2026 through the making of the Order enclosed. 2. Local Health Boards and NHS trusts in Wales must comply with the Directions enclosed i.e. they must, from 31 March 2026, exercise their functions in accordance with the relevant provisions of the Code of Practice. 3. In accordance with the provisions of the Code of Practice, Local Health Boards and NHS trusts in Wales must work collaboratively with local authorities in relation to the partnership and collaborative working requirements and guidance included in the Code of Practice. 4. Local Health Board and NHS trust in Wales commissioners of care and support services registered with Care Inspectorate Wales, and other relevant colleagues, are asked to sign-up to the Commissioning Care and Support (National Framework) Community of Practice platform referred to above.	Director of Nursing, Quality, Women and Family Health	N/A	Partially Complete	**May 2026 update**: wider steering group has been developed to review robust monitoring and QMS system specific to commissioned services; this will be reviewed as an agenda item and supported by the Exec for CSG			
WHC 2026 001	Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern	08/01/2026	08/01/2026	The Welsh Health Circular (WHC) 'Adopting a patient and family-initiated escalation approach' (WHC/2024/040) (/standardising-management-acute deterioration-whc2024035) sets out our expectation to implement a system which enables patients or their families to call for immediate help and advice if they are worried about deteriorating health. The NHS Wales approach will be called 'Call4Concern' and, to ensure equity and fairness, it will be available to patients and families in all in-patient settings providing adult, paediatric, neonatal and maternity services. The exemplary work to implement Early Warning Scores (EWS) for all age groups and maternity services in phase one has established a firm basis for building the elements of Call4Concern in phase 2.	Director of Nursing, Quality, Women and Family Health	31 July 2026 30 September 2026 31 December 2026	Partially Complete	**May 2026 Update**: WHC 2024/040 has been superceded by WHC 2026 001 Patient Wellness Scoring PDSA Implemented in May 2026 - full roll out expected in July 2026 on all physcial health inpatient wards SOP progressed incorporating changes in Mood and behaviour to capture opportunities to identify deterioration in a broad group of patients, including those who are unable to advocate for themselves. Initial scoping for Call4Concern will now be taken to exec leads, GMS partners and Llais for engagement in June/July 26 - due for implementation December 2026. Paediatrics and Community will participate by providing signposting to call4concern services in SLA health boards and signposting those who have been discharged into 111/GMS should signs of deterioration and concerns by patients and families occur. Mat/Neo moving forward with a community of practice in Wales - aligned to timelines. MH community of practice to be established nationally due to barriers regarding physical health access and intervention			
WHC 2026 002	Modernised Outpatient Dataset Phase 2: Planned Care activity.	03/03/3036	03/03/3036	The existing Outpatient dataset was introduced in 1999 and 2008 respectively and no longer reflects the new and modernised way planned care is delivered in Wales. The new Planned Care Activity dataset was coproduced with NHS colleagues as part of the modernised outpatient dataset (MODS) work programme. Full implementation by all health boards and trusts needs to be addressed as a matter of priority. I would therefore ask that all health boards ensure that the necessary updates are carried out to their patient administration and information management systems to fully comply with the DSCN and timelines identified.	Director of Allied Health Professions, Health Science and Digital	N/A	Partially Complete	**Update 27/05/2026** Phase 1 — Referrals: a month behind. The rescript is completed to bring the newly in-scope services into the dataset alongside the DSCN changes. First submission goes in next month. Phase 2 — Activity: on track for 1 July, with one outstanding dependency. The new mandatory Appointment Type item needs a WPAS change which is required by DHCW. PTHB can submit with that field blank in the interim if acceptable, and everything else will be compliant from go-live. **Risks** If DHCW's WPAS change timeline slips further, this will result in incomplete Phase 2 data submissions. We're tracking this with them. Phases 3 and 4 timelines still unknown, will update further once a WHC is published.	Jul-26	On-Track no evidence available at present. WPAS release containing required changes is on schedule.	
WHC 2026 018	Reminder of Statutory Duties under the Notification of	06/05/2026	06/05/2026	Local Health Boards and NHS Trusts in Wales are asked to: 1.Note this reminder of the statutory duties relating to the notification of infectious diseases; and	Director of Public Health	Immediate	Partially Complete	**07/05/2026 Update:** Materials will be prepared and distributed to registered medical practitioners in Powys as a reminder of their legal duty to promptly notify the Proper Officer of the local authority of any diseases notifiable under the 2010 Health Protection (Notification) (Wales) Regulations.	31/05/2026	07/05/26 Evidence of material being sent to registered medical practitioners can be provided once this is complete.	
WHC 2026 014	NHS Wales National Clinical Audit and Outcome Review Plan Annual	20/05/2026	30/04/2027	Health boards and trusts in Wales are required to fully participate in all audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2025/26, which shall also be available via the Welsh Government website	Director of Medical Services	30/04/2027	Partially Complete	**May 2026** -audit plan taken to PEQS - will be marked as complete April 27 following delivery of the programme.			

WHC 2026 024	Regualition 28 Prevention of Future Deaths Report - Assurance on alarm latching funtionality in acute monitored environments.	20/05/2026	20/05/2026	Review Current Practice Identify whether "latching" alarm functionality is enabled or disabled onphysiological monitoring equipment across all relevant clinical areas. Review historical incident data (e.g., Datix) for alarm-related events, nearmisses, or trends Assess risk and safety Review local risk assessments, policies and standard operating proceduresrelating to alarm management. Ensure arrangements are in place to minimise alarm fatigue and supporttimely and appropriate clinical response. Ensure clinical engagement and ownership, with appropriate input and sign-off from senior nursing and medical leads. Take appropriate action Where latching is currently enabled, assess whether continued use is safeand clinically justified. Implement changes where required with clear timescales for review, removal or further risk assessment. Ensure staff are: Competent in the use of physiological monitoring equipment Aware of alarm management principles and risks associated with alarmfatigue Appropriately trained in the use of physiological monitoring equipment Identify and reduce unwarranted variation in alarm configuration across sitesand	Director of Medical Services	Immediate	Partially Complete	**May 2026 Update** * Theatres and planned care have continuous monitoring in post operative recovery - along with MIU - this WHC has been shared and is being reviewed. * Total number of datix in relation to monitor alarms = 0 * WHC widely shared with all teams for information * Pending a decision on SOP and training review for theatre and MIU staff +/- confirmation of whether alarm latching is used. * Likely to have less significiant impact regarding alarm fatigue due to lower frequency of use.			

WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	Expected Target date of completion	What Evidence can be provided to ensure closure of WHC/MD	WHC/MD
WHC 2026 006	Listening to People - The ammended NHS Wales complaints, incidents and redress process	30/06/2026	27/03/2026	Assurance of implementation activities Clear Internal communications to staff at all levels Executive-Level oversight of compliance and learning Submission of assurance returns as required by Welsh Government	Director of Public Health/Executive Director of Nursing, Quality, Women & Family Health	01/04/2026	Complete	"May 2026 update - LTP fully adopted, training delivered across all areas with further follow up training in plan, supported by NHSP&I team. Reporting mechanisms in place, but being further enhanced through the development of a QMS framework. Executive fortnightly mneetings to oversee progress and performance outide of routine reporting during first 6 months of implementation.			
WHC 2026 012	Population Herallth Management	02/04/2026	02/04/2026	It is envisaged that Clinicians (such as GPs, nurses, allied health professionals), planners, commissioners, analysts, public health practitioners, local authorities, health boards, wider NHS organisations (such as Public Health Wales), and wider public sector bodies will apply PHM approaches in their work.	Director of Public Health	Immediate	Complete	**08/05/26 Update:**The Health Board will engage with the national Community by Design programme and wider PHM developments in Wales, working collaboratively with Welsh Government, NHS partners and other agencies. Our approach will be to apply PHM proportionately as a supportive planning and improvement framework, using linked intelligence, population insight and evaluation to inform service design, prevention and early intervention activity where appropriate. In doing so, we would see PHM as complementing rather than replacing broader population health and public health approaches, including action on wider determinants of health and inequalities. We would also emphasise the importance of sustainable implementation, data quality, pragmatic evaluation and organisational capacity in determining where PHM approaches are likely to add value locally.Complete	Complete	Population health management is an integral part of Community by Design. As a Welsh Government programme, PTHB is participating in Community by Design alongside all other NHS organisations and is therefore taking forward work in concert with the wider system. More broadly, population health management continues to be an ongoing area of work in NHS Wales, and is not amenable to a specific target date for completion. The purpose of WHC 2026 012 is to set out a single definition of population health management, the receipt of which PTHB acknowledges.	
WHC 2026 015	All Wales General Practice and Health Board Clinical Interface Standards	09/04/2026	09/04/2026	They replace WHC (2018) WHC/2018/014 - All Wales Communication Standards between Primary and Secondary Care. They apply to all NHS Wales clinicians communicating clinical information between General Practice and Health board run services. They also apply to clinicians working in the private sector who interface with General Practice.	Medical Director	Immediate	Complete	**April 2026 Update:** WHC Distributed as per 24.04.2026 via email Duplicated please see below		**April 2026 Update:** WHC Distributed as per 24.04.2026 via email	
WHC 2026 016	Updated 'National Supplementary Service Specification for non-routine immunisations for adults and children at risk'	02/04/2026	02/04/2026	Action required for the management of contact including: Provision of information on symptoms and signs of meningococcal disease to ensure rapid identification of possible cases and rapid treatment. Antibiotic chemoprophylaxis Eligibility for Meningococcus B vaccine	Director of Public Health/Executive Director of Nursing, Quality, Women & Family Health	Immediate	Complete	**07/05/2026 Update:** This information has been circulated to Primary Care at the point of publication. No Powys residents affected at the point of update. Supplementary Services update will remain live until a new update is published.	Ongoing	Information that was circulated to Primary Care for action in relation to outbreak in Kent region which may need action for any contacts residing in Powys. Any payments that have been made for treatment or vaccination	
WHC 2026 017	Enabling community pharmacies to supply medicines ordered by optometrists as part of providing NHS care in Wales	31/03/2026	31/03/2026	This Welsh Health Circular sets out important changes in primary care to improve patients' access to essential eye care services affecting NHS optometrists and community pharmacies in Wales, which come into force on 6 April. From 6 April, optometrists providing NHS services in Wales will be supplied with the new NHS WP10(SO) signed order form (see enclosure) to be used when ordering medicines as part of their NHS practice.	Medical Director	Immediate	Complete	**21/05/2026 Update:** Reviewed by Chief Pharmacist and Medicines Management Team. The Health Board is supportive of the service development and no additional local implementation actions were identified at this stage. Existing community pharmacy and prescribing support arrangements are considered sufficient to support the introduction of WP10(SO) forms for NHS optometry services in Wales. Any operational or contractual queries arising through implementation will be managed through existing governance arrangements.			
WHC 2024 02	Standards for Competency Assurance of Non-Medical Prescribers in Wales	N/A		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.	Medical Director	31/03/2026	Complete	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 Pharmasisit is in post in the next few weeks please, once we have a start date we will keep you updated when they start. **Jan 2026**: PTHB has strengthened its arrangements for Non-Medical Prescribing in line with the All-Wales Standards for Competency Assurance and the newly approved Non-Medical Prescribing Policy (July 2025). The Chief Pharmacist remains the nominated senior lead, with the Medical Director as accountable executive. The policy was formally consulted on in July 2025 and provides a clear framework covering governance, training access, scope of practice, competency assurance, revalidation, prescription pad management and audit requirements. A local implementation plan is in place, developed with HEIW support, and routine engagement continues with all-Wales NMP leads to ensure consistency. All NMPs are required to maintain an up-to-date annual scope of practice, evidence ongoing competency, and undergo regular appraisal and prescribing review in line with the policy. A centrally maintained NMP register and defined processes for approval, return-to-practice and change in scope provide organisational assurance. These arrangements ensure that PTHB is on track to deliver full compliance by 31st March 2026, with prescribing by non-medical prescribers demonstrably safe, competent and aligned with national standards. **June 2026 Update**: PTHB has made substantial progress towards implementation of the All-Wales Standards for Competency Assurance of Non-Medical Prescribers. A local implementation plan was developed with HEIW support and governance arrangements are now established through the approved Non-Medical Prescribing Policy (July 2025). Annual Scope of Prescribing Practice Statements and declarations of competence are in place for Independent Non-Medical Prescribers and Community Nurse Prescribers, supported by a centrally maintained register and ongoing compliance monitoring. Regular engagement continues through HEIW task and finish groups and all-Wales implementation meetings to support a consistent national approach. Work continues nationally and locally in relation to three-yearly prescribing appraisal arrangements, portfolio requirements and ESR system capability, particularly for small specialist services where identifying suitably qualified appraisers may be challenging JB - 21/05/2026		**21/05/2026 Update**: Approved PTHB Non-Medical Prescribing Policy (July 2025); implementation plan developed with HEIW; evidence of participation in all-Wales HEIW task and finish groups; centrally maintained NMP register; annual Scope of Prescribing Practice Statements and competency declarations; governance/audit processes; records of appraisal and prescribing review arrangements; Medicines Management governance reporting.	
WHC 2025 004	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26	15/04/2025	15/04/2025	Health boards and trusts in Wales are required to fully participate in all audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2025/26, which shall also be available via the Welsh Government website	Medical Director	01/04/2026	Complete	clinical audit programme delivered and reported prepared for PEQS		Superceded by WHC 2026 014	
WHC 2024 015	People's Experience Framework and People's Experience Survey	02/04/2025	02/04/2025	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".	Director of Nursing, Quality, Women and Family Health	Apr-25	Complete	**27.01.26 update** - Since the national launch of the refreshed Framework in April 2025, PTHB has been progressing implementation arrangements to ensure the systematic capture, analysis and use of people's experience to inform quality improvement and service design. Recruitment of a People's Experience Lead has increased capacity to support and strengthen governance, reporting and assurance arrangements for the Framework. A standardised People's Experience survey has been embedded as the primary mechanism for capturing feedback, with core questions and equality monitoring in place to support consistency and comparability across NHS Wales. Digital feedback routes have been expanded through CIVICA platform, and access to reporting systems (power BI) ae being widened to enable real time monitoring and local ownership of experience data. Work is ongoing nationally to strengthen accessible information standards and ensure feedback mechanisms are inclusive and responsive to diverse needs. All services have completed a self-assessment against the People's Experience Framework, identifying both areas of maturity and reas requiring further development. Key themes include the need to strengthen triangulation of experience data, improve transparency, and more clearly demonstrate how feedback informs service improvement and decision making. Engagement activity has continued across service changes and public engagement events. Feedback highlights strong compassion and professionalism among staff, alongside operational challenges affecting communication, flow, and discharge processes. The use of people's stories to support learning and Board-level insight is increasing, with plans to expand digital storytelling capability. A system-wide People's Experience Strategy has been developed to provide a clear strategic framework for delivery over the next three years. This will emphasise quality, continuous learning, co-production, and partnership working, and will be informed by further engagement withstaff, communities and stakeholders. Key Priorities 1: Civica review of hierarchy is completed and live, allowing people to provide feeback on more services within PTHB. 2: Co-production publication and promotion of the People's Experience Strategy and ongoing monitoring and implementation of the People's Experience Framework. 3: Focus on increasing use of accessible information and ensure seldom-heard groups' voices are promoted in feedback mechanisms. 4: Establish improved digital and physical feedback routes. **May 2026 update:** Executive support and oversight has facilitated development and improved ToR for the steering group function. Progress reports are being delivered to and monitored at Patient Experience Quality Safety committee.			
WHC 2023 06	Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 - Expired 01.04.24	05/04/2023		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	Medical Director	01.04.2023	Complete	**May 2025:** Almost complete, checking with Q&S colleagues to confirm **June 2026** - this is complete - it was shared responsibility with DONM . Following implementaion of duty of candour this is complete.		June 2026 - this is complete - It was shared responsibility with DONM . Following implementaion of duty of candour this is complete.	

