

Audit Risk & Assurance Committee

Tue 10 March 2026, 10:00 - 13:00

Agenda

10:00 - 10:00 **1. PRELIMINARY MATTERS**

0 min

 Agenda_ARAC_ 10March2026.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest. Board Members Register of Interests

 ARA_1.2_Board Members Register of Interest 2025-2026.pdf (3 pages)

10:00 - 10:00 **2. CONSENT AGENDA BUSINESS**

0 min

10:00 - 10:00 **3. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION**

0 min

3.1. Minutes of the previous meeting held on the 13 January 2026

Attached Chair

 ARA_3.1_Minutes_13 January 2026.pdf (9 pages)

3.2. Committee Action Log

Attached Chair

3.3. Internal Audit Annual Plan 2026/2027

Attached Head of Internal Audit

 ARA_3.3_ Internal Audit Plan 2026-27 Cover.pdf (2 pages)

 ARA_3.3a_Powys THB Internal Audit Plan 2026-27.pdf (27 pages)

3.4. Losses and Special Payments

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

 ARA_3.4_Losses and Special Payments March 26.pdf (3 pages)

10:00 - 10:00 **4. ESCALATED ITEMS**

0 min

There are no items for inclusion within this section

10:00 - 10:00 **5. ITEMS FOR ASSURANCE**

0 min

5.1. Approach to the Annual Accounts 2025/2026

Attached Director of Corporate Governance and Executive Director of Finance, Capital and Support Services

 ARA_5.1_Approach to Accounts March 2026.pdf (19 pages)

5.2. Internal Progress Report

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Attached Head of Internal Audit

- ARA_5.2_Powys ARAC Internal Audit Progress Report March 26 Cover.pdf (2 pages)
- ARA_5.2a_Powys ARAC Internal Audit Progress Report March 26.pdf (12 pages)

5.3. Internal Audit Reports: Clinical Supervision, Anti Racism Action plan, Policy Management, Follow-up DoLS

Attached Head of Internal Audit

- ARA_5.3a_Clinical Supervision Final Internal Audit Report.pdf (8 pages)
- ARA_5.3b_Anti-Racism Action Plan Final Internal Audit Report.pdf (10 pages)
- ARA_5.3c_Policy Mgmt Final Internal Audit Report_.pdf (8 pages)
- ARA_5.3d_DoLS Follow-up Final Internal Audit report.pdf (8 pages)

5.4. External Audit Reports: Structured Assessment

Attached External Audit

- ARA_5.4_External Audit Committee Update March 2026.pdf (11 pages)
- ARA_5.4a_Powys THB 2025 Structured Assessment Final.pdf (47 pages)

5.5. Counter Fraud Annual Plan- DEFERRED

Deferred Director of Corporate Governance and Executive Director of Finance, Capital and Support Services

5.6. Welsh Health Circular and Ministerial Direction Report

Attached Director of Corporate Governance

- ARA_5.6_Cover Paper_WHCs and MDs Report_March2026_final.pdf (5 pages)
- ARA_5.6a_Appendix1_WHCs that remain Outstanding.pdf (3 pages)
- ARA_5.6b_Appendix2_WHCs Completed since the previous report.pdf (1 pages)
- ARA_5.6c_Appendix3_MDs that remain Outstanding..pdf (1 pages)
- ARA_5.6d_Appendix4_MDs Completed since the previous report.pdf (1 pages)

5.7. Audit Findings Tracker

Attached Director of Corporate Governance

- ARA_5.7_Audit Findings_Cover Paper_March2026.pdf (12 pages)
- ARA_5.7a_Internal Audit - Findings Completed since the previous report.pdf (2 pages)
- ARA_5.7b_Internal Audit - Findings that are No Yet Due.pdf (2 pages)
- ARA_5.7c_Internal Audit - Findings that are Overdue.pdf (1 pages)
- ARA_5.7d_Internal Audit - Findings with revised deadlines.pdf (1 pages)
- ARA_5.7e_External Audit - Findings completed since the previous report.pdf (3 pages)
- ARA_5.7f_External Audit _Findings that are Overdue.pdf (2 pages)
- ARA_5.7g_External Audit_Findings with Revised Deadlines.pdf (4 pages)
- ARA_5.7h_External Audit _Findings Not Yet Due.pdf (2 pages)

5.8. Organisational Register of Interests, Gifts and Hospitality

Attached Director of Corporate Governance

- ARA_5.8_Cover Report Board Members Delaration of Interests, Gifts & Hospitality Feb2026.pdf (4 pages)
- ARA_5.8a_AppendixA_Declarations of Interest Feb_2026.pdf (4 pages)
- ARA_5.8b_AppendixB_Declarations of Gifts & Hospitality_Feb 2026.pdf (1 pages)

5.9. Board Assurance Framework and Strategic Risk Register Review Terms of Reference

Attached Director of Corporate Governance

- ARA_5.9_SRR and BAF Dashboard Cover_March 2026.pdf (3 pages)
- ARA_5.9a_Appendix A - Strategic Risk Register March 2026.pdf (74 pages)
- ARA_5.9b_Appendix B - Board Assurance Framework (BAF) Dashboard, March 2026.pdf (8 pages)
- ARA_5.9c_Annual Review of Stratgic Risk Assurance.pdf (36 pages)

Powell Bethan
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5.10. Review Terms of Reference

Attached *Director of Corporate Governance*

 ARA_5.10_ARAC Annual Review of Terms of Reference.pdf (2 pages)

 ARA_5.10a_AppendixA_Audit Risk and Assurance Committee Terms of Reference_ Draft May 2026.pdf (13 pages)

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

0 min

There are no items for inclusion within this section

10:00 - 10:00 7. CONSENT AGENDA

0 min

7.1. Internal Audit Reports: Catering Services (Substantial Assurance)

Attached *Head of Internal Audit*

 ARA_7.1_Catering Services Final Internal Audit Report.pdf (7 pages)

7.2. Single Tender Waivers (including extensions to contracts)

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

 ARA_7.2_Single Tender Waiver Report Mar 2026.pdf (2 pages)

7.3. PTHB Glossary (For Information)

Attached *Director of Corporate Governance*

 ARA_7.3_Powys Teaching Health Board Glossary.pdf (6 pages)

7.4. Review Standing Orders and Financial Instructions

Attached *Director of Corporate Governance*

 ARA_7.4_Annual update on changes to Standing Orders.pdf (2 pages)

7.5. Committee Governance Action Plan

Attached *Director of Corporate Governance*

 ARA_7.5_ARAC Effectiveness Continuous Development Plan 2025-26_March 2026.pdf (6 pages)

7.6. Committee Work Programme 2025/26 (For Information)

Attached *Director of Corporate Governance*

 ARA_7.6_ARAC Work Programme 2025-2026updated.pdf (1 pages)

10:00 - 10:00 8. OTHER MATTERS

0 min

8.1. Any Other Urgent Business

Verbal *Chair*

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

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

Powell Bethan
05/03/2026 16:28:03

8.4. Date of next meeting: 12 May 2026

8.5. CONFIDENTIAL ITEMS

“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”

Powell Bethan
05/03/2026 16:28:03

AUDIT, RISK AND ASSURANCE COMMITTEE

TUESDAY 10 MARCH 2026
10:00-13:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT



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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

AGENDA

Time	Item	Title	Attached / Verbal	Owner
	1	PRELIMINARY MATTERS		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest Board Members Register of Interests	Verbal/ Attached	All
	2	CONSENT AGENDA BUSINESS		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	ITEMS FOR APPROVAL / DECISION / RATIFICATION		
	3.1	Minutes of previous meeting held on 13 January 2026	Attached	Chair
	3.2	Committee action log	Attached	Chair
10:10 15	3.3	Internal Audit Annual Plan 2026/27	Attached	Head of Internal Audit
10.25 10	3.4	Losses and Special Payments	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
	4	ESCALATED ITEMS		
There are no items for inclusion within this section				
	5	ITEMS FOR ASSURANCE		
10:35 5	5.1	Approach to the Annual Accounts 2025/26	Attached	Director of Corporate Governance and Executive Director of Finance, Capital and Support Services
10:40 10	5.2	Internal Audit Progress Report	Attached	Head of Internal Audit
10:50 1hour	5.3	Internal Audit Reports: - Clinical Supervision - Anti Racism Action Plan - Policy Management - Follow-up DoLS	Attached	Head of Internal Audit
11:50	COMFORT BREAK (10mins)			
12:00 15	5.4	External Audit Report Structured Assessment	Attached	External Audit
	5.5	Counter Fraud Annual Plan and Reports Deferred	Attached	Counter Fraud

12:15 15	5.6	Welsh Health Circular Tracker	Attached	Director of Corporate Governance
12:30 10	5.7	Audit Findings Tracker	Attached	Director of Corporate Governance
12:40 5	5.8	Organisational Register of Interests, Gifts and Hospitality	Attached	Director of Corporate Governance
12:45 5	5.9	Board Assurance Framework and Strategic Risk Register	Attached	Director of Corporate Governance
12:50 10	5.10	Review Terms of Reference	Attached	Director of Corporate Governance
	6	ITEMS FOR DISCUSSION		
<i>There are no items for inclusion within this section.</i>				
	7	CONSENT AGENDA		
	7.1	Internal Audit Reports: Catering Services (Substantial Assurance)	Attached	Head of Internal Audit
	7.2	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
	7.3	PTHB Glossary (For Information)	Attached	Director of Corporate Governance
	7.4	Review Standing Orders and Financial Instructions	Attached	Director of Corporate Governance
	7.5	Committee Governance Action Plan	Attached	Director of Corporate Governance
	7.6	Committee Work Programme 2025/26 (For Information)	Attached	Director of Corporate Governance
	8	OTHER MATTERS		
13:00	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 12 May 2026 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: <u>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</u> "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"				

13:05	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declarations of Interest	Verbal	All
	8.8	Minutes of the In-Committee meeting held on 13 January 2026	Attached	Director of Corporate Governance
13:10 5	8.9	Committee Risk Register <i>SRR011 - Failure of Digital & Electrical Infrastructure</i>	Attached	Executive Director of Allied Health Professions, Health Science and Digital
13:15 10	8.10	WCCIS Assurance 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 – please submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

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POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26								Updated: February 2026
Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned
INDEPENDENT MEMBERS								
PTHB Chair	Carl Cooper	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	Kirsty Williams	Non Financial personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025. Left the Health Board on 30 September 2025
		Non Financial personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsidiary of Cardiff University	None	
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Financial personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Vice Chair	Rhiannon Beaumont-Wood	Non Financial professional interests	Outside Employment	Jun-23	Ongoing	Director and Owner of RBW Executive and Professional Coaching	None	16/02/2026
		Non Financial personal interests	Loyalty Interests	May-23	Ongoing	Non-Executive Member Dorset ICB (In the process of forming a cluster with Dorset ICB, Somerset ICB, Bath, East Somerset, Swindon and Wiltshire ICB)	Renumerated as per Non-Executive Member, Terms and Conditions	
		Non Financial personal interests	Loyalty Interests	Jun-24	Ongoing	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	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	Cathie Poynton	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	Steve Elliot	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	Ronnie Alexander	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current		Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	Simon Wright	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	