WHC 2025 026	NHS Wales National Clinical Audit Annual Rolling Programme for 2025/26	15/04/2025	15/04/2025	Welsh health boards and trusts should provide the resources to enable their staff to participate in all audits, reviews and national registries included in the annual plan (where they provide the service). They should ensure participation and full case ascertainment with completion of a full audit cycle. The findings and recommendations from clinical audit should link directly into the quality improvement programme and lead to improved patient care and outcomes.	Director of Allied Health Professions, Health Science and Digital	Apr-26	Complete	**Update Jan'26:** All audits are resourced approriately. May 2026 Update: Appropriate resources are aligned for planned and ad-hoc audits , staff are given the time and support needed to take part. Participation is monitored to make sure all required cases are submitted and data is complete.		Appropriate resources are aligned for planned and ad-hoc audits , staff are given the time and support needed to take part. Participation is monitored to make sure all required cases are submitted and data is complete. Audit results are reviewed through normal governance processes, with clear action plans put in place and followed up through re-audit to show	
WHC 2025 026	The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings	04/08/2025	04/08/2025	AVTs should only be used for supporting summarisation of discussions and consultations. The level of detail for the summarisation should be tested in 3line with what is clinically appropriate and required as part of professional practice. AVTs should not be used as a decision support tool for clinical diagnosis or treatment plans (unless it is in a pre-agreed test environment or as part of research studies). The NHS Wales health service provider must consult and seek approval of their respective clinical safety officers, Caldicott Guardians, Senior Information Risk Owners (SIRO), Information Governance and Cyber leads to ensure that all legislative and safety considerations are in place prior to the use of the technologies in live clinical settings.	Director of Allied Health Professions, Health Science and Digital	Apr-26	Complete	**Update Jan-26**: Initial scoping still to be undertaken. and we need to wait until the WCCIS procurement has completed and what supplier solution PTHB procures and whether it has functionality or not, we have included AVT as part of our specification, but we have not yet scoped the use of AVT in PTHB. Status remains 'No Progress' pending procurement completing and replacement solution identified, and then this will initiate next steps including clinical safety assessment, IG/CSO/SIRO approvals, and development of a local implementation approach. **Updated 21/05/2026** : These WHC Requirements have been embedded in our digital governance processes and hav actively been implemented on several occaisions.		Embedding of the principles layed out in this WHC have been consistently applied to serveral requests for consideration for ambient voice software for use within the halth board. The result is that all requests in the last six months have been declined based on non-compliance with the medical device requirements. Evidence of this enforcment in file below.	
WHC 2025 031	3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting	26/09/2025	26/09/2025	To ensure that health boards commence reporting in line with the DSCN by April 2026, the following is expected: All health boards and trusts: ▪ Update local processes and systems to comply with the Information Specification outlined in the DSCNs. ▪ Collaborate with the DHCW Data Acquisition team to agree and establish processes for data submission in preparation for collection.	Director of Allied Health Professions, Health Science and Digital	Apr-26	Complete	**Update Jan'26:** Waiting Well SPOC is due to be submitted from 1st April 2026. Working through data capture processes. On Track no issues forecast. **Updated 21/05/2026** : Data is being submitted as specified in the dscn.		Three datasets have been submitted using this DSCN as its basis.	
WHC 2026 007	Critical UK-wide Bone Cement Shortage – Immediate National Requirements for NHS Wales	24/02/2026	24/02/2026	All Health Boards must take the following actions with immediate effect: a. Maintain Emergency and Urgent Pathways Health Boards must ensure uninterrupted provision of: • Cemented hip fracture surgery and other trauma procedures requiring cement. • Infection-related orthopaedic procedures requiring cement. • Urgent oncological orthopaedic procedures requiring cement. • Urgent elective procedures meeting WON ACCPAP "Immediate Listing" criteria. This reflects the highest priority for use of nationally limited cement supplies. b. Health Boards must participate in the evaluation of the alternative cement product on trauma lists selected locally. This evaluation will be clinically led, time-limited, and used to determine suitability of the product for broader use. c. Pause Lower-Risk Elective Cemented Activity All routine elective primary cemented arthroplasty must remain paused unless the case meets national ACCPAP urgent criteria and has been clinically approved at Health Board level. A provisional national review of these measures will take place on 4–5 March 2026, with a current earliest restart date of 9 March 2026, subject to successful evaluation of the alternative product and confirmed supply sufficiency. d. Participate in National Sharing and Coordination of Cement	Medical Director	N/A	Complete	**March Update:** No action required for Powys due to not using this product.			
WHC 2026 008	NHS Research and Development Finance Policy 2026	10/03/2026	10/03/2026	All NHS organisations are required to comply with the NHS R&D Finance Policy. The policy sets out the systems and requirements for the costing, management, accountability, and distribution of all research funding in NHS Wales. While much of its financial governance aligns with wider NHS financial management, certain elements are specific to research activity and therefore require certain processes to be in place, for example, to cost and manage commercial research income, and per patient invoicing. The Welsh Government has refreshed the 2018 NHS R&D Finance Policy to ensure alignment with current funding streams, national policies and standards. Key changes are noted in Annex 1. This Welsh Health Circular therefore supersedes WHC/2018/005.	Director of Finance, Capital and Support Services	Immediate	Complete	**May 2026 Update: Shared an reviewed by HCRW Finance lead who has input into the revised WHC document, and confirmed it reflects current accounting practices.**	Jun-26	marked as complete and implemented - E-mail conformation can be provided.	
WHC 2026 015	All Wales General Practice and Health Board Clinical Interface Standards	09/04/2026	09/04/2026	Three important overarching principles guide this work The first is that the clinician who orders the test is responsible for reviewing, acting and communicating the result and actions taken to the General Practitioner and patient even if the patient has been discharged. The second is that every test result received by a GP practice for a patient should be reviewed and where necessary acted on by a responsible clinician even if this clinician did not order the test. The third is that patient autonomy should be respected, consideration given to reasonable adjustments for people with learning disabilities and mental health problems and, where appropriate, families, carers, care coordinators and key workers should be given the opportunity to participate in the handover process and in all decisions about the patient at discharge. Use of interpreter services should be considered if the patient doesn't speak English.	Director of Medical Services	Immediate	Complete	**April 2026 Update: WHC Distributed as per 24.04.2026 via email**	Immediate	April 2026 Update: WHC Distributed as per 24.04.2026 via email	
WHC 2026 022	2026/27 NHS Wales Financial Monitoring return guidance	29/04/2026	28/04/2026	Organisations are required to develop robust plans that deliver against the priorities set out in the 2026-27 NHS Planning Framework, within the 2026/27 funding allocations.	Director of Finance, Capital and Support Services	30/06/2026	Complete	April 2026 Update: Marked as completed as per evidence provided.		marked as complete and implemented as Finance will be using the new MMR template for month 1 reporting onwards in this financial year.	

WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	Expected Target date of completion	What Evidence can be provided to ensure closure of WHC/MD	WHC/MD
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	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.	Director of Nursing, Quality, Women and Family Health	Immediate	Partially Complete	**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. **29.01.2026 -** No update. **13/05/26 Update:** - The code sets out the values and quality standards for commissioning care and support. It is then underpinned by seven principles of effective and ethical commissioning which commissioners must embed within their commissioning practices and proactively encourage provides to embed them into service delivery. These standards do not apply to the core commissioning functions of the Health Board but applied to personalised care. The code is kept under review by Health Board teams and informs the policies and practices of relevant teams. It may be considered as a standard that could be taken forward in the future audit programme, and will be considered at the next DMT.			WG-24-39_Directi to-local-health-bo
WG-25-28	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services) (Wales) Directions 2025	15/05/2025	16/05/2025	The Local Health Board must, where necessary, vary the engaged GMS contractor's general medical services contract so that arrangements made pursuant to paragraph (1) comprise part of the GMS contractor's contract and the requirements of the arrangements are conditions of the contract. (6) The notice period for ending the agreement for service provision will be three calendar months for either the Local Health Board or the engaged GMS contractor. (7) Any disputes arising as a result of the provision of this Directed Supplementary Service will be dealt with in accordance with Part 10 of Schedule 3 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023. (8) Where the Local Health Board delivers this Directed Supplementary Service pursuant to an arrangement in accordance with paragraph 4(2), the Local Health Board must ensure that paragraphs 4(4) and 4(5) apply to such arrangements as they would do to an engaged GMS contractor	Director of Primary Care, Community and Mental Health	N/A	No Progress	**Jan 26** - delay in PSR regualtion and L&R advice has delayed implementation of this DSS. L&R advice confirmed mid January. All practices currently participating in old DES and LES have been served notice for PTHB to withdraw on 31/03/26. Currently laiiang with practices for signup to new DSS specification for implemtation from 01/04/26 May 2026 - No update received			WG-25-28.pdf
WG-25-72	The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	14/10/2025	15/10/2025	**Establishment of a Primary Care Contracted Services:** Outpatients Waiting Lists First Appointment Scheme: Each Local Health Board must establish, operate and, as appropriate, revise a PrimaryCare Contracted Services: Outpatients Waiting Lists First Appointment Scheme. (2) The underlying purpose of the Scheme is to enable a review of outpatient first appointment waiting lists by dentists, general medical practitioners, POS contractor and NHS pharmacists, for those patients who have been waiting less than 26 weeks who have previously been referred to secondary care before 15 October 2025, where the first appointment has not yet been undertaken or booked and, where a review indicates that definitive safe and effective treatments, investigations or assessments could be made within primary and community care, to enable the provision of services to those patients. It also aims to embed Community Health Pathways into clinical practice within Wales. **Primary Care Contracted Services: Outpatients Waiting Lists First Appointment Scheme:** 4.—(1) As part of its Scheme, each Local Health Board may only enter into arrangements for the provision of services, , with (a) a dentist; (b) a general medical practitioner	Director of Primary Care, Community and Mental Health		No Progress	**Jan 26** - delay in PSR regualtion and L&R advice has delayed implementation. L&R advice confirmed mid January. Patient lists prepared and Expressions of interest being sought from practices. Planned go-live date 01/02/26 May 2026 - No update received			WG25-72-directions-pcs-outpatients-waiting-

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.9

Audit, Risk and Assurance Committee	**Date: 07 July 2026**
Subject:	**POWYS TEACHING HEALTH BOARD (PTHB) BOARD MEMBERS DECLARATION OF INTERESTS, GIFTS and HOSPITALITY 2026/2027**
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Business Officer
Other Committees and meetings considered at:	

PURPOSE:

This paper presents the position as of 10 June 2026 in respect of:

- the Register of Interest for Independent Members, Executive Directors and those staff with budget oversight
- the Gifts and Hospitality register.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the contents of Register of Interests for PTHB Board Members and those staff with budget oversight as at 10 June 2026, and the PTHB Gifts and Hospitality Register; and
- Take **ASSURANCE** that the organisation has appropriate processes to support the collection, management and reporting of Declarations of interest and Gifts and Hospitality in line with the Standards of Behaviour Policy.

Approve/Take Assurance	Discuss	Note
Y	N	**Y**

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

EXECUTIVE SUMMARY:

The Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour. The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership. In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions.

BACKGROUND

In accordance with the requirements of PTHB's Standing Orders and the Standards of Behaviour Policy, a report is required to be received by the Audit, Risk and Assurance Committee (ARAC) which details the Declarations of Interest, Gifts and Hospitality received by Board Members.

In March 2025 the Board approved the revised Standards of Behaviour Policy. The key fundamental change within the revised policy was the addition of recording and maintaining a record of declarations of interests submitted by those staff with responsibility of budget oversight within the organisation.

In order to align Powys Teaching Health Board with other NHS bodies, subject to it not contravening their professional Codes of Conduct, in November 2025, the Board approved the revised Standards of Behaviour Policy and staff may accept gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This allowance excludes gifts of a nominal cash value.

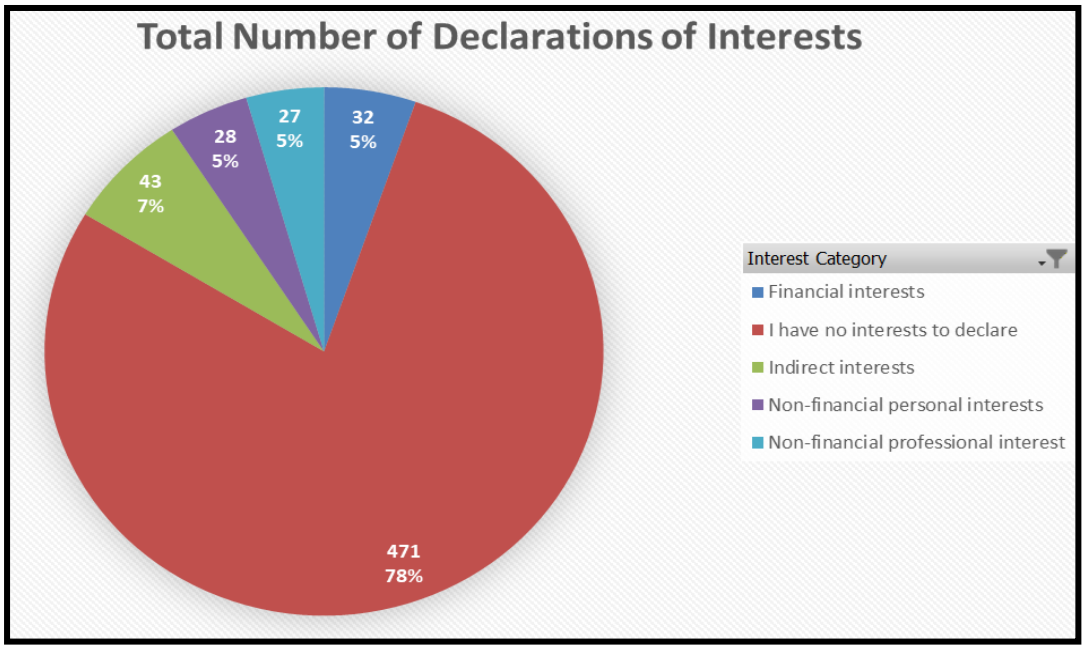
Following approval of the revised policy, the Corporate Governance Team has been working with the Board, Executive Directors and Senior Management teams to actively promote and raise awareness of the revised Policy which all employees at PTHB must adhere to, ensuring a clear understanding of all key aspects of behaviours.

The Register of Interests is maintained by the Corporate Governance Department with each declaration reviewed and checked by the team with any queries addressed prior to entry on the register. The Director of Corporate Governance reviews all Board level entries to the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests and any gifts and hospitality received or declined.

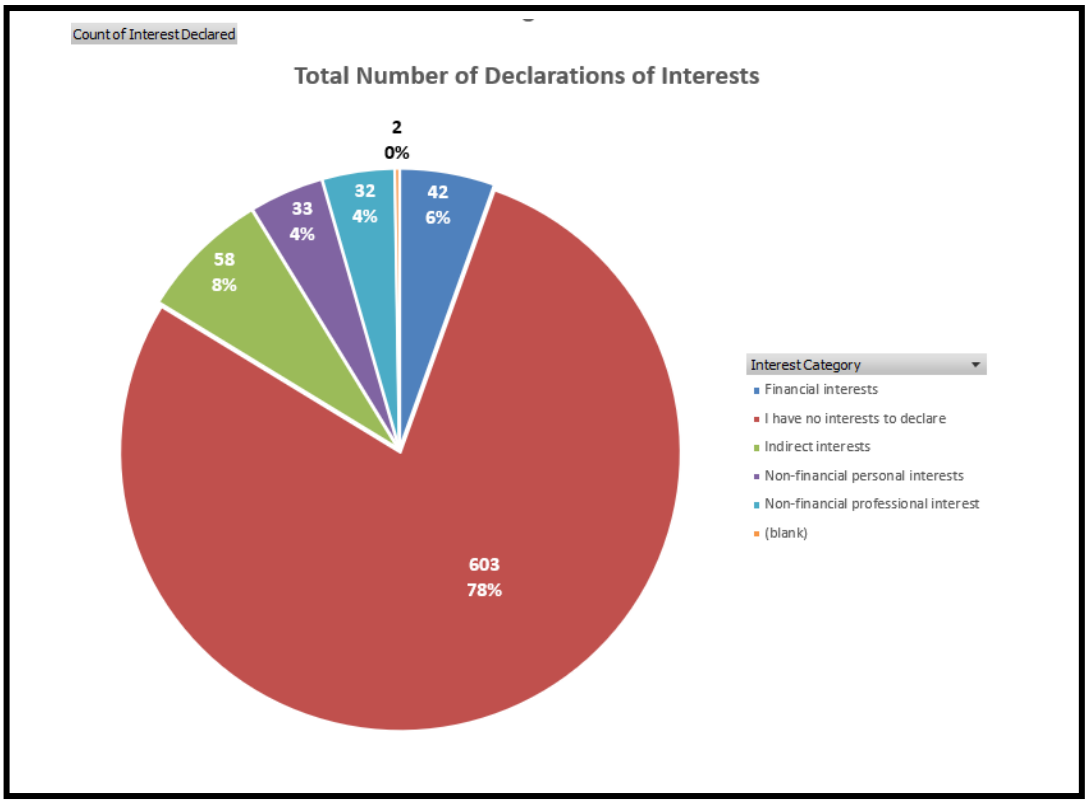
The chart below provides a summary position of the Declarations of Interest submissions received for 2026/27. The register for Declaration of Interests received to date in 2026/27 is attached at **Appendix A.**

Comparative Summary

March 2026 Position



July 2026 Position



The previous report in March 2026 showed a total of 601 Declarations of interest submissions received. As of 10 June 2026, a total of 770 Declarations had been declared, providing a significant increase of submissions received in year.

Since the previous report in March 2026, the Corporate Governance Team has undertaken a review of those staff with budgetary oversight and has increased targeted engagement to encourage individuals to complete their Declarations of Interest submissions. The table below highlights the current position for individuals with budgetary oversight. There has been an increase in the number of submissions received across the Health Board with a total of 116 submissions received out of a total of 139. For those individuals who have not yet completed their submissions, follow-up actions are currently underway to encourage staff to complete their declarations.

Total number of Budgetary Approvers	Total submission received	Outstanding
139	116	23

The Corporate Governance team have been actively promoting the Declaration of Interests across the organisation via service engagement and communication platforms. This includes external employees to ensure appropriate information and support is available.

Gifts and Hospitality

As of 10 June 2026, a total of 8 Gifts, Hospitality and Honoria had been declared within the register for 2025/2026. This showed a further increase of 33.3% on the previous 100% increase in comparison to the previous year, 2024/2025. The register for Declaration of Gifts and Hospitality in 2026/27 is attached at **Appendix B.**

All employees and Independent Members of the Board must ensure that they are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the Health Board. Declarations must be made to the Health Board for recording in the Register of Interests any relevant interests at the commencement of employment, whenever a new interest arises or if asked to do so at periodic intervals by the organisation. The onus regarding declaration will reside with the individual employee or Independent Member.

An escalation process has been implemented by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted. Progress has been made in this area, and the Corporate Governance Team is now pursuing best practice and encouraging all staff to declare interests where applicable.

The Standards of Behaviour Framework summary is set out here: Standards-of-behaviour-framework and (available on request). The Director of Corporate

Governance has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on PTHB's website and is also added to all Board and Committee agendas to ensure openness and transparency.
NEXT STEPS:
The Register of Declaration of Interests (Board Members) and Gifts and Hospitality Register for 2026/2027 will be continue to be published on the PTHB website and will be maintained by the Corporate Governance team. The register for the Board will continue to be provided to all Board and Committee meetings.

Employee Name	Consent Flag	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments
Alexander, Mr. Ronnie Joseph	Y	Y	Indirect interests	Outside employment	Independent Monitoring Authority - Non-executive Director. Remuneration - Public Office Payment	
Alexander, Mr. Ronnie Joseph	Y	Y	Indirect interests	Shareholdings and other ownership interests	Director of RA and CJ Consulting Ltd	Dividend payment only
Alexander, Mr. Ronnie Joseph	Y	Y	Indirect interests	Shareholdings and other ownership interests	Partner - Director of RA and CJ Consulting Ltd	Dividend payment only
Beaumont-Wood, Ms. Rhiannon Elizabeth	Y	Y	Indirect interests	Outside employment	Coaching services. Registered as a Director of RBW Executive and Professional Coaching Ltd	Self employed.
Beaumont-Wood, Ms. Rhiannon Elizabeth	Y	Y	Indirect interests	Outside employment	Dorset ICB (NHS Dorset) Non-Executive Member	My contract with Dorset ICB has now ended (as of 31st May 2026as my term has come to an end.
Beaumont-Wood, Ms. Rhiannon Elizabeth	Y	Y	Indirect interests	Outside employment	Nursing and Midwifery Council Registrant Council Member	This term is until March 2027, but the year will not update on the system for some reason.
Bowley, Mrs. Shan Mererid (Mezz)	Y	Y	Financial interests	Shareholdings and other ownership interests	Husband employed by Mitie Engineering as estimating manager, who holds contracts / work iwth some NHS Bodies/Organisations. Shares held by husband & myself in Mitie. Jointly hold share certificates Royal Mail.	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.
Bowley, Mrs. Shan Mererid (Mezz)	Y	Y	Non-financial professional interest	Loyalty interests	Fellowship membership of the Facutly of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date). Unclear which situation option to select as this is professional membership.
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is an Associate for Practice Solutions.	
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Last worked for the organisation in October 2024.
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Chair since June 2023, Board member since August 2016. Newydd/Cadarn Housing Group
Bushell, Miss Helen	Y	Y	Non-financial personal interests	Outside employment	Governor - Llangynwyd primary School (Bridgend)	Current term runs to November 2027
Cooper, Dr Carl	Y	Y	Indirect interests	Loyalty interests	Family Member Employment	Pharmaceutical Control Analyst. Cardiff & Vale UHB.
Cooper, Dr Carl	Y	Y	Indirect interests	Loyalty interests	Spouse's Employment	Sole Trader - Mandy Williams Consulting; The Welsh Wellbeing Coach
Elliot, Mr. Stephen Richard	Y	Y	Non-financial professional interest	Loyalty interests	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	
Elliot, Mr. Stephen Richard	Y	Y	Non-financial professional interest	Outside employment	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	
Giannasi, Mr. Michael Anthony (Mick)	Y	Y	Indirect interests	Outside employment	I am currently the Chair of Social Care Wales which is a Welsh Government Sponsored Body. I am due to retire on 15 July and have submitted notice to terminate my office from that date. From that date onwards, I will have no declarations of interest to make.	The Health Board has no direct contractual or financial relationship with Social Care Wales. However, as the regulator for the social care workforce in Wales, it is part of the wider health and care system and as such, matters may arise in the course off the Board's business which could be perceived by others to amount to a conflict.
Hooton, Mr. Paul Francis	Y	N	I have no interests to declare			
Hooton, Mr. Paul Francis	Y	N	I have no interests to declare			
Hooton, Mr. Paul Francis	Y	Y	Non-financial professional interest	Loyalty interests	I am a member of the Royal College of Nursing	
Hopgood, Mr. Peter Lewis (Pete)	Y	Y	Non-financial personal interests	Loyalty interests	Wife/Partner is a Finance Manager in Swansea Bay UHB.	Wife/Partner is currently employed as a Finance Manager in Swansea Bay UHB.
Johnson, Mrs. Nicola	Y	N	I have no interests to declare			
Lewis, Dr Rhobert	Y	Y	Indirect interests	Outside employment	External member Cross-party STEMM Group Welsh Government	Unsure of exact date. No payment involved. Continuing.
Lewis, Dr Rhobert	Y	Y	Non-financial professional interest	Outside employment	Chair NPTC Group of Colleges	And continuing No payment involved
Lorton, Mrs. Elaine Linda	Y	Y	Financial interests	Outside employment	Independent Member - ateb housing association	
Lorton, Mrs. Elaine Linda	Y	Y	Indirect interests	Outside employment	Daughter works for Aneurin Bevan University Health Board	
Lorton, Mrs. Elaine Linda	Y	Y	Indirect interests	Outside employment	Husband works for Hywel Dda University Health Board	
Lorton, Mrs. Elaine Linda	Y	Y	Non-financial professional interest	Outside employment	Chair of West Wales Care & Repair Board	Voluntary Board Member
Madsen, Mrs. Claire Louise	Y	Y	Financial interests	Outside employment		I sometimes do visiting lecturer work ad hoc for the University of the West of England
Madsen, Mrs. Claire Louise	Y	Y	Non-financial professional interest	Loyalty interests		Member of the Chartered Society of Physiotherapy
Owen Adams, Mrs. Jennifer	Y	Y	Non-financial personal interests	Loyalty interests	Brother is Senior Manager Freedom Leisure South Powys & Swansea	
Owen Adams, Mrs. Jennifer	Y	Y	Non-financial professional interest	Loyalty interests	Chair PSB Scrutiny Committee	