Independent Member (Third Sector)	Jennifer Owen Adams	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	10/06/2025
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	
		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None	
		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL	
Independent Member (Local Authority)	Christopher Walsh	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL	
Independent Member (Capital)	Michael Giannai	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
Independent Member	Ian Thomas	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	NIL	09/04/2025
EXECUTIVE MEMBERS								
Chief Executive Officer	Hayley Thomas	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
Executive Director of Finance, Capital and Support Services	Pete Hopgood	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
Executive Director of Allied Health Professions, Health Science and Digital	Claire Madsen	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
Executive Director of Nursing, Quality, Women and Family Health	Claire Roche	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025 Left the Health Board on 10 October

Family Health		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery		2025
Executive Medical Director	Kate Wright	Non-Financial professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025
Executive Director of People and Culture	Debra Wood Lawson	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated	29/05/2025
			Outside Employment	01-Sep-25	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL	
Executive Director of Public Health	Mererid Bowley	Non-Financial 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).	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance/ Board Secretary	Helen Bushell	Non-Financial professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Parnter - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	Lucie Cornish	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	Nicola Johnson	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	Elaine Lorton	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	
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	Nil	25/10/2025 Started with PTHB October 2025



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AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC)

UNCONFIRMED MINUTES OF THE MEETING HELD ON 13 JANUARY 2026 HELD VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ian Thomas	IT	Independent Member (General)
Ronnie Alexander	RA	Independent Member (General)
Rhobert Lewis	RL	Independent Member (General)
IN ATTENDANCE		
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Bethan Hopkins	BH	Audit Wales
Mike Jones	MJ	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Martyn Lewis	ML	Internal Audit
David Owen	DO	Assistant Director of IT and Digital
Sarah Pritchard	SP	Assistant Director of Finance
Stella Gwynne	SG	Deputy Board Secretary
Louisa Steele	LS	Counter Fraud
Hayley Thomas	HT	Chief Executive
Carl Cooper	CC	PTHB Chair
Jayne Lawrence	JL	Assistant Director of Primary Care (<i>Item 5.7 only</i>)
Amanda Legge	AL	All Wales Post Payment Verification Manager (<i>Item 5.7 only</i>)
Sue Tillman	ST	Post Payment Verification Manager (<i>Item 5.7 only</i>)
APOLOGIES FOR ABSENCE:		
Mick Gianassi	MG	Independent Member (General)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Matthew Evans	ME	Counter Fraud
Kirsten Jones	KJ	Llais

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/070)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (ARA/25/071)
No declarations of interest were received in addition to those already recorded on the register.
2. CONSENT AGENDA BUSINESS
The Chair asked Members if they wished to bring forward any items from the Consent agenda to the main agenda and noted that the Committee had previously agreed that any substantial assurance audit reports would be reported via the consent agenda. No items were requested for inclusion in the main agenda.
3. ITEMS FOR APPROVAL / RATIFICATION
1.3 MINUTES OF PREVIOUS MEETING (ARA/25/072)
The minutes of the meeting held on the 7 October 2025 were CONFIRMED as an accurate record subject to the following amendment: - On p6 of the minutes, regarding Did Not Attend (DNA) data, the action identified in relation to theatre utilisation/data for cancelled operations should have been assigned to the Executive Director of Primary Care, Community and Mental Health. - A few typo's were identified particularly in 'received' and 'assurance' in the capitalised sections. The following matters arising were raised by Committee Members: - On p6 of the minutes, regarding Did Not Attend (DNA) data, the action identified in relation to theatre utilisation/data for cancelled operations has not been transferred to the latest iteration of the Action Log. - It was queried how the utilisation of co-pilot AI had supported the development of the minutes, HB noted that a pilot had been run with x3 licenses deployed across the Corporate Governance team. The findings of the pilot were under review with the anticipation that further AI use would be rolled out in the next financial year.
1.4 ACTION LOG (ARA/25/073)
The Committee RECEIVED the Action Log, and the following updates were provided: - ARA/25/032 (Regional Partnership Board (RPB) Memorandum of Understanding (MoU)): HB highlighted that discussions had been held to clarify reporting points and purpose between the RPB and Health Board. An extension to the target date to March 2026 was requested to enable the finalisation of the document. - ARA/25/052 (Grant Thornton Review Report): HT confirmed that it was anticipated that the draft report would be shared at the forthcoming Board Development. It was noted that Welsh Government were in active discussion with the Health Board on the

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report, with a meeting due between Welsh Government and Grant Thornton that week, the report could then be shared as appropriate.

4. ESCALATED ITEMS

There were no items for inclusion in this section.

5. ITEMS FOR ASSURANCE

5.1 INTERNAL AUDIT PROGRESS REPORT (ARA/25/074)

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

- Two audits had been planned but were delayed
- One report was in draft,
- Seven reports had been finalised, with five included in the meeting's agenda with two included within the consent agenda. The remainder would be presented to the next meeting.
- Two adjustments to the plan were requested:
 - Digital Operating Model – Identified for removal from the plan due to duplication of coverage with the Structured Assessment Deep Dive into Digital Systems being undertaken by Audit Wales. Removal has been agreed with the Executive Director of Allied Health Professions, Health Science and Digital.
 - Community Care – Proposed that the timing of this audit is moved from Quarter 2 to Quarter 4 due to further discussions required to agree the scope and the availability of Internal Audit resources to deliver the work.

Independent Members welcomed the mechanism for providing early sightedness of finalised reports and HB noted that work was underway to develop report titles to provide greater clarity regarding scope rather than topic area.

Assurance was sought by members regarding the delay to the Asbestos Management audit and the mechanisms in place tracking any previously identified areas of concern. HT confirmed the policy and process in regard to asbestos management was well established and agreed that the previous report could be shared with Committee members for sightedness.

The Committee:

- NOTED the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports, and
- APPROVED the proposed adjustments to the 2025/26 plan.

5.2 INTERNAL AUDIT REPORTS (ARA/25/075)

IV introduced the item and noted that a summary of the following reports would be provided:

a) Digital Systems Uptake (Limited Assurance)

ML presented the report and highlighted that the report by necessity was retrospective in nature, therefore it was recognised that the new Benefits Management Framework had yet to be fully embedded. The key matters for management attention highlighted within the report were:

- Not all benefits had been fully defined and tracked;
- Not all projects had included a defined training stage;
- There was no established Change Management Framework, and change management was generally delivered by project managers;
- There was no overall uptake dashboard for tracking purposes; and
- The analysis of low uptake causes was not always rigorous.

Independent Members sought assurance by asking the following questions: *Was there a high incidence of resistance to change or were staff generally positive?*

CM noted that the report encapsulated a variety of projects so there would be variation, with some delivered by Digital Health and Care Wales (DHCW) and some by the Health Board. It was noted that due to limited budgets often funding must be prioritised therefore a cascade approach is often required due to limitations. DO reiterated that there had been no strength in resistance to change, however, digital capacity and operational capacity issues remained a challenge. It was highlighted that the digital teams are always looking to enhance capacity but also that investment must be realistic and proportionate in the current financial context.

Would the audit be reviewed in the 2026/27 audit plan?

IV confirmed that a follow up review would be undertaken in 2026/27 as with all limited assurance audits, progress would also be tracked via the Health Board's audit tracking process.

b) Continuing Healthcare (CHC) (Reasonable Assurance)

Independent Members sought assurance by asking the following questions: *Considering the focus of the forthcoming Grant Thornton review on CHC and the recent deep dive by the Finance and Performance Committee, did a mechanism for more regular review of actions need to be considered?*

RA, the Chair of Finance and Performance Committee agreed the need to reflect on the approach to CHC's and tracking actions more broadly. HB agreed this would be integrated into work programmes, particularly Finance and Performance Committee, and an action was agreed to ensure tracking of progress against key actions arising from the Grant Thornton review.

Action: Director of Corporate Governance.

c) Mental Health and Learning Disability (MH&LD) Triage and Assessment Process (Reasonable Assurance)

Independent Members suggested that the management actions in response to Finding 4 could be clarified for succinctness. IV recognised that work

would be continued into 2026/27 to ensure greater clarity of findings and management responses.

d) Core Financials (Reasonable Assurance)

Independent Members sought assurance by asking the following questions: *There is reference in the report to debt dating back as far as 2006, is this still current or had it been written off? Would this debt be covered by the severe debt provision if needed?*

PH confirmed that a small percentage had been identified, which would be rigorously reviewed in light of the audit. A process was in place regarding severe debt and there was no risk to the financial position from such debts.

e) Decontamination (Reasonable Assurance)

The Committee NOTED and DISCUSSED the Internal Audit reports.

5.3 INTERNAL AUDIT TREND REPORT (ARA/25/076)

IV presented the item which provided the Committee with information regarding trends and themes that can be identified through the analysis and review of the outcomes from previous internal Audits. The following areas of analysis were presented:

- Outcomes of Powys Audits from 2019/20 to date, benchmarked to the All-Wales position;
- Assurance ratings of Powys Audits from 2019/20 to date, benchmarked to the All-Wales position;
- Assurance ratings by domain for Powys from 2019/20 to date, benchmarked to the All-Wales position;
- Powys findings 2019/20 to date;
- Top 10 themes for Powys from 2019/20 to date benchmarked to the All-Wales position; and
- Definitions and key observations for considers.

HB welcomed the report and acknowledged the richness of data. It was confirmed that the Executive Committee would review the findings and factor analysis into the development of the 2026/27 audit plan. Thanks were expressed to Internal Audit colleagues for the helpful report.

Independent Members sought assurance by asking the following questions: *Over the reporting period there had been over 100 high priority findings, was there assurance that these had been dealt with?*

HB noted that the Audit Tracking report was due to come to the next meeting of the Committee which would identify all outstanding high priority audit findings.

The Committee RECEIVED the presentation as a basis to consider data trends over the reported period and where appropriate inform future Internal Audit Planning.

5.4 EXTERNAL AUDIT PROGRESS REPORT (ARA/25/077)

BH presented the report which provided an update on the current and planned accounts and performance audit work for the Health Board. It was noted that a correction was required to p6 of the report in regard to the Structured Assessment which was due to be submitted to the Health Board for clearance by the end of that week. BH also recognised that a high number of finalised reports were anticipated to report into the March meeting of the Committee and that she would remain in contact with HB to ensure appropriate scheduling.

MJ confirmed that the Charitable Funds Accounts audit had been completed and had reached an unqualified opinion. The accounts would be submitted to the Auditor General for Wales by the end of January 2026. MJ also noted that the review of the Health Board's accounts had begun, with Audit Wales and the Health Board in joint agreement to commence the audit early for 2025/26.

The Committee NOTED the External Audit progress report.

5.5 COUNTER FRAUD UPDATE AND REPORT (ARA/25/078)

LS provided an update to the Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2025/26.

Independent Members sought assurance by asking the following questions:
Where there any concern regarding delivery of the plan on the context of absence within the team?

LS noted some pressure areas in regard to strategic governance, however Powys continued to engage across all Health Boards to remain current. There were no other issues to escalate, and it was confirmed that the Health Board would meet the agreed work programme.

The numbers of staff working elsewhere whilst sick appeared high, were there any concerns regarding this?

LS confirmed that work was ongoing to analyse data and raise awareness within the Health Board. HT shared the concern and suggested she would raise the issue with the Director of People and Culture for awareness.

The Committee RECEIVED the update report for discussion and took ASSURANCE that appropriate counter fraud systems were in place.