Owen Adams, Mrs. Jennifer	Y	Y	Non-financial professional interest	Loyalty interests	Coopted member PAVO	
Owen Adams, Mrs. Jennifer	Y	Y	Non-financial professional interest	Loyalty interests	Member (not a NED) Glas Cymru	
Owen Adams, Mrs. Jennifer	Y	Y	Non-financial professional interest	Loyalty interests	Vice Chair PAVO	
Poynton, Ms. Catherine	Y	N	I have no interests to declare		no interests to delcare 22/04/2026	
Thomas, Mr. Ian	Y	Y	Indirect interests	Outside employment	Previous work as an associate for HICO consultancy	While I am not employed and have no interests in HICO, for transparency I am declaring that I worked as an associate with HICO between 2023-2024.
Thomas, Mr. Ian	Y	Y	Non-financial personal interests	Outside employment	I have worked with a team of consultants as an independent associate in the past	I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status
Thomas, Mrs. Hayley	Y	N	I have no interests to declare			
Walsh, Mr. Christopher Timothy	Y	Y	Financial interests	Outside employment	Associate Member of the Association of Genealogists and Registered Archivists	
Walsh, Mr. Christopher Timothy	Y	Y	Financial interests	Outside employment	Elected Member Powys County Council	
Walsh, Mr. Christopher Timothy	Y	Y	Financial interests	Outside employment	Sole Trader/Owner of Celebratory Gifts Heraldic Names	
Walsh, Mr. Christopher Timothy	Y	Y	Financial interests	Outside employment	Sole Trader/Owner:CTW Genealogy Research	
Walsh, Mr. Christopher Timothy	Y	Y	Indirect interests	Loyalty interests	Trustee/Chair: Brecon University Scholarship Fund	
Walsh, Mr. Christopher Timothy	Y	Y	Indirect interests	Outside employment	Brecon Town Council Elected Member	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Loyalty interests	Governor of Priory Church in Wales School	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Loyalty interests	Labour Party Member	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Loyalty interests	Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Loyalty interests	Member of Community Speed Watch Group	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Loyalty interests	Member of Society Genealogists	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial personal interests	Shareholdings and other ownership interests	Owner of Property in the County of Powys	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial professional interest	Loyalty interests	Member of Royal College of Nursing	
Walsh, Mr. Christopher Timothy	Y	Y	Non-financial professional interest	Loyalty interests	Registered Member of Nursing and Midwifery Council	
Wood-Lawson, Ms. Debra	Y	N	I have no interests to declare			
Wood-Lawson, Ms. Debra	Y	Y	Indirect interests	Outside employment	Non Executive Director of Cadarn Housing Association	I am a non Executive Director of a Housing Association and a member of their Group Board and Governance Committee The 'group' is a zonal partner with Powys for the provision of housing stock This is a remunerated appointment
Wood-Lawson, Ms. Debra	Y	Y	Indirect interests	Outside employment	Relative working and training in ABUHB	
Wright, Dr Katharine Louise	Y	Y	Non-financial professional interest	Hospitality	Attended digital conference which was funded by the hosting organiser (Health Strategy Forum).	An opportunity to meet with other NHS senior leaders and consider opportunities for use digital innovation in transforming Health care.
Wright, Mr. Simon	Y	Y	Financial interests	Outside employment	I am the Head of Partner Engagement for JS Group which works with the HE sector to support the efficient distribution of bursaries (including NHS related) and other one to many payments. JS Group is seeking to expand its services into the charity sector and to local and national governments.	
Wright, Mr. Simon	Y	Y	Financial interests	Outside employment	My wife is employed as a District Nurse for Cardiff and Vale Health Board	
Wright, Mr. Simon	Y	Y	Indirect interests	Loyalty interests	My sister is a Senior Operations Manager, Milestone Trust Bristol	
Wright, Mr. Simon	Y	Y	Non-financial personal interests	Loyalty interests	Labour Party Member	
Wright, Mr. Simon	Y	Y	Non-financial professional interest	Loyalty interests	I am a Senior Professional Fellow at Cardiff University and previously the Academic Registrar (2015-26). Cardiff University delivers a number of health care programmes	

Employee Name	Consent Flag	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments
Barnes, Mrs. Sarah	Y	N	I have no interests to declare			
Beavan, Mr. Paul	Y	N	I have no interests to declare			
Beavan, Mr. Paul	Y	N	I have no interests to declare			
Bennett, Mrs. Jacqueline Helen	Y	N	I have no interests to declare			
Bertie, Mrs. Hannah Mae	Y	N	I have no interests to declare			
Bocking, Mrs. Karen Jean	Y	N	I have no interests to declare			
Bowley, Mrs. Shan Mererid (Mezz)	Y	Y	Financial interests	Shareholdings and other ownership interests	Husband employed by Mitie Engineering as estimating manager, who holds contracts / work iwth some NHS Bodies/Organisations. Shares held by husband & myself in Mitie. Jointly hold share certificates Royal Mail.	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.
Bowley, Mrs. Shan Mererid (Mezz)	Y	Y	Non-financial professional interest	Loyalty interests	Fellowship membership of the Facutly of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date). Unclear which situation option to select as this is professional membership.
Brown, Mrs. Amanda Jane	Y	N	I have no interests to declare			
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is an Associate for Practice Solutions.	
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Last worked for the organisation in October 2024.
Bushell, Miss Helen	Y	Y	Indirect interests	Outside employment	My partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Chair since June 2023, Board member since August 2016. Newydd/Cadarn Housing Group
Bushell, Miss Helen	Y	Y	Non-financial personal interests	Outside employment	Governor - Llangynwyd primary School (Bridgend)	Current term runs to November 2027
Cassell, Mrs. Hayley	Y	N	I have no interests to declare			
Coles, Mrs. Lucy Brogan	Y	N	I have no interests to declare			
Cooper, Mrs. Vicki Andrea	Y	N	I have no interests to declare		No further comment	no further comment
Cornish, Mrs. Lucy Marie (Lucie)	Y	N	I have no interests to declare			
Crawley, Mr. Duncan Neil	Y	N	I have no interests to declare			
Davies, Mr. Geraint William	Y	N	I have no interests to declare		I have no declarations to declare	I have no declarations to declare
Davies, Mrs. Catrin Ann	Y	Y	Financial interests	Outside employment	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies. Spouse / Partner or other Relative. – Yes Director of Owen Davies Consulting Ltd and Gwagle Space Ltd	Ongoing for both companies owned by spouse.
Davies, Mrs. Sally Elisabeth	Y	N	I have no interests to declare			
Day, Mrs. Wendy Jane	Y	N	I have no interests to declare			
Deacon, Mrs. Tracey Elizabeth	Y	N	I have no interests to declare			
Deakins, Mrs. Victoria Louise	Y	N	I have no interests to declare			
Edwards, Miss Sarah Louise	Y	N	I have no interests to declare			
Edwards, Mrs. Amanda Jane	Y	N	I have no interests to declare			
Elliot, Mr. Jamie	Y	N	I have no interests to declare			
Evans, Mrs. Caroline	Y	N	I have no interests to declare			
Falvey, Mr. Aled Joseph	Y	N	I have no interests to declare			
Falvey, Ms. Katelyn Emma	Y	N	I have no interests to declare			

Farnsworth, Mr. David Mark	Y	Y	Non-financial personal interests	Loyalty interests	My spouse works as a clinical practitioner in dementia for St Michael's Hospice, Hereford.	I have no direct involvement in the commissioning of any services with this provider.
Farrow, Mrs. Amanda Rebecca	Y	N	I have no interests to declare			
Farrow, Mrs. Amanda Rebecca	Y	N	I have no interests to declare			
Ferneyhough, Mr. Matthew John	Y	N	I have no interests to declare			
Gee, Mr. Peter Phillip	Y	N	I have no interests to declare			
Grindell, Mrs. Helen Margaret	Y	N	I have no interests to declare			
Groves, Mrs. Emily Temperance	Y	N	I have no interests to declare			
Groves, Mrs. Emily Temperance	Y	N	I have no interests to declare			
Gwynne, Mrs. Stella Elizabeth	Y	N	I have no interests to declare			
Gwyther, Mrs. Tracey Louise	Y	N	I have no interests to declare			
Hamer, Mrs. Lauraine	Y	N	I have no interests to declare			
Hamer, Mrs. Susan Marea (Sue)	Y	N	I have no interests to declare			
Harris, Mr. Martin Douglas	Y	N	I have no interests to declare			
Harris, Mrs. Susan Dorothy	Y	N	I have no interests to declare			
Hartwright, Dr Christopher Gerald (Chris)	Y	N	I have no interests to declare			
Hills, Mrs. Alex Jayne	Y	N	I have no interests to declare			
Hobbs, Mr. Philip Mark	Y	N	I have no interests to declare			
Hobbs, Ms. Rhiannon Catrin	Y	N	I have no interests to declare			
Hobbs, Ms. Rhiannon Catrin	Y	N	I have no interests to declare			
Holt, Mr. Anthony	Y	N	I have no interests to declare			
Hopgood, Mr. Peter Lewis (Pete)	Y	Y	Non-financial personal interests	Loyalty interests	Wife/Partner is a Finance Manager in Swansea Bay UHB.	Wife/Partner is currently employed as a Finance Manager in Swansea Bay UHB.
Hughes, Mr. Owen	Y	Y	Financial interests	Clinical private practice	I am a director of a limited company called psych45 ltd. I use this company to run training events, clinical private practice and expert witness work	
Hymers, Mrs. Louise	Y	Y	Indirect interests	Loyalty interests	My husband is employed by RNIB as one of the Eye Care Liaison Officers covering PTHB - this is a commissioned service via an SLA between PTHB and RNIB - I have no interaction with the commissioning process of his role, or his role within the health board.	
Ingram-Jones, Mrs. Jayne Elizabeth	Y	N	I have no interests to declare			
Jamieson, Mrs. Judith Rosemary	Y	N	I have no interests to declare			I have no conflicts of interest to declare
Jamieson, Mrs. Judith Rosemary	Y	N	I have no interests to declare			
Johnson, Mrs. Nicola	Y	N	I have no interests to declare			
Jones, Mr. Gareth Paul	Y	N	I have no interests to declare			nothing to declare
Jones, Mrs. Donna Leela	Y	N	I have no interests to declare			
Jones, Mrs. Donna Leela	Y	N	I have no interests to declare			