5.6 ASSURANCE OF RISK MANAGEMENT ARRANGEMENTS (ARA/25/079)

HB presented the item which provided a summary of the progress made and associated risks to the implementation and ongoing development of the Health Board's Risk Management Framework (RMF) and Board Assurance Framework (BAF). HB also welcomed comments and feedback on the proposed template for the Annual Review of Strategic Risk Assurance.

Independent Members sought assurance by asking the following questions:
What was the position regarding directorate risk arrangements and risk registers?

HB noted that approaches and standards were variable, with work planned for the forthcoming year to support services and directorates to improve risk control.

Whilst helpful, the proposed template was heavy on textual information, had modernised systems been considered to help condense information?

HB welcomed the feedback and agreed this would be considered as part of further development.

The Committee:

- Took ASSURANCE regarding the progress made in the implementation of the RMF and BAF since the last report and the plans in place to further mature and integrate risk management;
- RECEIVED the proposed template for the Annual Review of Strategic Risk Assurance provided; and
- NOTED the current risks associated with the implementation of all aspects of the RMF and BAF.

5.7 POST PAYMENT VERIFICATION MID YEAR REPORT 2025 (ARA/25/080)

Jayne Lawrence, Amanda Legge and Sue Tillman joined the meeting.

AL presented the report which provides a mid-year summary of Post Payment Verification (PPV) action and findings. The paper highlighted PPV progress and how practices have been performing over the current Post Payment Verification cycle. It also compared the overall performance of the Health Board against the national PPV visits.

Independent Members sought assurance by asking the following questions: *What was the balance between a lack of understanding of systems and process vs genuine fraud?*

AL confirmed the majority of cases were due to a lack of understanding and that PPV training events would continue to be delivered to all Health Boards and contractors when required, including one-on-one training requirements, particularly for new practice staff within the Primary Care setting.

The Committee RECEIVED the report and took ASSURANCE that effective PPV management was in place.

Jayne Lawrence, Amanda Legge and Sue Tillman left the meeting.

5.7 DIGITAL FIRST ANNUAL PLAN (ARA/25/081)

DO presented the item which provided a summary of Year 2 of 3 of the Digital Strategic Framework (2023–2027), highlighting a commitment to a “Digital First” approach for Powys. The focus remained on delivering measurable benefits for patients, staff, and partners through digital innovation, aiming for safe, effective, and person-centred care.

Independent Members sought assurance by asking the following questions:

What was the mechanism for assurance regarding digital systems and were there any concerns regarding capacity?

DO noted that there were several governance mechanisms from the Board and Board Committees to Clinical Service Boards, which the team attends. It was highlighted that the Powys team was the smallest in Wales, however there was a strong commitment in the team to growing capacity and capability.

Committee members raised concern regarding the integration of the NHS Wales App with NHS England. It was highlighted that the issue had been ongoing for several years, and with over 50% of the Powys population referred into NHS England concern was raised regarding the need to ensure that the Powys population was not at a disadvantage. CM recognised the concern and confirmed that the issue had been raised with Welsh Government and Digital Health and Care Wales (DHCW).

The Committee AGREED to ALERT the Board to ongoing compatibility issues within the NHS Wales App. Specifically, the lack of cross border functionality with NHS England, with no clear timescale for resolution. It was agreed that further exploration of the issue would be undertaken to identify if it were specific to Powys patients or relevant across NHS Wales. **Action: Director of Allied Health Professionals, Health Sciences and Digital.**

The Committee:

- Took ASSURANCE that appropriate arrangements were in place to ensure ongoing delivery of the Digital Strategic Framework, with considerable progress made to align with Ministerial digital priorities.
- Took ASSURANCE that relevant actions and workstreams were being implemented to enhance and modernise the Digital Services offering as outlined in the Framework.
- RECOGNISED that alongside these assurances and achievements, significant challenges remain; while digital solutions should enable faster discharge and more accurate transfer notes, delays with the Cross Border programme, competing national and local priorities, workforce pressures, and capacity constraints are slowing adoption across the organisation.

5.7 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/25/082)

SP presented the item and highlighted that there had been five Single Tender Waiver (STW) requests made between 25 September 2025 and 31 December 2025. These were the first STWs received in 2025/26. 3 of the STWs had arisen from Healthcare Research Wales (HCRW), a hosted body of PTHB, and were STWs due to their highly specialist nature.

Independent Members sought assurance by asking the following questions:
Given that 5 STWs had arisen in a short time period, and that there was a significant total value of around £400k, was there confidence that all

requests satisfied all of the required criteria and were of an exceptional nature?

SP confirmed that the timing was coincidental, with 1 linked to the North Powys Programme, 1 recurrent with a view to shifting to a clinic provider in the near future and the other 3 linked to a functional transfer into the Health Board from Welsh Government via HCRW. Whether the 3 HCRW STWs were to be recurrent was dependent on tripartite strategy decisions made between HCRW, Welsh Government and the Health Board.

Committee members noted their support for the STW in regard to the Parkway Clinic, however reiterated the importance of ensuring that there was no feasible procurement options before commencing a STW.

The Committee:

- NOTED the five Single Tender Waiver requests made between 25 September 2025 and 31 December 2025; and
- Took ASSURANCE relevant reporting and review mechanisms were in place.

6. ITEMS FOR DISCUSSION

There were no items for discussion.

7. CONSENT AGENDA

The below reports were taken under the Consent Agenda and recommendations supported:

- **FOR ASSURANCE:**
 - **7.1** Internal Audit Reports (Substantial Assurance)
 - Primary Care Clusters Project Management
 - Staff Development Programme
 - **7.2** Information Governance & Records Management Report
- **FOR INFORMATION:**
 - **7.3** Committee Work Programme 2025/26
 - **7.4** PTHB Glossary

8. OTHER MATTERS

8.1 ANY OTHER BUSINESS (ARA/25/083)

No other business was raised.

8.2 COMMITTEE REFLECTIONS (ARA/25/084)

The following feedback was noted:

- Well chaired and consistent approach/scrutiny from ARAC members and attendees;
- Balance of strategic and more detailed discussions;
- Acknowledged the level of detail in the papers produced; and
- Productive discussions in key areas.

8.3 DATE OF NEXT MEETING (ARA/25/085)

10 March 2026 via Microsoft Teams

Meeting closed at 12:28.

Prepared by Bethan
09/03/2026 16:28:03



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda Item: 3.3

Audit, Risk and Assurance Committee		10 March 2025
Subject:	Draft Internal Audit Plan 2026/27	
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary Ian Virgil, Head of Internal Audit	
Prepared by:	Head of Internal Audit	
Other Committees and meetings considered at:	Informal Executive Committee – 25 March 2026 who contributed to the prioritising of the plan and supports its submission to the Audit, Risk & Assurance Committee.	
PURPOSE:		
To present the draft Internal Audit Plan for 2026/27 to the Committee for review comment and approval.		
To present the updated Internal Audit Mandate and Charter to the Committee for review and approval.		
RECOMMENDATION(S):		
The Audit, Risk & Assurance Committee are requested to:		
• Approve the Internal Audit Plan for 2026/27; • Approve the Internal Audit Mandate and Charter; and • Note the associated Internal Audit resource requirements and Key Performance Indicators.		
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	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	

EXECUTIVE SUMMARY:

The draft Internal Audit plan for 2026/27 has been developed following review of the Health Board's key objectives, Board Assurance Framework, Strategic Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents.

Planning discussions were held with each of the Executive Directors, the Chief Executive and Independent Members to inform development of the plan.

An initial version of the draft plan was shared with the Executive Committee for review and comment, and to inform prioritisation of the potential audits to ensure that the plan can be delivered within the available resources.

The plan covers the whole of the 2026/27 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

BACKGROUND AND ASSESSMENT:

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

It is a requirement of the Global Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be completed in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit, Risk and Assurance Committee approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards.

The Internal Audit Mandate and Charter has been updated as at March 2026 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

NEXT STEPS:

Progress towards delivery of the Internal Audit plan will be reported to each meeting of the Committee during 2026/27.

Powell Bethan
05/03/2026 16:28:03

Internal Audit Plan

2026/27

Powys Teaching Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Powys Teaching Health Board's (the 'Health Board') management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards. The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement.
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

- 1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of the Health Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee, the Patient Experience, Quality and Safety Committee and the Finance and Performance Committee).
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and strategic risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the strategic risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Under the approach we have adopted for several years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the Health Board will need to pay an additional £92,897 (£95,131 in 2025/26) over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2026/27.

This additional amount is made up of two elements:

1. £59,384 (£59,384 in 2025/26) to cover work provided on all aspects of the plan other than Capital & Estates; and
2. £33,513 (£35,747 in 2025/26) for work undertaken by our Capital & Estates team as part of the overall audit plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, the Internal Audit Plan will be supplemented through the year by major project/programme audits agreed through the respective SOC/OBC/FBC/BJC funding provisions approved by Welsh Government.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit

NHS Wales Shared Services Partnership

Powell, Bethan
05/03/2026 16:28:03

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
1. Risk Management / Assurance Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	IA / Exec / SRR	Corporate Governance / Board Secretary	Q4
2. 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.	IA / Exec	Corporate Governance / Board Secretary	Q1/2
3. Themes from Internal Audit work Potential advisory engagement providing analysis of the themes from Internal audits undertaken for the Health Board over previous years.	IA / Exec	Corporate Governance / Board Secretary	Q3
4. 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. <i>The exact scope, focus and timing of the audit to be determined once the Health Board has agreed its formal management responses to the report and developed them into an action plan.</i>	IA / SRR	Finance, Capital & Support Services / Planning, Performance & Commissioning	Q3/4

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
5. 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.	IA / SRR	Finance, Capital & Support Services / Planning, Performance & Commissioning	Q1/2
6. 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.	IA / SRR 001	Finance, Capital & Support Services	Q2/3
7. 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.	IA / Exec / SRR 007	Finance, Capital & Support Services	Q3
8. Capital Systems (Targeted Estates Fund) (Deferred from 25/26 plan) Acknowledging the Health Board's £3.4m Target Estates Funding (TEF) allocations provided by Welsh Government during 2025-27, we will seek to obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated funds.	IA / Exec / SRR 007 Deferred from 25/26 plan	Finance, Capital & Support Services	Q1

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
9. 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.	IA / Exec / SRR 007	Finance, Capital & Support Services	Q3
10. 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.	Deferred from the 25/26 plan	Finance, Capital & Support Services	Q1
11. 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. Exact scope and timing of the audit to be agreed.	IA	Medical	Q3
12. 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.	Exec / SRR012	Public Health	Q2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
13. 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.	Exec / SRR 008	Public Health	Q3
14. 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.	Exec / SRR 010	Allied Health Professions, Health Sciences & Digital	Q1/2
15. 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.	Exec	Allied Health Professions, Health Sciences & Digital	Q1
16. Follow-up: Digital Systems Uptake Follow-up of 2025/26 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	Follow-up	Allied Health Professions, Health Sciences & Digital	TBC
17. Care at Home Services (Deferred from 25/26 plan) Review of the plans and processes in place to provide care within patient's homes in order to avoid admission to hospital. Cover the work of GPs, Community Care Teams and virtual wards targeting high risk patients.	Exec / IMs / SRR 003, 004 & 005 From 25/26 plan	Primary, Community Care & Mental Health	Q1

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
18. 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.	IA / Exec	Primary, Community Care & Mental Health	Q3/4
19. Agency staff usage Review of controls in place around the use of non-ward based agency staff for AHPs, Medics and community nursing.	Exec / SRR 004	Primary, Community Care & Mental Health	Q2/3
20. Health & Safety Review of the governance and oversight arrangements for Health & Safety following recent changes to arrangements, sub-committee structure and Executive responsibility.	Exec	People & Culture	Q3/4
21. Better Together Transformation Programme Review of the first phase engagement, lessons learned and how they have informed planning for the second phase.	IA / Exec / SRR 012	People & Culture	Q2
22. 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. Potentially consisting of an initial advisory element in Q1 to support the development of an auditing tool and then an assurance audit in Q4.	Exec / SRR 004	Nursing, Quality, Women & Family Health	Q4

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Strategic Risk Register (SRR) / Rationale	Executive Lead/Responsible Director	Planned start
23. 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.	Exec / SRR 004	Nursing, Women & Family Health	Q2/3
24. 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.	IA / Exec / SRR 004	Nursing, Women & Family Health	Q3/4
25. 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.	IA / Exec / SRR 003 & 004	Planning, Performance & Commissioning	Q2/3

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Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2025/26 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	80%
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	85%
Report turnaround draft response to final reporting [10 working days]	✓	95%

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Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Powys Teaching Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk & Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Powys Teaching Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk & Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:
- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
 - the appropriate assessment and management of risk, and the related system of assurance.
 - the arrangements to monitor performance and secure value for money in the use of resources.
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.
- 2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

- 3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk & Assurance Committee and Accountable Officer.
- 3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk & Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk & Assurance Committee:
- approving the internal audit mandate and charter.
 - approving the risk based internal audit plan.
 - approving the internal audit resource plan.
 - receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.
- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
 - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
 - 3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
 - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk & Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk & Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit, Risk & Assurance Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit, Risk & Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk & Assurance Committee also has regular private meetings with the Head of Internal Audit.
- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit, Risk & Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk & Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk & Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned.
 - reviewing specific operations at the request of the Audit, Risk & Assurance Committee or management, this may include areas of concern identified in the corporate risk register.
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
 - ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.
- 7.3 If the Head of Internal Audit or the Audit, Risk & Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales requirements of the Mandate & Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

the provision to the Accountable Officer and the Audit, Risk & Assurance Committee of an overall opinion each year on the organisation’s risk management, control and governance, to support the preparation of the Annual Governance Statement.

- audit of the organisation’s risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation’s objectives and risks.
- improvement of the organisation’s risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

- 8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.
- 8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.
- 8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.
- 8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.
- 8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.
- 8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

- 9.1 Internal Audit will report formally to the Audit, Risk & Assurance Committee through the following:
- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
- a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification.
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

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- d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.
- e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and
- f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit, Risk & Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk & Assurance Committee requirements; and
- The Audit, Risk & Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.

The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk & Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk & Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.

- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk & Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk & Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk & Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2026

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Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Mandate and 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 regarding 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 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.

Global 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. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

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Powys Teaching
Health Board

Agenda item: 3.4

Audit Risk and Assurance Committee		Date: 10 March 2026	
Subject:	Losses and Special Payments – Bad debt write off		
Approved and presented by:	Executive Director of Finance, Capital Estates and Support Services		
Prepared by:	Deputy Director of Finance Assistant Director of Finance (Accounts and Services)		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
To request approval of the Audit Risk and Assurance Committee for the write of of Bad debt and note Ex Gratia loss submitted to Welsh Government in respect of the recognition payment related to Health Care Support Workers			
RECOMMENDATION(S):			
The Committee is asked to:			
• APPROVE the write off of debts as outlined in the paper totalling £210,474.75. • NOTE the submission to Welsh Government for approval for the losses element of the Band 2/3 recognition payment for Health Care Support Workers			
Approve/Take Assurance		Discuss	Note
Y		N	N

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

EXECUTIVE SUMMARY:

At the January 2026 Audit Risk and Assurance Committee the outcome of the Core Financial Audit 2025/26 recommended a review of bad debts with the outcome of this review to be put forward for approval for write off at the March 2026 committee meeting.

OUTCOME OF REVIEW:

Bad Debt Write Off

A review of the Aged debt Listing at 31st January 2026 was undertaken by the Assistant Director of Finance and the outcome of the review identified a number of long standing debts that are recommended for write off.

Bad debt write off has not been submitted for a number of years and, therefore, this list below includes a considerable number of debts that have exceeded the 6 year statute for recovery of debts.

Category	Count of Invoice Numbers	Sum of Write off amount
Ineligibility NHS costs	15	£647.07
Low Value	14	£419.79
Overpayment of Salary	112	£87,774.77
Provision of Services	13	£17,397.36
Provision of Training	8	£1,044.00
Recharge of Health Costs	8	£15,190.30
Recharges to Local Authority	12	£58,740.40
Rent and utilities	11	£6,774.23
Other	9	£12,968.20
Lease Car Charge	9	£9,518.63
Grand Total	211	£210,474.75

There is no financial impact for the 25/26 financial accounts as all debts have previously been fullu provided for as part of the Annual Accounts Bad debt provision arrangements in prior financial years.

Health Care Support Worker Recognition Payment

The HCSW or equivalent roles are an essential part of healthcare delivery, with postholders often being the staff who spend the most time with patients. These roles have evolved and expanded to take on more responsibilities, with individuals undertaking fundamental care roles, such as washing and dressing, assisting with mobility, assisting with feeding, basic observations and increasingly some clinical care, but without the pay and recognition for all the duties in the expanded role.

In August 2021, the UK Staff Council approved revised Job profiles and agreed updated guidance to clarify the difference between the roles of a Band 2 Health Care Support Worker (HCSW) and Band 3 Senior Health Care Support Worker (SHCSW). This clarified that Band 2 HCSWs mainly undertake personal care duties, while clinical care duties should be undertaken by a Band 3 SHCSW and other registered nursing colleagues.

These revised profiles apply with effect from 5th August 2021.

Within the Health Board and in line with national guidelines the Health Board has approved a local agreement for ward based Health Case Support Workers to be recognised as Band 3 in line with Agenda for Change national profiles whose duties have been assessed as meeting the Senior Health Care Support Worker job profile.

As part of this agreement a 'Recognition Payment' will be made to eligible staff. The recognition payment reflects the clinical work that may have been completed previously in line with the Band 3 duties as per the Agenda for Change national profile for Band 3.

The Health Board assessment is that this recognition payment is as per the Manual of Accounts an Ex Gratia payment. This means that it is a payment which a health body is not obliged to make or for which there is no statutory cover or legal liability.

The recognition payment is defined as a sum of money to recognise the clinical work that may have been completed previously in line with the Band 3 duties. Payment will be based on each staff members total length of service with a maximum service back to January 2021 being considered.

The estimated full costs for 2025/26 is approximately £0.850m, with the 'Recognition' payment being assessed at between £0.470m and £0.500m. As this is above the Health Board losses delegated limit a request to Welsh Government is being made to approve this payment.

NEXT STEPS:

Both of these amounts will be reported within the THB Annual Accounts for 2025-26 as part of the Losses and Special Payments notes.

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT



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Powys Teaching
Health Board

Agenda item: 5.1

Audit Risk and Assurance Committee		Date: 10 March 2026
Subject:	ANNUAL ACCOUNTS 2025/26 Timetable and Principles for the Financial Methodology and Approach at Year End	
Approved and presented by:	Executive Director of Finance, Capital Estates and Support Services	
Prepared by:	Deputy Director of Finance Assistant Director of Finance (Accounts and Services)	
Other Committees and meetings considered at:	None	
PURPOSE:		
The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an outline of the approach and principles to be adopted for completion of the 2025/26 Annual Accounts together with the planned approach to key financial areas		
RECOMMENDATION(S):		
The Audit Committee is asked to:		
- NOTE the content of this report; and take ASSURANCE a plan is in place to deliver the annual accounts and report; - NOTE the planned approach to accounting areas including use of estimates where needed as outlined within the paper.		
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:

The Health Board has a statutory duty to complete and submit Annual Audited Accounts to Welsh Government. This paper is to inform the ARA Committee of the work completed to date and the further steps required. Plus, the key methodology to be adopted in completing the Annual Accounts process.

DETAILED BACKGROUND AND ASSESSMENT:

The purpose of this paper is to update the Committee on the plans in place to close the Annual Accounts for the year ending 31 March 2026.

This paper outlines the timetable and key dates for delivery of the Annual Accounts.

NEXT STEPS:

Both of these amounts will be reported within the THB Annual Accounts for 2025-26 as part of the Losses and Special Payments notes.

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1. INTRODUCTION

- 1.1. The purpose of this paper is to provide the Audit Committee with a briefing on the plans in place to close the Annual Accounts for the year ending 31st March 2026.
- 1.2. As well as the timetable and key dates for delivery of the Annual Accounts this paper will also highlight key financial areas and the approach adopted in Powys on the assessment of these and the impact of this on the Annual Accounts.

2. BACKGROUND

- 2.1. A detailed and comprehensive closedown timetable with supporting guidance notes has been developed and made available to all staff within the Directorate via email. A meeting has been arranged with the team to go through it.
- 2.2. Once the final version of the Manual for Accounts is received, which is expected this month, this will be saved on a shared drive within the Directorate for staff reference as required.
- 2.3. The key dates and milestones from the main Annual Accounts Closure Timetable are summarised in the table below:

Annual Accounts Task	Deadline
Issue NHS Debtor Balance Statements to other NHS Wales bodies	2 April 2026
EASTER	3-6 April 2026
Sign off date for Agreement of NHS Wales Debtors & Creditors	10 April 2026
Issue Income transactions to NHS Wales bodies	10 April 2026
Sign off date for agreement of NHS Wales Income & Expenditure	20 April 2026
Finalise Health Board Outturn Position	13 April 2026
Close Health Board old year financial ledger	13 April 2026
Submit LMS to Welsh Government	21 April 2026
Preparation of draft Accounts Senior Finance Team review	24 April 2026
Submission of Draft Accounts to Welsh Government	1 May 2026 (noon)

Annual Accounts Task	Deadline
Submission of Draft Accountability Report and Performance Overview (including Remuneration Report) to Welsh Government	8 May 2026
Submission of Audited Accounts	30 June 2026 (noon)

- 2.4. To note these timescales are similar in comparison to 2024/25 due to the Audit Wales planned audit timescale remaining at the extended 2024/25 audit timeline previously communicated to all NHS Wales bodies. Details of this is included within the committee papers under the Audit Wales Audit Plan/Update.

3. GOVERNANCE AND RISK ISSUES

- 3.1. The Audit Committee meeting scheduled for Tuesday 12th May 2026, will receive the draft Annual Accounts, Accountability and Performance Report and the Remuneration Report.
- 3.2. A provisional meeting of the Audit Committee had been arranged 9th June 2026 but will require amending now that the audit timeline is not reducing as expected. This meeting will be to review the full audited statements and reports, with a Board meeting to formally adopt them scheduled for 24th June 2026. The deadline for submission of the approved audited accounts and associated reports to Welsh Government is indicated to be 30th June 2026.
- 3.3. In closing the accounts, the following key issues are drawn to the attention of the Committee and Audit Wales with regards to the general technical accounting treatment that will be employed by Powys Teaching Health Board in closing the draft annual accounts.
- 3.4. In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.
- 3.5. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.
- 3.6. The subsequent sections of this paper set out the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial

Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

A. CAPITAL ISSUES

i. De-recognition

The approach developed by the All Wales Technical Accounting Group (TAG) Capital Sub Group for use since 2009/10, is that PTHB will require revaluations from the District Valuer where schemes completing in-year have works costs exceeding £0.5m. Subject to completion of some schemes leading up to year-end there are two good housekeeping valuations that we anticipate will require revaluation this year at Llandrindod Hospital (to include Westdene and Spa Road) and Brecon Hospital.