Kelly, Miss Nicola Jane	Y	N	I have no interests to declare			
Kirkham, Mrs. Michelle	Y	N	I have no interests to declare			
Lawrence, Mrs. Jayne Louise	Y	N	I have no interests to declare			
Lines, Mrs. Clare Peace	Y	Y	Indirect interests	Outside employment	My husband is; *A trustee of the Wales Council for Voluntary Action * The Chair of the Gateway Dental Practice * The Chair of Social Investment Cymru Committee (WCVA) * Member of Carers Trust Wales Advisory Board My daughter-in-law is an analyst in the CMOs Department and from 1.7.26 will work for the HSA	Update May 2025 - positions have been held for longer
Lines, Mrs. Clare Peace	Y	Y	Indirect interests	Outside employment	My husband: Is a trustee of the Welsh Council for Voluntary Action Chairs Social Investment Cymru Committee (WCVA) Chairs the Gateway Dental Practice Is a Member of the Carers Trust Wales Advisory Board Is the Director of a Communications Consultancy which from time to time undertakes work in the wider NHS. My daughter in law works in the WG CMOs Department and from 1st July 2026 will work for the HSA.	
Lorton, Mrs. Elaine Linda	Y	Y	Financial interests	Outside employment	Independent Member - ateb housing association	
Lorton, Mrs. Elaine Linda	Y	Y	Indirect interests	Outside employment	Daughter works for Aneurin Bevan University Health Board	
Lorton, Mrs. Elaine Linda	Y	Y	Indirect interests	Outside employment	Husband works for Hywel Dda University Health Board	
Lorton, Mrs. Elaine Linda	Y	Y	Non-financial professional interest	Outside employment	Chair of West Wales Care & Repair Board	Voluntary Board Member
Lote-Jones, Mrs. Anna-Marie Lynnette (Anna)	Y	Y	Non-financial personal interests	Outside employment	My sister in law is employed by PTHB - Charlotte Lote	
Madsen, Mrs. Claire Louise	Y	Y	Financial interests	Outside employment		I sometimes do visiting lecturer work ad hoc for the University of the West of England
Madsen, Mrs. Claire Louise	Y	Y	Non-financial professional interest	Loyalty interests		Member of the Chartered Society of Physiotherapy
McGowan, Mrs. Emma Jayne	Y	N	I have no interests to declare			
McGowan, Mrs. Emma Jayne	Y	N	I have no interests to declare			
McIntyre, Mr. Mark Edward	Y	N	I have no interests to declare			
Morris, Miss Louise Marie	Y	N	I have no interests to declare			
Moss, Mr. Christopher	Y	N	I have no interests to declare			
Osborne, Mr. Adrian Peter	Y	Y	Non-financial personal interests	Outside employment	I am Chair of the Trustees of Powys Citizens Advice which is in receipt of grant funding from the health board and other partner bodies, and is a tenant at Ladywell House which is linked to the North Powys Wellbeing programme. Trustee from 1 April 2025, Chair from 29 October 2025.	
Owen, Mr. David Michael	Y	N	I have no interests to declare			
Parry, Miss Jane	Y	N	I have no interests to declare			
Pearce, Dr Adam Hugh	Y	Y	Financial interests	Outside employment	I run a small independent publisher called Melin Bapur books (www.melinbapur.cymru) as an additional (self) employment. I have also previously delivered Equality training, including to NHS Wales orgnaisations, on a freelance basis; I have and will not solicit any such work through my NHS Wales role.	I have previously received a payment from Public Health Wales in my capacity as Melin Bapur CEO for delivering a speaking engagement. This engagement was not solicited by myself and was totally coincidental to my employment by NHS Wales, and was carried out on my own time.
Phillips, Ms. Justine	Y	N	I have no interests to declare			
Powell, Mrs. Sarah Lucy	Y	N	I have no interests to declare			
Price, Dr Fiona Catherine Mary	Y	N	I have no interests to declare			
Price, Miss Jayne Elizabeth	Y	Y	Indirect interests	Outside employment	Husband Interests Husband & Pharmacist consultant providing support to Pharmacy departments in NHS England and Wales. Husband working as a pharmacy and medicines consultant providing advisory and expert services to: Bain & Co. Global consultancy. Input to specific pharmacy and medicines projects including individual NHS Trust work and commercial organisations. Eleanor Healthcare Logistics: Defined project to provide insight as to NHS thinking around Intravenous Fluids. Rx-Info: - Ad Hoc advice on future strategic direction of the NHS around medicines data. Ferring: - Market access expert input. Newmarket Strategy: - Consultancy. Input to specific pharmacy and medicines projects including commercial aseptic providers. Husband; Pharmacist; undertaking consultancy work for NWSSP on medicines supply and logistics. Husband &; Pharmacist; undertaking consultancy support for Cardiff University Health Board &; Aseptic Services SMPU and Pharmacy services for Velindre Cancer Centre.	
Price, Miss Jayne Elizabeth	Y	Y	Indirect interests	Shareholdings and other ownership interests	Brother in law owns building in Welshpool currently rented by Rowlands Pharmacy. I have no interest or gain in this.	
Price, Miss Jayne Elizabeth	Y	Y	Indirect interests	Shareholdings and other ownership interests	Second cousin is senior GP partner for Newtown Medical Practice	
Price, Mrs. Angela Sonia	Y	N	I have no interests to declare			

Pritchard, Mrs. Sarah Elizabeth	Y	Y	Indirect interests	Loyalty interests	My son is a planning officer with Bannau Brycheiniog National Parks to which the HB will submit planning applications for contruction works on its land and buildings,	I will not be making any planning applications directly but may be required to facilitate payment for such applications but based on budget holder approval.
Pritchard, Mrs. Sarah Elizabeth	Y	Y	Indirect interests	Shareholdings and other ownership interests	My brother owns a petrol station in Sennybridge where THB fleet fuel cards may be used.	I have no personal/owner interest in this business but declaring family relationship as this business may have possible transactions with the THB via third party vendor for fuel cards
Prothero, Miss Kate Jessica	Y	N	I have no interests to declare			
Prothero, Miss Kate Jessica	Y	N	I have no interests to declare			
Pullen, Mr. Hywel Richard	Y	N	I have no interests to declare			
Quarrell, Miss Catherine Linda	Y	N	I have no interests to declare			
Quarrell, Mr. Andrew Phillip	Y	N	I have no interests to declare			
Randell, Mrs. Rebecca Claire	Y	N	I have no interests to declare			
Rees, Mrs. Kelle Marie	Y	N	I have no interests to declare			
Rees, Mrs. Kelle Marie	Y	N	I have no interests to declare			
Robbins, Mrs. Rachael Louise	Y	N	I have no interests to declare			
Roberts, Dr Oltea Rossela (Rossela)	Y	N	I have no interests to declare			
Roberts, Dr Oltea Rossela (Rossela)	Y	N	I have no interests to declare			
Rogerson, Miss Emma Marie	Y	N	I have no interests to declare			
Ruthven-Hill, Miss Samantha (Sam)	Y	N	I have no interests to declare			
Samuel, Mrs. Joanna	Y	N	I have no interests to declare			
Scott, Dr Corinne	Y	N	I have no interests to declare			
Shone, Mrs. Linzi Ann	Y	N	I have no interests to declare			
Shooter, Dr Ben Michael	Y	N	I have no interests to declare			
Shooter, Dr Ben Michael	Y	N	I have no interests to declare			
Slade, Miss Jessica Jayne	Y	N	I have no interests to declare			
Slade, Miss Jessica Jayne	Y	N	I have no interests to declare			
Slade, Miss Jessica Jayne	Y	N	I have no interests to declare			
Smart, Mrs. Amanda Louise	Y	N	I have no interests to declare			
Summerfield, Mrs. Tanya Maria	Y	N	I have no interests to declare			
Sussex, Mr. Paul Jonathan	Y	N	I have no interests to declare		I have no conflicts of interest to declare.	
Symes, Mrs. Amie Louise	Y	Y	Non-financial personal interests	Clinical private practice	Director of BEST KEPT SECRET AESTHETICS WALES LTD.	Joint Director of this Ltd company undertaking private clinical practice in aesthetics. No direct or relationship with NHS activity.
Symes, Mrs. Amie Louise	Y	Y	Non-financial personal interests	Outside employment	Director of LLAMORS LTD.	Joint director with my husband, working in the construction of new residential dwellings. No direct or related interest in public service.
Symes, Mrs. Amie Louise	Y	Y	Non-financial personal interests	Shareholdings and other ownership interests	Registered Landlord - rental of residential dwellings	I am joint owner of a portfolio of residential dwellings with my husband. I am the RentSmart Wales registered landlord undertaking activities in line with legislative obligations. No affiliation with NHS activity, property located outside the county of Powys.

Tannahill, Mr. Wayne Robert (Wayne)	Y	N	I have no interests to declare			
Tannahill, Mr. Wayne Robert (Wayne)	Y	N	I have no interests to declare			
Tarrant, Miss Hayley	Y	N	I have no interests to declare			
Taylor, Mr. Peter Martin Henry	Y	N	I have no interests to declare			
Taylor, Mr. Peter Martin Henry	Y	N	I have no interests to declare			
Thomas, Mr. Christian Delfryn	Y	N	I have no interests to declare		No Intereest to Declare	
Thomas, Mrs. Christina Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Thomas, Mrs. Tanya Marie	Y	N	I have no interests to declare			
Tolley, Dr Warren	Y	N	I have no interests to declare		I have no interests to declare	I have no interests to declare
Tossell, Mrs. Eleri Rachel	Y	N	I have no interests to declare			
Toy, Mrs. Julia Anne	Y	N	I have no interests to declare			
Vitolo, Miss Lydia	Y	N	I have no interests to declare		I have no declarations to declare and am happy for this to be published	I have no declarations to declare and am happy for this to be published
Walters, Mrs. Amanda Jayne	Y	N	I have no interests to declare			
Waters, Mrs. Felicity Jayne	Y	N	I have no interests to declare			
Wheeler Sexton, Mrs. Jayne	Y	N	I have no interests to declare			
Wheeler, Miss Tab	Y	N	I have no interests to declare			
Williams, Mrs. Nicola Catherine	Y	N	I have no interests to declare			
Williams, Mrs. Nicola Catherine	Y	N	I have no interests to declare			
Williams, Mrs. Nicola Catherine	Y	N	I have no interests to declare			
Wood-Lawson, Ms. Debra	Y	N	I have no interests to declare			
Wood-Lawson, Ms. Debra	Y	Y	Indirect interests	Outside employment	Non Executive Director of Cadarn Housing Association	I am a non Executive Director of a Housing Association and a member of their Group Board and Governance Committee The 'group' is a zonal partner with Powys for the provision of housing stock This is a remunerated appointment
Wood-Lawson, Ms. Debra	Y	Y	Indirect interests	Outside employment	Relative working and training in ABUHB	
Woods, Miss Anne	Y	N	I have no interests to declare			
Wright, Dr Katharine Louise	Y	Y	Non-financial professional interest	Hospitality	Attended digital conference which was funded by the hosting organiser (Health Strategy Forum).	An opportunity to meet with other NHS senior leaders and consider opportunities for use digital innovation in transforming Health care.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.10

Audit, Risk and Assurance Committee	Date: 07 July 2026
Subject:	**Committee Effectiveness: Governance Development Plan 2026-27**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A
Appendices :	Appendix A – Governance Development Plan 2026-27

PURPOSE:

This report provides the Committee with the plan for continuous development, based upon the matters identified as actions arising the 2025-26 annual review of Committee effectiveness.

The 2026-27 plan comprises of actions arising from and relevant to all Committees (Cross Committee Action Plan) and the Board.

RECOMMENDATION(S):

The Committee is asked to:

a. **RECEIVE** the Governance Development Plan 2026-27 and
b. **TAKE ASSURANCE** that the implementation of development actions will be monitored and reported on throughout the year as a key principle of good corporate governance.

Approve/Take Assurance	Discuss	Note
x		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	A commitment to good governance and robust corporate systems are a key enabler of all of our wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

COMMITTEE EFFECTIVENESS
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. PTHB has adopted a two-yearly approach to Committee Effectiveness Reviews, with an in-depth questionnaire in year 1 and a more informal facilitated discussion approach in year 2. 2025/26 constitutes year 2 of the current cycle, and in March 2026 a Board Development session provided Board members with the opportunity to discuss in a shared environment the effectiveness of our Committees. A key aspect of the effectiveness review is the formulation of actions based upon identified opportunities for continuous improvement as part of the process. The outcome of the Board Development discussion and the actions arising have been reviewed and formed into a development plan by the Corporate Governance team, which has subsequently been received and supported by the Chair's Forum and Board Development. Implementation of the Governance Development Plan 2026-27 (Appendix A) will be monitored by the Corporate Governance team throughout the year, and an update on implementation will return to the Committee in Q4 of 2026/27.

NEXT STEPS:
Implementation of the Governance Development Plan 2026-27 (Appendix A) will be monitored by the Corporate Governance team throughout the year, and an update on implementation will return to the Committee in Q4 of 2026/27.

Appendix A – Governance Development Plan 2026/2027.

Committee Effectiveness: Governance Development Plan 2026–2027

Theme	Action	Owner	Timeline	Status
Committee Agenda Focus	a) Executive/Assistant Directors to feedback where greater clarity re the expected content/focus of agenda items would be beneficial b) Committee Chair's to provide clarity in meetings regarding the content/discussion required around agenda items	Governance Team / Executive Directors / Committee Chairs	Q1	Underway
Committee Agenda Focus	Review of proportionality of Committee reporting across key services/areas of risk as part of the development of annual work programmes	DCG / Governance Team / Executive Directors / Chairs	Q1	Underway
Board Member Training	Focused Board Member training on key areas e.g. financial recovery, scrutiny vs assurance etc. as part of	PTHB Chair / DCG	Q2	Not yet due

	structured Board Development programme			
Organisational Learning	Undertake to identify a comparable organisation for benchmarking of key data beyond NHS Wales	DCG / Governance Team / DPP&C	Q3	Not yet due
Organisational Learning	Identify partners or opportunities to hear from and share learning with relevant organisations and sectors	PTHB Chair / DCG / Committee Chairs	Q4	Not yet due
Board Out and About	Review potential for half-day IM out and about sessions as part of Board Development twice per year	PTHB Chair / DCG	Q2 – Q4	Not yet due

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.1

Audit, Risk and Assurance Committee	**Date: 07 July 2026**
Subject:	**Committee Risk Register Update**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Corporate Governance, Risk and Assurance Officer
Other Committees and meetings considered at:	N/A
Appendices :	Appendix A – Committee Risk Register

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Strategic Risk Register (SRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **NOTE** the update that the next Committee Risk Register will be presented at the next meeting in October 2026.