As per Welsh Government Technical Update Note 2 there will also be a desktop valuation undertaken for capital expenditure that has not been subject to a formal valuation since the last quinquennial valuation undertaken in 2022. The intention of the desktop valuation, is that buildings additions for an NHS body are not carried at a value greater than the audit materiality level of the Statement of Financial Position either in a financial year or on a cumulative basis between quinquennial valuations, unless supported by revaluation evidence to include enhancing schemes identified as part of the desktop valuation review.

Any schemes that are recognised as enhancing schemes by the DV in the desktop valuation and those that do not fall under the above criteria will be treated as buildings additions and not impaired on recognition but depreciated during the periods between the quinquennial valuations.

ii. IFRS 16

International Financial Reporting Standard (IFRS) 16 Leases came into effect on 1st April 2022. It provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value.

This standard effectively changes the accounting treatment of some leases from revenue transactions (off balance sheet) to capital transactions (on balance sheet) and has resulted in a number of changes to the accounts content and format.

This note will continue to be updated to include new leases taken out and any change to existing leases since 1st April 2025.

B. PRIMARY CARE ACCRUALS

The format of the working papers for Primary Care Accruals will be the same as that used in previous years and will provide clear linkages and audit trails from the Annual Accounts back to the General Ledger.

i. GMS Enhanced Services

Given the timescales allowed for practices to claim Enhanced Services, some of the claims may not be received until the following years, therefore, the HB is required to estimate the final out-turn. The HB would review the latest claims from each practice for each enhanced service and estimate the final out-turn, by taking account of current or prior year trends (where seasonality impacts) on the given service. The accrual will be based on best estimates and information available at M12 and clearly identified in a working paper.

ii. GMS QIF (Quality and Improvement Framework)

Under the QIF scheme, GP Practices achieve a certain level of points and these are multiplied by £x value per point (varies depending on practice weighted list size) to establish the payments due.

iii. Pharmacy Contract

No changes are proposed for the approach to calculating the accruals from 2024/25. Estimates will predominantly be an adjusted straight line, which includes any adjustments for additional identified costs as part of the year-end review.

iv. Primary Care Prescribing

Information on Prescribing costs is available two months in arrears and, therefore, requires a level of estimation for year-end accruals. Historically, the Health Board has used the Prescribing Audit Report from NHS Wales Shared Services Partnership to support the estimation of year end accruals.

The Health Board has continued to utilise other NHS organisations estimates, and understand their prescribing patterns and trends, which has included the work of the NHS Business Service Authority in England, as well as dispensing days analysis undertaken by other Health Boards in Wales. This is analysed alongside other information to provide greater insight on high-cost areas, including CAT M, NCSO and DOACs.

The continued variable trend, month on month in 2025/26 has required the Health Board to add trend forecasting to the information identified above when calculating a position to forecast.

The Health Board will review these forecasting methodologies at the time of accounts closure together with any additional supplementary information available and together with its Chief Pharmacist will take a view of an appropriate accrual.

C. RETROSPECTIVE CONTINUING HEALTH CARE CLAIMS (OMBUDSMAN PROVISION)

i. Background

At the start of 2011/12, the PTHB Ombudsman Nursing team was disbanded and all cases received prior to 15th August 2010 (Phase 1), were transferred to the All Wales Retrospective Continuing Health Care Team hosted by Powys Teaching Health Board (Powys HB), to be managed using a standardised All Wales approach.

During 2014, the Welsh Government launched an advertising campaign to draw the public's attention to the cut-off date for retrospective continuing NHS health care claims relating to the period 1st April 2003 to 31st July 2013 (Phase 3). Claimants needed to register their intent to claim by 31st July 2014, and no later than 31st December 2014 (later extended by Welsh Government to 31st January 2015), to provide evidence of their right to make the claim and proof of fees paid to the care home or domiciliary agency. The intent to claim and the supporting documentation had to be submitted to the All Wales Retrospective Review Team within Powys HB.

Financial responsibility for all post 2003 claims, regardless of when they were received, rests with the Health Board and pre 2003 cases with Welsh Government.

During 2019/20, the All Wales Retrospective CHC team were disbanded and any remaining phase 2 and phase 3 claims which had not been settled reverted to the management of the Powys Teaching Health Board.

Further annual publicity campaigns have resulted in the ability to claim for periods post July 2013. For phase 4 and subsequent phases, the average success rate will be continued to be used to make a reliable estimate for probable claims based on the average weekly rate. All phase 4,5 & 6 cases have now been settled. As at 31st March 2026 a provision will be provided for the phase 7-9 claims, currently recording 7 cases.

D. REPORTING ISSUES

i) Pension 9.4%

The recent Department of Health and Social Care (DHSC) consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019/20 for employer contributions will continue in 2025-26.

A transitional approach was agreed with the Business Services Authority, whereby an employer rate of 20.68% will apply from 1 April 2019. However, from 2019-20 the Business Services Authority has only collected 14.38% from NHS Wales bodies. Central payments have been made by Welsh Government for the outstanding 6.3% on behalf of NHS Wales bodies. This central contribution was increased to 9.4% in 2024/25 and remains in 2025/26.

It is important that notional transactions are recorded in NHS Accounts to record the true costs of the pension contributions the bodies have incurred. Therefore, adjustments are made in the accounts for the 9.4% and a specific note is completed under Note 34 Other Information to explain the relevant accounting entries to the reader of the accounts. The amount to be included will be provided to the Health Board by Welsh Government but will be compared to the 14.38% contribution payable by Powys THB for reasonableness.

ii) Scheme Pays

In December 2019, Welsh Government confirmed that clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold would be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31st July 2021). The NHS employer would then make a contractually binding commitment to pay them a corresponding amount on retirement.

For the 2019/20 accounts no disclosure with regard to this policy was provided as the information to determine whether a provision or contingent liability was required was not available. For the 2020/21 accounts a narrative contingent liability note was disclosed detailing the scheme as insufficient information was available to support a provision. For the 2021/22 accounts a provision was required for the future costs of this commitment by NHS bodies. Welsh Government is working with the NHS Pensions Agency and Government Actuaries Department to identify the estimated costs for each health body and there will be a requirement for each health body to disclose a provision in the 2025/26 accounts. There will not be an impact to the financial performance of the Health Board as Welsh Government has advised that, as in 2024/25, the provision will be offset within the financial statement by a debtor to Welsh Government. This is similar to the process for the Welsh Risk Pool.

E. MOVEMENT IN OTHER KEY PROVISIONS

I. Early Retirement Pension Provision / Permanent Injury

There has been a further change in the Discount Factors to be applied in line with the draft Manual for Accounts issued by Welsh Government in December 2025. This directs health boards to use 2.95% this year (2.40% 2024/25). Together with a recent change in life expectancy will result in a financial cost increase of £0.027M this year.

PTHB also account for the permanent injury provision in respect of a former member of staff of Health Authorities which were reorganised into Health Boards in April 2003. This provision although not material within the THB accounts is funded by Welsh Government in the THB allocation letter and, therefore, any financial impact on movement of this provision year on year is covered by this funding. Together with a recent change in life expectancy will result in a financial cost increase of £0.002M this year which is slightly less than the funding provided.

II. Defence Fee Provision for Probability 3 (possible) Successful Legal Claims

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

As is the case for previous years, to comply with the requirements of IAS 37: Accounting for Provisions, Welsh Government has issued guidance regarding the accounting treatment of defence fees for legal claims where the chance of success is deemed as possible (6-49% chance of success).

For the defence legal costs provision of claims within the possible category, the obligating event is a claim being received in respect of Clinical Negligence or Personal Injury.

It is probable, when considering the possible claims as a cohort, that this obligating event may lead to a future transfer of economic benefit in that the organisation may incur some costs in investigating the alleged claim. Therefore, a provision is required for the possible claims as a cohort and for which a reliable estimate can be made based on local information held for similar cases. The estimate cannot be made reliably on a claim-by-claim basis; rather the analysis of historical information covering a three-year period is used.

The table below shows the prescribed accounting treatment to be applied for all claims based on their probability of success:

Probability of Success of Claim	Accounting Treatment
Certain 95-100% Success	<i>Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports</i>
Probable 50- 95% Success.	<i>Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports</i>
Possible 6-49% Success	<i>Defence Fee Provision Required – Provision to be based on the Welsh Health Legal Services quantum reports</i> - Organisations with numerous claims should base the provision on three years historical cost data. Note there may be different % values for clinical negligence and personal injury cases, and the % values will be calculated using the methodology agreed.
Remote 0- 5% success	<i>No provision or contingent liability required</i>

In 2023/24 the Health Board provided on the basis outlined in the table above with the percentages used to provide for probability 3 cases being 28% for Clinical Negligence cases and 56% for Personal Injury cases. This percentage was revisited in 2024/25 and has been revised to 48% for Clinical Negligence cases and 59% for Personal Injury cases and will remain for 2025/26 calculations. Based on the 3rd quarter

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quantum reports from Welsh Health Legal Services this has resulted in an increase in the provision of £0.316m. This figure may be subject to change as more recent quantum is received. The THB is responsible for the first £0.025m of any claim with the rest being underwritten by the Welsh Risk Pool.

PTHB also account for claims against the previous Health Authorities, which were reorganised into Health Boards in April 2003. These claims are fully managed by the Welsh Risk Pool on behalf of the THB. This provision although material within the THB accounts is fully funded by Welsh Risk Pool. Therefore, any financial impact on movement of this provision year on year is reimbursed to the Health Board via the Welsh Risk Pool so has no impact on the reported position of the Teaching Health Board.

III. Accounting for Redress Provisions

At the end of the 2018/19 financial year responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool. At the same time, Welsh Risk Pool changed the accounting requirement for redress cases from a cash basis to an accruals basis, therefore, requiring provisions to be included in the 2018/19 accounts for redress cases for the first time. This accounting treatment is again in place for 2025/26 with provisions for redress cases being included in the accounts based on estimated claim costs provided locally by the Concerns Team. Therefore, as at month 10 a provision of £0.168M is anticipated for this scheme in the 2025/26 year-end accounts. This amount may be subject to change based on the receipt of March 2026 quantum's but is not expected to be significant. As all payments made in respect of redress cases except for the claimant's legal costs (capped at £1,920) are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

IV. GP Indemnity Scheme

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GPs and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. To date the health board has received eleven claims under this scheme with six remaining ongoing. Therefore, as at month 10 a provision of £2.408M is anticipated for this scheme in the 2025/26 year-end accounts. This amount may be subject to change based on the receipt of March 2026's quantum. As all payments made in respect of such cases are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

F. Other Matters

i) Annual Leave

Historically, the Health Board has required all staff to utilise annual leave in full and so no annual leave accrual has been included within the Annual Accounts. However, 2020/21 and 2021/22 were unprecedented years and it was recognised that staff across all disciplines may not have had the opportunity to take their full annual leave entitlement. Therefore, a provision was included within the 2020/21 and 2021/22 Annual Accounts.