Approve/Take Assurance	Discuss	Note
Y	Y	x

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

COMMITTEE RISK REGISTER

The Committee has routinely received a Committee Risk Register which draws together relevant risks from the Corporate Risk Register (CRR) to provide a summary of the significant risks to the Health Board's within the Committee's remit.

The Board is actively undertaking an annual review of its Strategic Risk Register (SRR) to ensure that the risks continue to accurately reflect and align with the Health Board's strategic priorities. Following review, a summary of the revised SRR will be presented to the Board in July for consideration and subsequently the revised SRR to the Board for approval in September. The updated Committee Risk Register (CRR) will be provided to the Audit, Risk and Assurance Committee at its next meeting in October 2026.

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

Agenda item: 7.2

Audit, Risk and Assurance Committee	Date of Meeting: 07 July 2026

Subject:	Confirmation of Clinical Audit Programme
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Director of Corporate Governance/Board Secretary
Other Committees and meetings considered at:	Patient Experience, Quality and Safety Committee (30 April 2026) – who approved the 2026/27 clinical audit plan.

PURPOSE:

The Audit and Risk Assurance Committee is required, under its Terms of Reference to ensure that a Clinical Audit programme is in place for the Health Board. This paper presents the Committee with confirmation of the PTHB Clinical Audit Programme 2026/27 (Appendix A).

The Patient Experience, Quality and Safety Committee considered and approved the plan at its last meeting on the 30 April 2026. The plan is attached as **Appendix A.**

RECOMMENDATION(S):

The Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
Y		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing		
2. Provide Early Help and Support		
3. Tackle the Big Four		
4. Enable Joined up Care		
5. Develop Workforce Futures		
6. Promote Innovative Environments		

7. Put Digital First		
8. Transforming in Partnership		

BACKGROUND

Clinical Audit, the systematic review of actual performance against expected standards, remains an important benchmarking tool in determining the level of our clinical standards and is an important tool in guiding continuous quality improvement.

It will provide assurance in areas where procedures are inherently high-risk, or where new processes and policies have been introduced. It may also identify areas of concern where the significant input of resources may be required.

A Clinical Audit Plan has been approved for 2026/27 which incorporates the following:

- High volume basic activities which require a high level of compliance.
- Concerns identified during investigations of Nationally Reportable Incidents or complaints.
- New policies or changes to existing policy / practice to confirm new practice is established.
- The prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- Clinical audits required to confirm that practice has improved where concern had been raised.

The plan was developed and approved by the Assistant Directors with responsibility for;

- Women and Children's Services
- Community Services Group
- Mental Health and Learning Disabilities Group
- Medicines management
- Primary Care

A copy of the current Clinical audit Plan 2026/27 can be found in Appendix A. It has been reviewed by Executive Committee and approved by PEQS.

National Clinical Audit Programme

The National Clinical Audit Programme is a programme of audits commissioned by the London-based Healthcare Quality Improvement Partnership (HQIP) on behalf of the UK Department of Health.

Any national audits that are continuing as part of a multi-year audit plan are included in this program and any others will be added to the Clinical Audit program once known.

Progress against the Clinical Audit Plan will be reported within agreed timeframes to PEQ&S. This will highlight:

- Any significant actions to be taken from needs identified in the audits.
- The sharing of appropriate learning across services.
- The sustainable implementation of any safety improvements made.

Community Services Group					
Theatre and Endoscopy					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement AfPP requirement JAG requirement	Staff Survey	Annual	Theatre / Pre Operative Assessment / Endoscopy	Theatre/Endoscopy Co Ordinator's	Quarter 4
Service Evaluation High volume activity	Hand hygiene/Bare below the elbow via MEG reporting system	Monthly	Theatre / Pre Operative Assessment / Endoscopy	Theatre/Endoscopy Co Ordinator's	Quarter 4
Service Evaluation National alert	Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation Audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation	Environmental Audit Process Improvement Tool (PIT) Infection Control. Brecon and Llandrindod.	Annual	Theatre	Infection Prevention and Control team	Quarter 4
Service Evaluation MDPOCT requirement	Medical Devices Audit	Bi yearly	Theatre	Theatre Co Ordinator	Quarter 1 Quarter 4
Service Evaluation New policy change	NEWS 2	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation IRMER requirement	Radiation Audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care / Theatre team leader	Quarter 2
Service Evaluation AfPP requirement	Surgical Patient Satisfaction audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator	Quarter 4

Service Evaluation	Surgical patient story	Annual	Theatre	Corporate Patient Experience Lead	TBC Corporate Patient Experience Lead to complete
Local Audits for Service Improvement AfPP requirement	Consent	Annual	Theatre	Theatre Co Ordinator / Data Audit Support Officer	Quarter 3
Local Audits for Service Improvement AfPP requirement	Theatre record keeping audit	Weekly	Theatre	Theatre Co Ordinator and team	Quarter 4
Service Evaluation AfPP requirement	Swab Instrument and Sharps count observational audit	Monthly alternative sites	Theatre	Scrub practitioners and designated TSW's	Quarter 4
Service Evaluation Incident – new process put in place	Post operative surgical consultant follow up appointments	6 monthly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator /Team leaders	Quarter 2 Quarter 4
Service Evaluation	Local environmental audit via MEG reporting system	Quarterly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator	Quarter 4
Service Evaluation	Mattress Audit via MEG reporting system	Quarterly	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation AfPP requirement	Theatre Service AfPP review	3 yearly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator /Team leaders	Quarter 4 Next due 2028
Service Evaluation AfPP requirement	Surgical Pathway Observational audit	Annual	Theatre	Theatre Co Ordinator /Team leaders	Quarter 4
Service Evaluation AfPP requirement	8 Day Readmissions & 30-Day Mortality Report	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4

Service Evaluation JAG requirement	Annual planning & productivity report	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 3
Local Audits for Service Improvement Incident – compliance with policy	Audit of open access referrals into our service	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Local Audits for Service Improvement Incident – compliance with new process	Bowel Screening Wales pathology reporting audit	Annual	Endoscopy	BSW/ Business Support Manager Planned Care	Quarter 3
Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Annual	Endoscopy	Bowel Screening Wales	Quarter 4
Local Audits for Service Improvement JAG requirement	Pain / Comfort Audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement JAG requirement	Consent	Annual	Endoscopy	Endoscopy Coordinator/Data Audit support officer	Quarter 3
Service Evaluation JAG requirement	Decontamination Audit Process Improvement Tool (PIT) Infection Control Brecon	Annual	Endoscopy	Infection Prevention and Control team	Quarter 4
Service Evaluation JAG requirement	Environmental Audit Process Improvement Tool (PIT) Infection Control Brecon	Annual	Endoscopy	Infection Prevention and Control team	Quarter 4
Service Evaluation JAG requirement	Endoscopist satisfaction survey	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement Incident – compliance with new process	Audit for Endoscopy Screening assessment	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation JAG requirement	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Quarter 4
Service Evaluation JAG requirement	Individual endoscopists KPIs	6 monthly	Endoscopy	Endoscopy Clinical Lead	Quarter 1 Quarter 3
Service Evaluation MDPOCT requirement	Medical devices audit	Bi yearly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 4

Service Evaluation JAG requirement	Patient satisfaction survey	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation JAG requirement	Patient story	Bi yearly	Endoscopy	Corporate Patient Experience Lead	Quarter 1 Quarter 3
Service Evaluation JAG requirement	Post colonoscopy colorectal cancer rate (PCCRC) and Post endoscopy upper GI cancer (PEUGIC)	Annual	Endoscopy	Endoscopy Clinical lead	Quarter 2
Local Audits for Service Improvement JAG requirement	Record Keeping	Weekly	Endoscopy	Endoscopy Coordinator and team	Quarter 4
Service Evaluation IHEEM requirement	Scope traceability	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement Policy change	Single cancer pathway process	Annual	Endoscopy	External audit results sent to Senior Clinician Theatre/Endoscopy Planned care	Quarter 2
Service Evaluation JAG requirement	Vetting and validation of endoscopy referrals	Annual	Endoscopy	Clinical lead Endoscopy	Quarter 4
Service Evaluation IHEEM requirement	Local environmental audit via MEG reporting system	Quarterly	Endoscopy	Endoscopy Co Ordinator	Quarter 4
Service Evaluation	Mattress Audit via MEG reporting system	Quarterly	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation IHEEM requirement	Cairn Technology - Peracetic Acid monitoring	Annual	Endoscopy	Cairn Technology	Quarter 2
Service Evaluation JAG requirement	8 Day Readmissions & 30-Day Mortality Report	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Local Audits for Service Improvement Policy change	PGD 0083C (Supply of Moviprep for Bowel Screening)	6 months prior to expiry of PGD operational from 11/06/25 - 10-06-28	Endoscopy	Endoscopy Coordinator	Next due Quarter 1 2028
Local Audits for Service Improvement Policy change	PGD 0149A (Administration of Adrenaline in Endoscopy)	6 months prior to expiry of PGD	Endoscopy	Endoscopy Coordinator	

		operational from 01/08/25 - 12-06-28			Next due Quarter 1 2028

Community Services Group					
Therapies and Health Science					
Driver	Audit Title	Start Date	Service	Lead	End Date
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Pregnancy Status (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Correct use of radiographic markers (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Reject analysis (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Radiographer commenting audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Local Audits for service improvement	QA reporting Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Sonography Service Audit (multiple audit rounds)	Quarter 1	Radiography	Clinical Governance Lead for Sonography	Reported Quarterly
Audits performed for accreditation schemes	Reporting Radiography Service Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly

Audits performed for accreditation schemes	Compliance with Standard operating procedures (multiple audit rounds)	Quarter 2	Radiography	Head of Radiography	Reported Quarterly
Welsh Government National Audit Programme	Audiology - Tinnitus Standards	Quater 1	Audiology	Senior Audiologist	Quater 3
Local Audits for service improvement	Adult SLT use of introduction of biozoon	Quarter 1	Speech and Language Therapy	Clinical Lead	Quarter 4
Local Audits for service improvement	Change in children's service delivery	Quarter 1	Speech and Language Therapy	Clinical Leads	Quarter 3
Local Audits for Service Improvement	Therapy Outcome Measures Audit	Quarter 1	Speech and Language Therapy	Head of Speech and Language Therapy	Quarter 4
Other National Audits	Transforming MND Care Audit Tool’	Quarter 3	CNRT	MND care coordinator	Quarter 4
Other National Audits	National Respiratory Audit Programme (NRAP)	Quarter 1	Community Respiratory (Pulmonary Rehabilitation)		Quarter 4
Local Audits for service improvement	HCPC Notes audit	Quarter 3	CMATS	Service Lead for FCP/CMATS	Quarter 3
Local audits following change in procedure	Orthopaedic benefits tracker - 35 domains	Each quarter	CMATS	MSK consultant Physio	Each Quarter
Local audits following change in procedure	FCP outcome data	Each quarter	FCP	Service Lead for FCP/CMATS	Each Quarter
Local audit for service improvement	template compliance/documentation audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Local audit for service improvement	clinical letters audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Local audit for service improvement	Nutritional screening audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	TBC National
Other National Audits	SNAPP	TBC National	Therapies & Health Sciences	Consultant Therapist - Stroke	TBC National
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	TBC National
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 1	OT	Professional Head of OT	Quarter 4

Service Evaluation	MSK Transformation Business Case	Quarter 4	Physio	Professional Head of Physio / Consultant MSK	Quarter 1

Community Services Group					
Unscheduled Care					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Differing Diagnosis (previously Missed Fractures Audit)	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Mattress audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Hand Hygiene Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	PGD Audit	Annual	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Documentation Audit Child Attendances under 18 (Formally knows as Paeds under five audit – scrutiny of every attender under five)	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Adult Documentation Audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Routine Enquiry Audit	Quarterly Quarter 4	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Was Not Brought Audit	Quarterly Quarter 3	Unscheduled Care	Senior Manager	Quarter 3 2027

Local Audits for Service Improvement	Harm & Mortality (Cardiac arrests, major trauma, death in dept) – Report on occurrence and collate annually.	Annual	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Patient Feedback – Quarterly paper survey/continuous QR code access.	Quarterly Quarter 4	Unscheduled Care	Senior Manager	Quarter 4 2027

Community Services Group					
Nursing (Ward and Community)					
Driver	Audit Title	Start Date		Lead	End Date
Local Audits for Service Improvement	NEWS 2 Audit – National spreadsheet	Weekly (wards 1 in 9)	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	NEWS Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Wristband Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Dols Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Environmental Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Welsh Language Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	DNACPR Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Annual Quarter 4 2026	Nursing (Wards)	Ward Managers	Quarter 4 2027
Local Audits for Service Improvement	Hydration and Nutrition Audit	Quarter 4 2025	Nursing (Wards)	Senior Nurses	Quarter 4 2026

Service Evaluation	Medical Devices Aduit	Biyearly – Jan & June	OPD	Senior Nurse Manager	Q1 & 4 2027

Community Services Group					
Specialist Nursing					
Driver	**Audit Title**	**Start Date**		**Lead**	**End Date**
Other National Audit & Service Evaluation	Parkinson's UK National Audit	2 yearly Data collection 1-5-26 – 30-9-26 Submission 31-10-26	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	Quarter 3 2026
Local Audits for Service Improvement	Pressure Damage Audit	Annual Quarter 1 2026	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	Quarter 1 2027
Local Audits for Service Improvement	Diabetes Ward Audit	Annually	Specialist Nursing - Diabetes	Diabetes Team Lead	Quarter 1 2026
Service Evaluation	Clinic PREM Data	Quarterly	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	Prescribing Data	Quarter 1	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	Transition Clinic PREM Data	Biannual (New) Quarter 2	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2025
Service Evaluation	Pad PREM	Biennial 2025	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	COBWEB PREM	Biennial 2025	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	CIVICA/PREMS clinic data	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026

Other National Audit & Service Evaluation	National Audit of Cardiac rehab/PROMS	Annually Completed Aug 2025	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 2 2026
Service Evaluation	CROMS data	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026
Local Audits for Service Improvement	Quality Assurance Audits for ECHO scans at neighbouring DGH.	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026

Community Services Group					
Outpatient Services					
Driver	Audit Title	Start Date		Lead	End Date
Local Audits for Service Improvement	ENT LocSSIPs Audit	Annual – Q1 (June) 2026	OPD	Senior Nurse Manager	Q1 2027
Local Audits for Service Improvement	Pessary LocSSIPs Audit	Annual Q2 (September) 2026	OPD	Senior Nurse Manager	Q2 2027
Local Audits for Service Improvement	Eye Care Health Risk Rating	Annual Q2 (July) 2026	OPD	Senior Nurse Manager	Q2 2027
Local Audits for Service Improvement	Gynaecology LocSSIPS Audit	6 monthly Q1 (June) 2026	OPD	Senior Nurse Manager	Q1 2027
National Ophthalmic Audit	Cataract Outcomes Audit – Pulled from Live Audit Database	Monthly	OPD	Senior Nurse Manager	Q4 2027
Service Evaluation	Colposcopy QA Audit	3 yearly – Completed April 2025	OPD	Cervical Screening Wales	Q1 2028

Service Evaluation	WET AMD Outcomes Audit	Annual Q2 (August) 2026	OPD	Mr Faris Arif	Q2 2027
Service Evaluation	Hand Hygiene Audit	Monthly	OPD	Senior Nurse Manager	Q2 2027
Service Evaluation	Medical Devices Aduit	Biyearly – Jan & June	OPD	Senior Nurse Manager	Q1 & 4 2027
Local Audits for Service Improvement	Staff Survey	Yearly	OPD	Senior Nurse Manager	Q3 2027
Local Audits for Service Improvement	Patient Satisfaction Survey	Monthly	OPD	Senior Nurse Manager	Q4 2027

Primary Care

Primary Care

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Audit of Minor Injury Services OR Audit of Lithium Prescribing	TBC	GP Surgery	Practice Manager	Quarter 4
Local Audits for Service Improvement	Audit of diabetes care	TBC	GP Surgery	Practice Manager	Quarter 4

Primary Care

Community Dentistry

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Patient Experience Audit	Real-time patient	Community Dentistry	CIVICA – Heidi Thomas	Real-time patient

		feedback throughout the year			feedback throughout the year
Other National Audit	WHTM01-05	Autumn/winter 2026	Community Dentistry	Rachael Anwyl	Autumn/winter 2026
Local Audits for Service Improvement	Clinical notes and written Consent to treatment audit	Dec 2026	Community Dentistry	Lloyd Bovensiepen/Susan Bracegirdle	Dec 2026
Local Audits for Service Improvement	Best Practice prevention – Delivering Better Oral Health	Sept 26	Community Dentistry	Nurse Led - TBC	Oct 26
Local Audits for Service Improvement	Antimicrobial Stewardship	Dec 2026	Community Dentistry	Lloyd Bovensiepen	Jan 2027
Local Audits for Service Improvement	Alignment between planned treatment and delivered treatment in scheduled appointments	June/July 2026	Community Dentistry	TBC	July/Aug 2026
Local Audits for Service Improvement	Time spent on treatment interventions by patient group (Adults, Children, Special Care), Excluding Inhalation Sedation	Autumn 2026	Community Dentistry	TBC	Autumn 2026
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of dental radiographs in the Community Dental Service	Continuous yearly run chart	Community Dentistry	Warren Tolley/ Catherine Adams *Note: All staff undertaking radiographs to continuously undertake radiography self-auditing	Continuous yearly run chart

Women and Children's Service					
Midwifery					
Driver	Audit Title	Start Date	Service	Lead	End Date
NHS Performance & Improvement	NEWTT2 pathway	April 2026 rolling audit	Maternity	Mat Neo Lead	October 2026
Local Audit for Service Improvement	All Wales Handheld Maternity Records / Electronic Patient Record	Rolling	Maternity	Clinical Supervisor for Midwives	October 2026
Service evaluation	Maternity Triage Telephone Calls Process Review	Six monthly rolling audit	Maternity	MatNeo Lead	June 2026
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning	Annually	Maternity	Perinatal Mental Health	December 2026
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH *(Business as usual)*	Annually	Maternity	Consultant Midwife	May 2026
Local Audit for Service Improvement	Clinical Information Sharing Caseload *(Business as usual)*	Annually	Maternity	Clinical Supervisors/Consultant Midwife	March 2027
Local Audit for Service Improvement	GAP / GROW	Annually	Maternity	Practice Facilitator	Sept 2026
Local Audit for Service Improvement	BFI standards	Annually	Maternity	Infant Feeding Lead Midwife	October 2026
Safeguarding	Was Not Brought (WCCIS)	Rolling monthly	All Services	Lead Advanced Nurse Practitioner	Quarter 4
Safeguarding	Routine Enquiry	Quarterly Q1	PHN	AHoPHN	Quarter 4
National Audit	Down Syndrome Pathway	Annual	Com Paeds	Medical Lead	Quarter 3

National Audit	Quality of Adoption Medicals	TBC	Com Paeds	Medical Lead	Quarter 4
National Reporting	HCWP mandatory contacts compliance	Quarterly	PHN	AHoPHN	Quarter 4
National Reporting	HCWP 2 (School Age Children) Implementation	Bi Annual	PHN	AHoPHN	Quarter 2 Quarter 4
National Reporting	Transition and Handover from Children's to Adult services	Bi Annual	Children's Services/ Adult Services / Mental Health & LD Services	HoS (Children's Services) **With support from** HoS Therapies, HoS CAMHS, HoS LD	Quarter 2 Quarter 4
National Reporting	ALN Compliance	Quarterly from Q3	Children's Services incl Therapies and CAMHS	DECLO	Quarter 4
Service Evaluation	Children's Continuing Care, review following repatriation	Bi-annual Q2	CCNS	HoS	Quarter 2 Quarter 4
Service Evaluation	ND Open Pathways Audit	Quarterly Q1	ND	HoS	Quarter 4
Service Evaluation	Meeting the Health Needs of Children in school		CCNS/ Special Schools	Lead Advanced Nurse Practitioner	Quarter 3
Local Audit for Service Improvement	Caseload Audit to include acuity	Quarterly Q1	Children's Services	Operational Leads & HoS	Quarter 4
Local Audit for Service Improvement	Quality and timeliness of Record Keeping	Rolling Annually	Children's Services	Professional Leads & HoS	Quarter 2
Local Audit for Service Improvement	Environments of Care Audit (clinic venues / bases)	Biannual	HV	AHoPHN/HoS	Quarter 2 Quarter 4

Mental Health and Learning Disabilities					
Mental Health and Learning Disabilities					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits in response to NRI/Identified risk	Audit of Environmental Ligature Risk Assessment	Q1	All MH	Senior Nurse - Inpatient Matron role	Quarterly
Local Audits in response to NRI/Identified risk	Audit of WARRN risk assessments	Q4	All MH	CTP Lead/Governance Lead	2027
Local Audits in response to NRI/Identified risk	Audit of Security Risk Assessment	Q2	All MH&LD	Head of MH Operations	Quarterly
Local Audits for Service Improvement	Audit of Care and Treatment plans	Q4	All MH	CTP Lead/Governance Lead	Q4
Welsh Government National Audit Programme	NCISH Suicide audit	Q2	All MH	Suicide and Self Harm Prevention Lead	Q4
Welsh Government National Audit Programme	National review of schizophrenia audit	Q4	All MH	Clinical Director MH&LD	Q4
Local Audit for Service Improvement	Inpatient Physical health monitoring audits	Q1	Ward Based	Clinical Director MH&LD	Q4
Local Audit for Service Improvement	RCP/NICE quality standards for inpatient care	Q1	Ward Based	Senior Nurse - Inpatient Matron role	Q4
Local Audit for Service Improvement	Medicine management audit	Q1	All MH&LD	Service Managers and Ward Managers	Monthly

Local Audit for Service Improvement	Hand hygiene/Mattress audits	Q1	Ward Based	Ward Managers	Monthly
Local Audit for Service Improvement	Record Keeping	Q1	All MH	Team Leads/Ward Managers/IG	Q4
Local Audit for Service Improvement	Did Not Attend audit.	Q1	All MH	Business and Performance Manager	Q4
Local Audit for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Q2	Ward Based	Service Managers and Ward Managers	Q4
Local Audit for Service Improvement	Was Not Brought audit	Q4	CAMHS	CAMHS Operational Lead	Quarterly
Local Audit for Service Improvement	Early Intervention in Psychosis audit	Q2	CAMHS	CAMHS Operational Lead	Q4
Local Audit for Service Improvement	Outcome Measure Audit	Q2	CAMHS	CAMHS Operational Lead	Q4
Local Audit for Service Improvement	LPMHSS Pathway Audit	Q2	Psychology	Service Manager LPMHSS/Psychology	Q4
Local Audit for Service Improvement	S117 Audit	Q1	All MH	Head of MH Operations	Q4
Local Audit for Service Improvement	MH Act Compliance	Q2	All MH	HoMH Nursing	Quarterly
Local Audit for Service Improvement	Adult & Older Adult CMHT MDT Audit	Q2	Community Based	Head of MH Operations	Quarterly
Local Audit for Service Improvement	Epilepsy audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Liaison data audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Champion training audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Anti-psychotic and physical health audit	Q2	All MH&LD	Consultant Psychiatrist/Head of SOAD	Q4
Local Audits in response to NRI/Identified risk	Therapeutic observations audit	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly
Local Audits in response to NRI/Identified risk	WCCIS and V4 MHM forms audit	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly

Local Audits in response to NRI/Identified risk	Advocacy audit	Q2	All MH&LD	Head of LD	Quarterly
Local Audits in response to NRI/Identified risk	Discharge letters audit from in-patient services.	Q2	All MH&LD	Clinical Director MH&LD	Q4
Local Audits in response to NRI/Identified risk	Escorting patients off hospital grounds	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly
Local Audits in response to NRI/Identified risk	Educational audit	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	Older adult CMHT discharge audit	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	s136 audit	Q2	All MH&LD	Clinical Director MH&LD	Q4

Medical Directorate

Medicines Management

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audit for Service Improvement	ADHD Prescribing Audit (including all-setting dashboard and private prescribing	Q3	Medicines Management / Mental Health Pharmacy	Mental Health Pharmacist	Q4
Local Audits for Service Improvement	GLP-1 Prescribing Audit	Q2	Medicines Management	Emlyn Prichard	Q3
Audits performed for accreditation schemes / Safety & Governance	Medical Gases Site Audit (linked to safety and savings programme)	Q1	Medicines Management / Estates Interface	Jayne Price	Q2
Local Audits for Service Improvement	Medication Storage Audit (PSN055 compliance across hospital and clinic sites)	TBC	Medicines Management	Kath Harries	Q4
Local Audits for Service Improvement	Denosumab Optimisation Audit (biosimilar implementation across care settings)	Q2	Medicines Management	Claire Jones	Q3

Audit Driver Key:

	Driver

	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident/Identified Risk
	Service Evaluation
	Other

Progress Key:

	Progress
	Complete
	On Track
	Indicates audit Rolled Forward from 2021/22 Programme
	Not undertaken due to lack of capacity
	Cancelled as being no longer required

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.3

Audit, Risk and Assurance Committee	**Date: 07 July 2026**
Subject:	SINGLE TENDER WAIVERS
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	None

PURPOSE:

To inform the Audit Risk and Assurance Committee that there have been no Single Tender Waiver requests made between 1 April 2026 and 31 May 2026

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there have been No Single Tender Waiver requests made between 1 April 2026 and 31 May 2026

Approve/Take Assurance	Discuss	Note
N	N	Y

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

EXECUTIVE SUMMARY:
In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements
HEADING:
The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its May 2026 meeting which covered the period from 1 March 2026 and 31 March 2026. It is confirmed there has been no Single Tender Waiver requests made between 1 April 2026 and 31 May 2026.

NEXT STEPS:
A report on use of Single Tender Waivers will be submitted to each Audit, Risk and Assurance Committee meeting. A nil report will also be reported if applicable.