The Executive Team communicated in 2022/23 to the organisation that it was now reverting back to its policy and for all staff to utilise annual leave in full and so it is not anticipated that an annual leave accrual will be included within the Annual Accounts

ii) Continuing Health Care

The administration of CHC cases and the timely notification of changes to the Finance team was identified as a concern by the external auditors as part of the 2024/25 audit. Although the value of the CHC liability was considered to be materially correct, process changes were recommended to lead to improvements.

Overall, no changes are proposed for the approach to calculating the accruals from 2024/25. Accruals will be based on the NCCD maintained by the service. However, there has been significant work undertaken during 2025/26 to improve the recording of information since the findings of the 2024/25 ISA 260 report. A separate update document is provided within Appendix A to demonstrate progress made against the previously communicated action plan to address the weaknesses identified by the 2024/25 audit findings.

iii) Commissioning Contracts (note NCA no change)

The LTA arrangements are as follows:

- English Contracts – through the year an agreed cash value is paid to each provider monthly. However, as the contract is in the main on a cost per case agreement using the English Tariffs rates, work is required to estimate the impact of actual performance in the Annual Accounts using the most up to date information available. Final settlement of this creditor / debtor will not be resolved until early summer once the full MDS data has been received and reviewed in detail by the Health Board.
- Welsh Contracts - paid in year at an agreed value based on historic activity and financial values uplifted by an All Wales %. At the end of the year contract performance is agreed using a marginal rate and finalised prior to the end of the financial year as part of the intra NHS Balance Agreement process.

iv) Pay matters

Currently, on an All Wales basis, consideration is being given to whether the banding of some Health Care Support Workers is appropriate and in line with Agenda for Change. NHS Employers is co-ordinating this work on behalf of Health Boards and

Trusts. This exercise has concluded within Powys THB and has led to most ward based HCSW roles being moved from a Band 2 to a Band 3, which has translated into an increased cost. An element of the payment made to individuals is represented by a recognition payment and this will be defined as an ex gratia payment and, therefore, a loss and special payment in the region of of £0.470 to £0.500m. Due to value a request to Welsh Government to approve this loss is being made. It is expected the payments in respect of this exercise will be paid in the March 2026 payroll, however, if for any reason this does not happen an accrual for the actual will be created as a non NHS payable for the year end accounts.

v) Wye Valley NHS Trust Invoice

An invoice for £5m from Wye Valley NHS Trust was received in March 2025 in respect of 2024/25. It has the description "Recognition of discussions regarding parity of funding with English commissioners inc remoteness uplift, PFI and inflation".

The Health Board strongly refuted the charge and is awaiting backing information giving the rationale for the sum sought. The amount was not recognised as expenditure in 2024/25 and instead the issue was disclosed in the 2024/25 Annual Accounts as a contingent liability. An approach to the accounting treatment, which was accepted by the external auditors.

In 2025/26, Wye Valley NHS Trust has invoiced a further £8.1m in relation to the same issues. The Health Board continues to strongly refute the charge and is awaiting backing information giving the rationale for the sum sought.

The matter has been escalated to Welsh Government and the Trust has escalated the matter within the NHS England system. Welsh Government is supportive of the position taken by the Health Board.

As the year end approaches, the Trust has not rescinded the two sets of invoices. Therefore, the Health Board is in receipt of £13.1m worth of invoices, which it does not recognise. It is proposed that the matter will again be disclosed fully in the Annual Accounts and the amount of £13.1m included as a contingent liability.

4. REMOTE WORKING

It is anticipated that the Audit Team will be working remotely for the period of the audit. The THB finance department continue to work closely with the Audit Wales Team to make arrangements for information flow and communication methods to facilitate this and it is not anticipated that this approach will be detrimental to the delivery of the Audit.

The THB and Audit Wales teams, as in previous years, will utilise the Inflo software for provision of working papers and responses to audit queries.

5. RECOMMENDATIONS

5.1. The Audit Committee is asked to note and approve:

- a) The timetable, key dates and milestones for the submission of the Annual Accounts for 2025/26;
- b) the arrangements in place for the review and adoption of the Annual Accounts;
- c) the approach for accounting for capital issues;
- d) the approach for accounting for primary care accruals;
- e) the retrospective continuing health care claims;
- f) the anticipated movements in other key provisions;
- g) the approach to accounting for other specific matters. In particular, the accounting treatment of invoices from Wye Valley NHS Trust amounting to £13.1m.

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Appendix A – Continuing Healthcare

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

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

The timetable has been produced and communicated within the Finance Team and the operational CHC teams on a weekly basis and monthly meeting has taken place with operational team to assess and monitor progress in different areas.

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

A thorough review of Month 10 packages to identify the 1:1 packages not yet invoiced was produced and shared with operational services. The service is currently actively seeking confirmation that where no charges have been received from the providers that the care was not required and, therefore, no monies are due.

- **Invoices:** Service teams are to be more proactive with seeking missing invoices from suppliers. If PTHB is liable for the costs, then it is committed to pay. This will happen periodically and not just at year end. This will reduce the level of additional work required leading up to year end and improve the accuracy of the information in the system and the monthly forecasting.
- **Invoice Payment Failures:** PTHB failed to meet its PSPP target of paying invoices within 30 days, with 40% of delayed payments linked to CHC. This impacts supplier relationships, especially in the care home sector. Working on the time delays in which invoices enter the organisation and

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

There was an improvement in November following additional hours being worked by CHC and finance team members to undertake the backlog delay in processing. Working additional hours was not sustainable by team members. A recruitment for additional capacity has taken place. However, the successful applicant was unable to start until late February 2026. Due to the capacity issues above there continues to be some delay experienced with the processing of invoices.

The Finance team has undertaken a statement review to ensure that the full extent of invoices raised for CHC packages of care are within the organisation and a list is held and chased on a regular basis.

Public Sector Payment performance for Continuing Healthcare payments 2025-26 year to date

	Total		% over 30 days	
	Number	Value	Number	Value
April	293	2,657,626.55	51.19%	56.32%
May	427	3,363,368.25	49.41%	56.97%
June	374	2,380,003.86	55.08%	60.44%
July	419	3,373,728.17	54.42%	63.12%
August	440	3,252,501.54	51.14%	54.89%
September	448	2,832,819.19	52.90%	53.49%
October	488	3,963,937.30	51.43%	49.34%
November	461	3,397,220.00	36.66%	43.23%
December	540	3,835,858.15	49.44%	41.07%
January	337	2,342,708.52	47.18%	45.51%
	4,227	31,399,771.53	49.75%	52.06%

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

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

• **Relationships:** Working on relationships with Powys County Council. This involves clearing old year disputes. Work is already underway to remove these. This includes the proposal of PCC Funds Flow Form Review. CHC

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team to review and gather feedback on implementation and necessary amendments before responding to PCC.

The CCAP's framework will continue an extended 12 month payment to the end of 2026/27. A review of future provision beyond this date is on going. From the end of June 2025 to the last statement from Powys County Council, received on 16th January 2026, the amount of aged debt relating to CHC had reduced from £0.563M to £0.138M. Of the remaining amount £0.012M is currently with PTHB for action and the remaining £0.126M is awaiting action from PCC.

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

Following a thorough review of all packages of care at month 10 closedown a list of packages awaiting invoices was shared with the council. This amounted to 92 lines (note some lines were repeated for the same patient but different period timescales were outstanding). This also included activity periods prior to 25/26. As at the writing of this paper the THB has received responses from PCC and the Finance and Operational teams are assessing the responses.

Learning Disability: Additional reviews and the involvement of clinical teams to ensure accurate assessments due to complex nature and joint packages. Potential using the new proposed Funds Flow Form with Powys County Council to ensure initial agreement on splits to ensure timely updates of NCCD & invoicing is clear. The Use of the Funds Flow Form is welcomed and will be implemented from 1st April 2026 in line with the introduction of a new finance system at Powys County Council.

- **Domiciliary Care:** CHC team have been working with Local Authorities on their frameworks in 25/26, to use the approved providers. This ensures Rural and Town rates match. This allows invoices to be paid on a more timely basis as rates are agreed and known by the team reducing the number of queries and any time delays.

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

We have started to develop joint brokerage work with PCC and adopted their DPS (albeit informally). This has had a positive impact on cost efficiency for community patients receiving packages of care at home, by using the same providers as the Council and staying within the PTHB DPS has supported consistency and market stability.

- **Statements:** This is a finding from completing the additional audit work. In most cases it was identified that the homes are on top of their invoicing and send them to PTHB in a timely manner but there was a delay in them

being processed by operational CHC service teams. Statements are to be requested from our suppliers and that the support team in Finance review these periodically following the current process with Agency suppliers. (as we do with Agency providers). CHC team will be responsible for requesting any missing invoices.

During January 2026 the finance team requested statements from all care providers and the majority of these have been received and analysed. There remains a small number of providers who have yet to produce a statement and the THB Finance team are chasing for this on a regular basis.

Backlog of processing invoices from CHC to Finance/NWSSP

- **Recording Data on NCCD:** Commitment by Nurse Assessors and CHC admin teams to ensure data is recorded in a timely manner. Recent additional work has been undertaken by allowing additional bank shifts and cross cover in the team to update the NCCD and includes recording of new packages and passing invoices for processing and payment. The need to ensure no single points of failure has been identified.
- **Administrative Constraints:** Delays in CHC processing experienced at the year end were impacted by the capacity of the admin team. Investment in this area is critical to meet service demands together with these audit recommendations and improve financial performance.

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

A recruitment for additional capacity of 1.0 wte has taken place, however, due to notice period the successful applicant was unable to start until late February 2026. Wider review of CHC operational teams has been paused whilst the outcomes of the recent Grant Thornton report were received. The recommendations made are currently being assessed.

Year End and the time to reflect on accruals added

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

It has been implemented with operational teams that pending packages are indicated in the NCCD, which is able to be extracted in the form of a report and a review of these

is undertaken frequently. A judgement will be made on all pending packages at year end based on the most up to date information held at that time as cases are not formally activated on NCCD until the required governance has been met to activate the case.

- **Materiality:** Finance team to look at both credit and debit balances at year end. It is not possible to look at all the debit balances at year end due to number of cases and time constraints. This review will be based on materiality or top twenty. Based on 24/25 accrual values per case over £50K would be fourteen packages, over £25K 53 packages over £20K 74 packages over £10K would 175 packages. This would be on top of the current review of credit balances and debit balances under £500 to reduce immaterial accruals on the balance sheet. Finance will complete an analysis prior to year end of any balance where invoices are outstanding to NCCD YTD £s.

From the Month 10 shutdown position the Finance team have reviewed all packages that are showing positive or negative balances difference of £1k against the indicated care package costs and invoices chased where missing on a priority of largest variance balance downwards. Alongside this a thorough review of all outstanding liabilities from 24/25 financial year end (mostly PCC and covered by exercise above) and communications with both the service and care provider undertaken to ensure resolved by end of financial year.

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

The monthly meetings for the last quarter of the year have been undertaken with both Finance and Service present. Discussion points include looking at outstanding queries for all financial years, ensuring NCCD is up to date and looking at packages where no invoices have been received year to date. This has all been fed into the weekly timetable that Finance issue out.

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

Work in this regard has been outlined above and significant resource within the Finance Department will continued to be focussed on this area as the financial year end approaches. The statement exercise referred to above will continue to year end to ensure the correct categorisation of liabilities as non NHS payables

for care costs that a formal invoice has been raised or an accrual where the cost is expected but no invoice has been received.

The current position against the previously communicated action plan is as follows:

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

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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Addysgu Powys
Powys Teaching
Health Board

Agenda Item: 5.2

Audit, Risk and Assurance Committee		10 March 2026
Subject:	Internal Audit Progress Report	
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary Ian Virgil, 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 the proposed adjustments to the 2025/26 plan.		
Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

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

The following audit reports have been finalised since the January 26 meeting of the Committee:

- Catering Services – Food Safety Standards (Substantial Assurance)
- Clinical Supervision (Reasonable Assurance)
- Anti-Racism Action Plan (Reasonable Assurance)
- Policy Management (Reasonable Assurance)
- Deprivation of Liberties Safeguards Follow-up (Assurance Not Applicable)

The full copies of the reports are also included as a separate item within the agenda.

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

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

BACKGROUND AND ASSESSMENT:

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

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

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

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

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

NEXT STEPS:

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

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Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
March 2026

NWSSP Audit and Assurance Services



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



GIG
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WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board



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1. *Introduction*

2. *Assignments with Delayed Delivery*

3. *Outcomes from Completed Audit Reviews*

4. *Delivery of the 2025/26 Internal Audit Plan*

5. *Changes to the 2025/26 Plan*

3

3

3

4

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Appendix A

Appendix B

Appendix C

Appendix D

Assignment Status Schedule

Report Response Times

Key Performance Indicators

Assurance Opinions

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1. Introduction

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

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

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

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
North Powys Integrated Wellbeing Hub	Draft Report	TBC	Delay in agreeing the draft report due to ongoing discussion and required amendments.
Estates Assurance Asbestos Management	Draft Report	TBC	Delay in completion of fieldwork due to availability of Internal Audit resources.
Mortality Reviews	Work in Progress		Management request to pause fieldwork due to absence of lead contact.

3. Outcomes from Completed Audit Reviews

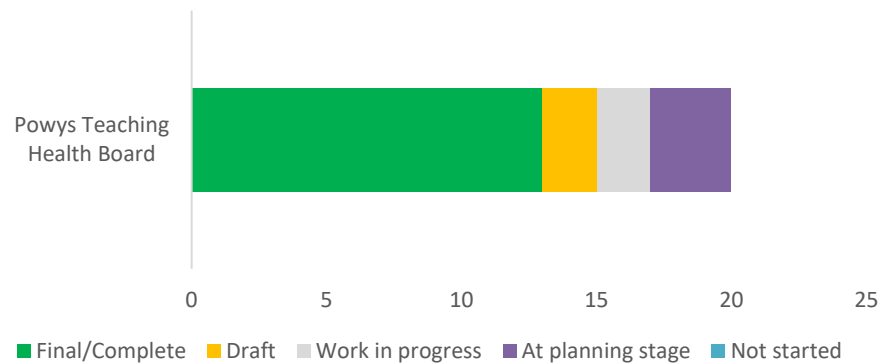
Five assignments from the 2025/26 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The full versions of the reports are included in the committee’s papers as a separate agenda item.

FINALISED AUDIT REPORTS		ASSURANCE RATING	
Catering Services – Food Safety Standards	Substantial		
Clinical Supervision	Reasonable		
Anti-Racism Action Plan			
Policy Management			
Deprivation of liberties Safeguards Follow-up	N/A		

4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 20 reviews included within the 2025/26 Internal Audit Plan (including the changes highlighted below), and overall progress is summarised below.



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

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

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

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

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

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

5. Changes to the 2025/26 Plan

- Systems Discretionary Capital – Proposed for deferral to the 2026/27 plan due to a shortage of Internal Audit resources to enable delivery. Deferral has been agreed with the Associate Director of Capital, Estates and Facilities.
- Community Care – Proposed for deferral to the 2026/27 plan due to a change of scope to focus on Care at Home Services. The deferral has been agreed with the Executive Director of Primary, Community Care & Mental Health.
- Site Co-ordination – Proposed for deferral to the 2026/27 plan due to an on-going management refresh of the processes in place. Deferral has been agreed with the Associate Director of Capital, Estates and Facilities and the Chief Executive.
- Mattresses Follow-up – Proposal to add a follow-up of the 2025/26 Limited Assurance audit of Mattresses into the 2026/27 plan as it had been previously omitted.

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ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2024/25 Plan								
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.		Primary, Community Care and Mental Health	3		Planning		May
2025/26 Plan								
Duty of Candour	To consider the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.	22	Nursing, Quality, Women & Family Health	2		Final Report	Reasonable	October
Digital Systems Uptake	To review the level of uptake and utilisation of digital systems once they have been introduced.	20	Allied Health Professions, Health Sciences & Digital	1		Final Report	Limited	January
Continuing Healthcare	To review recent changes / future plans within the Health Board around addressing the current level of cases and costs associated with CHC, including a focus on the placement review process.	10	Primary, Community Care & Mental Health	2		Final Report	Reasonable	January
Staff Development Programmes	Review of the processes for developing and delivering staff development programmes, linked into Management Charter / Compassionate Leadership.	16	People, Culture & Transformation	2		Final Report	Substantial	January
MH and LD Triage and Assessment Process	Review of the new Single Point of Access Triage and Assessment Model for Mental Health Services in PTHB. Linked to anticipated reduction in need for agency staff and impact on variable pay.	11	Primary, Community Care & Mental Health	1		Final Report	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Core Financials	Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management / Accounts Receivable / Capital Asset Management.	04	Finance, Capital & Support Services	3		Final Report	Reasonable	January
Primary Care Clusters – Project Management	How are the project management processes working to enable implementation of developments.	13	Primary, Community Care & Mental Health	3		Final Report	Substantial	January
Decontamination	Review of the Health Board's structures and processes for decontamination of equipment, to ensure compliance with standards and legal requirements.	23	Nursing, Quality, Women & Family Health	4	3	Final Report	Reasonable	January
Clinical Supervision	Establish the level of compliance with the Health Board's Clinical Supervision Policy across staffing groups. Focus on frequency / quality of supervision and quality of recording.	18	Allied Health Professions, Health Sciences & Digital	2		Final Report	Reasonable	March
Catering Services – Food Safety Standards	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.	09	Finance, Capital & Support Services	3		Final Report	Substantial	March
Deprivation of liberties Safeguards Follow-up	Follow-up of 2024/25 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	21	Nursing, Quality, Women & Family Health	2	4	Final Report	N/A	March
Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	02	Corporate Governance / Board Secretary	3		Final Report	Reasonable	March
Anti-Racism Action Plan	Review of delivery against the Health Board's Anti Racism Plan.	17	People, Culture & Transformation	4		Final Report	Reasonable	March
North Powys Integrated Wellbeing Hub	To evaluate the processes and procedures put in place by to support the management and control arrangements	07	Finance, Capital & Support Services /	3		Draft Report	TBC	March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
	applied to deliver the project through to the Submission of the FBC.		People, Culture & Transformation					
Estates Assurance Asbestos Management	To evaluate the controls and practices in place to ensure that the key asbestos regulatory requirements are adequately addressed, and appropriate management arrangements were embedded within the organisation.	05	Finance, Capital & Support Services	3		Draft Report	TBC	May
Budget Setting	To review how the Health Board sets delegated budgets to meet its agreed financial plan.	03	Finance, Capital & Support Services	3		Work in Progress		May
Mortality Reviews	Review of processes for dealing with deaths that are referred back to the Health Board by the medical examiner for further review.	24	Medical	3		Work in Progress		May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance / Board Secretary	4		Planning final brief issued		May
Vaccine Storage	Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.	25	Public Health	4		Planning final brief issued		May
Mattresses Follow-up	Follow-up of 2024/25 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	25	Allied Health Professions, Health Sciences & Digital	4		Planning		May
Reviews removed from the plan								
Route Map to Sustainability	Advisory review of the plans and processes in place for the development of the Health Board's Route Map to Sustainability.	15	People, Culture & Transformation	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board. Agreed by October ARAC				
Strategic Commissioning	Review of commissioning processes with focus on developments around strategic	14	Planning, Performance & Commissioning	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board. Agreed by October ARAC				

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
	nature of commissioning, linked to affordability for Powys.							
Digital Operating Model & Strategy	Review of the Health Board's new Digital Operating Model following previous Section 33 arrangements being brought in-house.	20	Allied Health Professions, Health Sciences & Digital			Removed due to duplication of coverage with the Structured Assessment Deep Dive into Digital Systems undertaken by Audit Wales. Agreed by January ARAC		
Systems – Discretionary Capital	To obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated discretionary capital funds.	06	Finance, Capital & Support Services			Deferral due to a shortage of Internal Audit resources to enable delivery. To be agreed by March ARAC		
Community Care	Review of how different teams within the community are working together for care of the patient.	12	Primary, Community Care & Mental Health			Deferred due to a change of scope to focus on Care at Home Services. To be agreed by March ARAC		
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	08	Finance, Capital & Support Services			Deferred due to an on-going management refresh of the processes in place. To be agreed by March ARAC		

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REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Duty of Candour	Reasonable	Final	12/09/25	03/10/25	26/09/25	26/09/25	G
Continuing Healthcare	Reasonable	Final	30/09/25	21/10/25	21/10/25	21/10/25	G
Digital Systems Uptake	Limited	Final	02/10/25	23/10/25	29/10/25	29/10/25	R
Staff Development Programmes	Substantial	Final	15/10/25	05/11/25	27/10/25	27/10/25	G
Decontamination	Reasonable	Final	08/12/25	31/12/25	16/12/25	16/12/25	G
Primary Care Clusters – Project Management	Substantial	Final	03/12/25	24/12/25	18/12/25	18/12/25	G
Core Financials – General Ledger Management & Accounts Receivable	Reasonable	Final	09/12/25	02/01/26	19/12/25	19/12/25	G
MH and LD Triage and Assessment Process	Reasonable	Final	04/12/25	29/12/25	29/12/25	05/01/26	G
Clinical Supervision	Reasonable	Final	19/12/25	14/01/26	28/01/26	28/01/26	R
Catering Services – Food Safety Standards	Substantial	Final	23/01/26	13/02/26	13/02/26	13/02/26	G
Deprivation of liberties Safeguards Follow-up	N/A	Final	12/02/26	05/02/26	16/02/26	16/02/26	G
Anti-Racism Action Plan	Reasonable	Final	06/02/26	27/02/26	25/02/26	25/02/26	G
Policy Management	Reasonable	Final	18/02/26	11/03/26	26/02/26	26/02/26	G

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KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	May 2025	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	A	69% 11 from 16	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 15 from 15	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	85% 11 from 13	85%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 13 from 13	95%	v>20%	10%<v<20%	v<10%

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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 / Not Appropriate	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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Clinical Supervision

Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTH-2526-18

October - December 2025

28 January 2026

10 March 2026

Director of Allied Health Professions, Health
Science and Digital

Ian Virgil, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit

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Executive Summary

Purpose

Our review of Clinical Supervision was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

The Health Board updated their Clinical Supervision and Reflective Practice Policy in May 2025. Our audit focused on the level of compliance with the Health Board's Clinical Supervision Policy across relevant staffing groups, the frequency of supervision meetings and the quality and recording of supervision meetings.