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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

QUALITY:

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

EQUALITY:

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

RISK ASSESSMENT:

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

Powell,Bethan
07/07/2026 16:11:14

Audit, Risk and Assurance Committees 2026-27

Item Title	May 12/05/2026	June 23/06/2026 (Annual Accounts)	July 07/07/2026	Oct 06/10/26	Jan 12/01/2027	09-Mar
Minutes of previous meeting	✓		✓	✓	✓	✓
Declaration of Interests	✓		✓	✓	✓	✓
Action Log	✓		✓	✓	✓	✓
Committee Risk Register	✓		✓	✓	✓	✓
Annual Work Programme	✓		✓			
Work Programme (updated through year)			✓	✓	✓	✓
Annual Assessment of Committee Effectiveness						
Committee Governance Action Plan			✓	✓		✓
Committee Annual Report	✓					
Audit Findings Tracker			✓			✓
WHC/MD Tracker			✓			✓
Organisational Register of interests, Gifts and Hospitality			✓			✓
Board Assurance Framework	✓					
Review of Terms of Reference						✓
Review of Standing Orders and Standing Financial Instructions						✓
Confirmation of Clinical Audit Programme			✓			
Approach to the Annual Accounts						✓
PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	✓					
PTHB Final Accountability Report and Financial Accounts and Letter of Representation		✓				
Head of Internal Audit Opinion Draft	✓					
Head of Internal Audit Opinion Final			✓			
Internal Audit Annual Plan						✓
Internal Audit Progress Report	✓ **25/26**	✓ **26/27**	✓	✓	✓	✓
Internal Audit Reports (as required)	✓	✓	✓	✓	✓	✓
Internal Audit Trend Report					✓	
Enquiries of Management and Those Charged with Governance		✓				
External Audit Annual Plan	✓					✓
External Audit Progress Report	✓		✓	✓	✓	
External Audit Reports (as required)	✓	✓	✓	✓	✓	✓
Structured Assessment						✓
Counter Fraud Annual Plan	✓					✓
Counter Fraud Update	✓		✓	✓	✓	
Counter Fraud Reports (as required)	✓		✓	✓	✓	✓
Single Tender Waivers Annual Report	✓					
Single Tender Waivers (including extensions to contracts)	✓		✓	✓	✓	✓
Losses and Special Payments Annual Report	✓					
Losses and Special Payments	✓			✓		✓
Post payment Verification Yr End May, Mid Yr Jan	✓				✓	
Review of Risk Management Framework	✓					
Assurance of Risk Management arrangements inc. revised Risk Management Toolkit						✓
Audit Handbook				✓		
Hosted Body annual report (HCRW)	✓					✓
Information Governance and Records Management Annual Report			✓			
IG Toolkit (National Audit replaces Caldicott Principles)	✓					
Information Governance and Records Management Performance and Assurance Monitoring Report					✓	
Strategic risk deep dive: Digital Infrastructure (In-Commiittee)			✓		✓	
Digital First Annual Plan					✓	
Digital First 6monthly monitoring report (including cyber security)	✓			✓		
SFI executive financial delegation limits				✓		
WCCIS Update **- In-Committee Item**			✓		✓	✓
Policy Management Assurance Report	✓			✓		
Grip and Control	✓					

Powys Teaching Health Board Glossary (Last updated juli 26)

Acronym	
AD ECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCEO	Deputy Chief Executive Officer
DCG	Director of Corporate Governance
D I&T	Director of Improvement & Transformation
E MD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People, Culture & Transformation
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHS&D	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
ED PCCMH	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
AF	Audit Findings
APB	Area Planning Board
AGS	Annual Governance Statement
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 Taf 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
DOI	Declaration of Interest
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time

GLP-1	Glucagon Like Peptide
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
G&H	Gifts and Hospitality
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
IBG	Investment Benefit Group
ICB	Integrated Care Board
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
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MD's	Minimum Data Set
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
ODEC	Organisational Development, Engagement and Communications
OOC	Out of County
OOH	Out of Hours
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PMVA	Prevention and Management of Violence and Aggression
PPPH	Planning, Partnerships and Population Health Committee

PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
REES	Race Equality Employment Standard
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
RMF	Risk Management Framework
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	The Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TaODEC	Tactical Organisation Development, Engagement and Communication
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
TUPE	Transfer of Undertakings Protection of Employment

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
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust
WCD	Written Controlled Document
YTD	Year to Date

Standards of Behaviour

Final Internal Audit Report

2026/27

Powys Teaching Health Board

Substantial Assurance

Contents

Review Reference	PTH-2627-02XX
Fieldwork	May – June 2026
Executive Sign Off	17th June 2026
Audit Committee	July 2026
Executive Lead	Helen Bushell – Director of Corporate Governance/Board Secretary
Audit Team	Ian Virgill, Head of Internal Audit
	Andrea Calise, Audit Manager

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

Executive Summary

Purpose

Our review of the Standards of Behaviour was completed in line with the 2026/27 Internal audit Plan for the Powys Teaching Health Board ('the Health Board'). The purpose was to review the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour, including declarations of interest and declarations of gifts, hospitality and sponsorship.

Overview

The Welsh Government's Citizen-Centered Governance Principles apply to all 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 service in Wales.

The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

All NHS bodies in Wales should have a Standards of Behaviour Framework / Policy in place that sets out the arrangements for ensuring that all staff comply with the principles, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship.

We have concluded substantial assurance on this area. The matter requiring management attention is:

- A number of Declarations of Interest had still not been completed at the time of review.

The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- We reviewed the Standards of Behaviour Policy and noted that further information needs to be included on the different versions of the Declarations of Interest Registers in place. The Policy also needs to clarify the publishing arrangements for the Declaration of Interests Registers and Register of Gifts, Hospitality, Honoraria and Sponsorship.

Scope & Assurance Summary

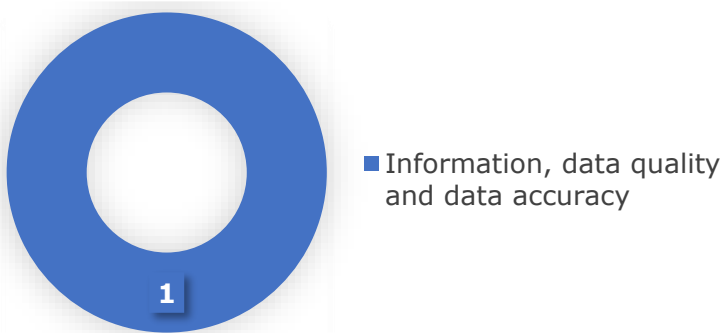
Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The Health Board has an appropriate and up to date Standards of Behaviour Policy in place which is accessible to staff and the public, and effective processes are in place to raise staff awareness of the requirements of the policy.	-	**Substantial**
2	Effective arrangements are in place to ensure that Declarations of Interest are completed, updated and reviewed in accordance with the requirements of the Policy. There is a Declarations of Interest Register in place that is reviewed on a regular basis and reported to the Audit, Risk and Assurance Committee at agreed intervals.	1	**Reasonable**
3	Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship whether accepted or declined is maintained and reported to the Audit, Risk and Assurance Committee at agreed intervals.	-	**Substantial**

Management Actions

0
High Priority

1
Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Choose an item.

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: The Health Board has an appropriate and up to date Standards of Behaviour Policy in place which is accessible to staff and the public and effective processes are in place to raise staff awareness of the requirements of the policy.	Substantial

Overview / Summary of Observations

Information on Standards of Behaviour is included in the Health Board's Standing Orders which are accessible to both the public and Health Board staff. There is an up to date Standards of Behaviour Policy in place, which is accessible to the public via the Health Board's website and to staff via the Policy and Procedures pages on the Intranet (SharePoint).

A review of the policy confirmed that it is in date. Aligns to the NHS Wales Values and Standards of Behaviour Framework and provides clear and comprehensive guidance on the actions and processes to be followed for the Declaration of Interests and offers of Gifts, Hospitality, Honoraria and Sponsorship.

However, we did identify a minor issue concerning the information detailed in the policy regarding the Declaration of Interest Registers which would benefit from enhancement. We also noted that although the policy states that the Register of Gifts, Hospitality, Honoraria and Sponsorship should be published on the Health Board's website, this was not the case at the time of our audit fieldwork.

The Corporate Governance Department has implemented a number of processes to raise awareness of the Standards of Behaviour Policy within the Health Board.

In addition, a sample of staff within the Organisational Leadership Group were contacted regarding how they promote awareness of the policy within their departments and they were able to demonstrate the actions being undertaken.

Objective 2: Effective arrangements are in place to ensure that Declarations of Interest are completed, updated and reviewed in accordance with the requirements of the policy. There is a Declarations of Interest Register in place that is reviewed on a regular basis and reported to the Audit, Risk and Assurance Committee at agreed intervals.	Reasonable

Overview / Summary of Observations

Within Powys Health Board the requirement to complete a Declaration of Interest applies to all Board members as well as staff that have budgetary oversight. To ensure this occurs the Corporate Governance Department maintains a schedule of all staff that they are notified that have budgetary oversight. All staff are required to complete the declaration of interest via the Electronic Staff Record system (ESR). The Standards of Behaviour policy details the process to be followed by staff.

On a quarterly basis the Corporate Governance Team receives an ESR report that records the names and details of all staff that have recorded a Declaration of Interest. This information will then be reviewed and compared to the Budgetary Oversight list and current version of the Declarations of Interest to ensure that all information is aligned.

As part of the quarterly review the Corporate Governance Team will identify staff who have not completed a declaration of interest and also any interests that may no longer apply and appropriate action will be undertaken.

We were able to confirm that the Health Board maintains two versions of the Declarations of Interest:

- Board Members Declaration of Interest
- Health Board Declarations of Interest (includes staff that have budgetary oversight)

However, review of the Corporate Governance tracker used to monitor completion identified weaknesses in the design and operation of this control. The tracker is manually maintained and relies on inconsistent status descriptions, with limited evidence of key control dates (e.g. request issued or follow-up undertaken). In addition, a number of declarations remained outstanding at the time of review. **(Key Finding 1)**

The Standards of Behaviour Policy states that the Declaration of Interest Register must be submitted at least annually to the Audit, Risk and Assurance Committee for review and consideration. We can confirm that for 2025/26 the Declaration of Interest Register was actually submitted to the Audit, Risk and Assurance Committee twice (October 2025 and March 2026).

The Standards of Behaviour Policy also states that the Declaration of Interest Register should be published on the Health Board's internet site. We can confirm that the Board Members Declaration of Interest Register 2026/27 is published on the internet but the version including staff who have budgetary oversight has not been published.

Key Findings		Risk & Impact	Agreed Management Action
1	**Procedural framework** A review of the budgetary approvers' Declaration of Interest (DOI) tracker, maintained by the Corporate Governance team, identified that 34 out of 151 individuals (23%) were yet to submit a DOI statement as at June 2026. The tracker is manually maintained and lacks a consistent structure and key control information	Declarations of Interest are not completed or updated in a timely and comprehensive manner, increasing the likelihood of undisclosed conflicts of	**Agreed Action** The Health Board will ensure that all outstanding Declarations of Interest are completed and returned in line with policy requirements. In addition, the Health Board should strengthen the design of the tracker by introducing a standardised format, including clear status categories and key control information (e.g. request,

	(such as status and follow-up dates), limiting visibility over completion. We also note that compliance rates are not currently being reported to the Audit, Risk and Assurance Committee.	interest and weakening governance, transparency.	follow-up and completion dates), and ensure that compliance is routinely monitored and reported to the Audit, Risk and Assurance Committee.
			
			Expected Evidence of Implementation:
			• Updated Declaration of Interest register showing all required staff have submitted a completed declaration
			• Revised tracker format including:
			  ○ standardised status categories (e.g. complete, outstanding, not required)
			  ○ clearly recorded key dates (e.g. request issued, follow-up actions, completion date)
			• Confirmation report to Audit, Risk and Assurance Committee demonstrating full (or improving) compliance

		Medium Priority	**Officer:** Corporate Governance, Risk and Assurance Officer **Target Implementation Date:** 31st March 2027
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship which requires recording. A register of declared Gifts, Hospitality and Sponsorship whether accepted or declined is maintained and reported to the Audit, Risk and Assurance Committee at agreed intervals.	**Substantial**

Overview / Summary of Observations

The Standards of Behaviour Policy sets out the process that must be followed for the consideration and approval of offers of Gifts, Hospitality and Sponsorship. It provides comprehensive information / examples of different types of offers that staff may receive.

To raise awareness the Corporate Governance Department issues periodic reminders to staff regarding their responsibilities. The Department has also attended senior management team meetings across various departments and directorates to deliver presentations on the Standards of Behaviour Policy.

A Register of Gifts, Hospitality and Sponsorship is maintained by the Corporate Governance Department for each Financial Year. We reviewed the registers for 2025/26 and 2026/27 and found that the content was appropriate. Where gifts had been accepted, these were in line with the policy requirements.

The policy outlines requirements for both the publishing and reporting of the register. While the register should be published on the Health Board's website, this was not the case at the time of fieldwork.

We confirmed that updates on the register were submitted to the Audit, Risk and Assurance Committee in October 2025 and March 2026. At the October meeting, no offers were reported, while at the March meeting a copy of the register was presented for review.

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.