Overview

We have concluded **reasonable** assurance on this area. During the audit we were not provided with access to individuals records to review clinical supervision session notes as management felt this could be interpreted as a breach of trust. Our Testing was therefore undertaken through a survey sent to all Psychology and Therapies staff that should be in receipt of clinical supervision. The findings identified and assurance provided are therefore largely based on the results of the survey responses received.

The significant matters requiring management attention are:

- The frequency of Clinical and Live supervision sessions is not in line with the clinical supervision policy for all supervisees.
- Clinical supervision sessions are not being adequately recorded for all supervisees.
- The take up by clinical supervisors of clinical supervision training courses offered by the Health Board is very low.

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

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	Clinical supervision meetings are held at least quarterly and live supervision annually in line with the Clinical Supervision policy for all relevant clinical staff.		1	Reasonable
2	Supervision is adequately recorded and includes clear objectives and outcomes, and the type of supervision (Management Supervision; Clinical Supervision; Professional Supervision) and approach (one to one; triparty; Group; Peer Group) is appropriate.		2	Reasonable
3	The frequency and quality of clinical supervision meetings is monitored, and action is taken where issues are identified.		-	Substantial
4	Supervisors are adequately trained.		3	Reasonable

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Management Actions

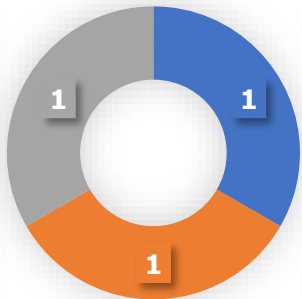


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Performance Monitoring
- Training & Development

Risk Types

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: Clinical supervision meetings are held at least quarterly and live supervision annually in line with the Clinical Supervision policy for all relevant clinical staff.

Reasonable

Overview / Summary of Observations

The clinical supervision policy is up to date and clearly sets out the clinical supervision requirements for all relevant staff. The policy is readily available to all Health Board staff via the PTHB SharePoint site, and awareness of the requirement for clinical supervision is being actively promoted by line managers and clinical supervisors.

At the time of our audit there was no central record of clinical supervision or annual live supervision sessions held or planned. Testing identified that quarterly clinical supervision is being undertaken regularly, and in many cases more often than quarterly, but sessions are timetabled in individual's diaries rather than in a central record which is acceptable given the volume of sessions being undertaken. Testing did however identify that live supervision is not being undertaken annually for all staff, and a small number of Therapies staff were not receiving clinical supervision at least quarterly.

Key Findings		Risk & Impact	Agreed Management Action
1	Frequency of Supervision Not all staff are receiving live supervision annually and clinical supervision quarterly as required by the Clinical Supervision Policy. Testing of a sample of 28 Therapies staff identified that annual live supervision was not being received by 11/28 staff (40%), and 3/28 (10%) were having clinical supervision less frequently than quarterly. Testing of a sample of 30 Psychology staff identified that all were receiving clinical supervision quarterly or more frequently. However, testing of a reduced sample of 17 Psychology staff identified that annual live supervision was not being received by 12/17 staff (70%).	Clinical supervision is not undertaken in accordance with the clinical supervision policy and fails to meet the needs of supervisees.	Agreed Action: 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.
		High Priority	Expected Evidence of Implementation: Increased compliance with the requirements of the clinical supervision policy.
	Theme: Performance Monitoring	Control Operation	Officer: Christopher Hartwright, Head of Psychology. Victoria Deakins, Head of Therapies & Health Sciences Target Implementation Date: April 2026

Objective 2: Supervision is adequately recorded and includes clear objectives and outcomes, and the type of supervision (Management Supervision; Clinical Supervision; Professional Supervision) and approach (one to one; triparty; Group; Peer Group) is appropriate.

Reasonable

Overview / Summary of Observations

The Clinical Supervision Policy requires sessions to be recorded by the supervisee in a format that includes SMART goals and actions that will be reviewed at future supervision sessions, with a copy being retained by the supervisee on their CPD file. Although not mandatory, the policy includes a template for recording sessions that should be signed off by both the supervisee and supervisor. The policy also recommends that each supervisee has a Clinical Supervision contract with the supervisor and completes a standard Supervision Checklist when setting up sessions. The supervisee must also ensure that each session is recorded in ESR.

As we were not able to access individual’s clinical supervision records, compliance with the above requirements was tested via a survey sent out to Psychology and Therapies supervisees. The survey was completed by 30 Psychology supervisees and 28 Therapies supervisees. All staff that responded to the survey were receiving clinical supervision on a one-to-one basis, with some also taking part in group sessions. In most cases responses indicated that goals and actions were being set. However, supervision notes were not being kept by all supervisees. Where notes were being kept, most were not using the template from the Clinical Supervision Policy. There was also limited use of the standard Clinical Supervision contract and checklist, and not all sessions were being recorded on ESR.

As we were not given access to review supervision notes, we were unable to assess if clinical supervision sessions included the setting of clear objectives and outcomes.

Key Findings		Risk & Impact	Agreed Management Action
2	Recording of Clinical Supervision Sessions Our survey identified that: - 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%).	Clinical supervision is not undertaken in accordance with the clinical supervision policy and fails to meet the needs of supervisees.	Agreed Action: Awareness sessions will be run for supervisors and staff receiving clinical supervision to help improve compliance with the clinical supervision policy.
			Expected Evidence of Implementation: Increased compliance with the requirements of the clinical supervision policy.

	Sessions were being recorded in ESR for 25/30 Psychology supervisees (83%) and 18/28 Therapies supervisees (64%).		
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Operation	Officer: Christopher Hartwright, Head of Psychology Victoria Deakins, Head of Therapies & Health Sciences Target Implementation Date: April 2026

Objective 3: The frequency and quality of clinical supervision meetings is monitored, and action is taken where issues are identified.

Substantial

Overview / Summary of Observations

There is no central record of clinical supervision meetings held or planned, but the frequency of clinical supervision meetings is being monitored by clinical supervisors on an individual basis. We were informed that this is also being done by line managers through the PADR process, although we were unable to verify this.

Testing identified that clinical supervision was being undertaken at least quarterly for most supervisees, and many were receiving supervision more frequently than this. It was also encouraging that overall, 55/58 respondents to our survey were happy that clinical supervision was meeting their development needs and they were happy with the clinical supervision they were receiving.

Many respondents also provided constructive comments about the clinical supervision they were receiving, and these have been shared separately with Senior Management and could be used to further improve the quality of clinical supervision.

Powell, Bethan
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Overview / Summary of Observations

Training needs should be identified during supervisor's PADR and feed into the relevant service training plan. The clinical supervision policy requires supervisors to be adequately trained and recommends they undertake a number of training courses that are offered by the Health Board.

A sample of clinical supervisors was selected to ascertain if they had attended any of the clinical supervision training provided by the Health Board as specified in the Clinical Supervision Policy. For the sample tested, the majority of staff with clinical supervision duties had received suitable training outside of the Health Board, but the take up of the Clinical Supervision courses provided by the Health Board was very low. Clinical supervision may be improved by raising awareness of the availability of these courses so more clinical supervisors undertake the specific courses provided by the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
3	Clinical Supervisor Training 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.	Supervisors may not be adequately trained.	Agreed Action: 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.
			Expected Evidence of Implementation: Increased numbers of staff attending the training courses.
	Theme: Training & Development	Medium Priority Control Operation	Officer: Christopher Hartwright, Head of Psychology Victoria Deakins, Head of Therapies & Health Sciences Target Implementation Date: April 2026

Powell, Bethan
05/03/2026 16:28:03

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.

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.



Anti-Racism Action Plan

Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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Review Reference	PTH-2526-17
Fieldwork	January 2026
Executive Sign Off	25 February 2026
Audit Committee	March 2026
Executive Lead	Debra Wood-Lawson, Executive Director of People and Culture
Audit Team	Ian Virgil, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit

Powell Bethan
05/03/2026 16:28:03

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

The purpose of our review was to assess the systems and processes in place for implementation and embedding of the Health Board Anti-Racism Action Plan.

Overview

In June 2022, the Welsh Government published its Anti-Racist Wales Action Plan, setting out Wales-wide objectives to incorporate anti-racist principles into the public sectors services and employment practices. Under the plan, public sector organisations are required to develop local action plans showing how they will work to achieve the various Wales-wide objectives locally over the timescales identified in the plan.

The Anti-Racism Action Plan is published on the Health Board's website and covers the period 2024-26. This has been shared with the Health Board's Minoritised Ethnicity Staff Network and the Workforce Policy Review Group which facilitates Trade Union input into the process. The plan has also been written to ensure alignment with the Welsh Government Anti-Racism Plan. The Anti-Racism Action Plan is owned by the Equality Team within the People and Culture Directorate and feeds into the Health Board's Strategic Equality Plan.

In the 2021 census, 94.9% of the population of Powys described their Ethnicity as White (Welsh, English, Scottish or British), rising to 97.7% when including all other White groups (including Irish, European and all Traveller groups). These figures are among the highest in Wales and correspondingly the proportion of the population identifying as Black, Asian or other non-white groups is one of the lowest in Wales at just 2.2%, compared to 6.2% for the whole of Wales. As of 31st March 2025, the Electronic Staff Record reports 3.7% of staff (a total of 96 individual staff members) identified as Black, Asian, mixed-race, or other non-white ethnic Minorities, or specified their ethnic group as 'other'. A further 55 staff identified as White but of non-UK or Irish ethnicity, and 185 were unknown.

Our review has noted that work to date has largely focused on validating the current position for the Health Board and understanding the reasons for any apparent outliers in reported information. However, good progress has also been made in the areas of training, recruitment, and in reviewing local policies to ensure that they are inclusive. The Health Board should now be in a position to drive forward further actions outlined in the plan.

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

- The Action Plan contains several actions that appear significantly overdue against the target completion date but are shown as still being on track.
- Reporting on progress of the Action Plan is to the People & Culture Committee but currently this is only formally scheduled annually.
- The Black, Asian and Ethnic Minority Network currently lack sufficient numbers, and require a more formal approach to enable it to play a key role in helping to take the actions forward.
- Communication of the Action Plan and events designed to support its messages have been limited to date.

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 Anti-Racism Action Plan in place that has been approved and endorsed by the Board.	-	Substantial
2	Actions to achieve the Anti-Racism Action Plan have been documented and progress is monitored by the Board and/or an appropriate Committee.	1,2	Reasonable
3	Work has been undertaken, through training and communications, to embed the requirements of the Anti-Racism Action Plan across the Health Board.	3,4	Reasonable
4	The Health Board's Integrated Medium-Term Plan and other strategic documents reflect the requirements of the Anti-Racism Action Plan.	-	Reasonable

Management Actions

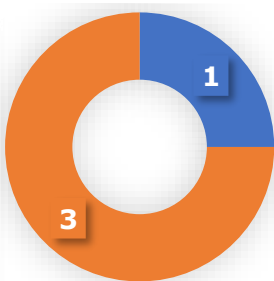


High Priority



Medium Priority

Themes



■ Communication & Engagement

■ Governance

Risk Types

Legal & Regulatory Non-Compliance

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Findings & Agreed Action Plan

Objective 1: The Health Board has an Anti-Racism Action Plan in place that has been approved and endorsed by the Board.

Substantial

Overview / Summary of Observations

The Anti-Racism Action Plan was approved at the Board meeting held on 29 January 2025 and the minutes of the meeting confirm the approval. Questions were asked by the Board on whether a Minority Ethnic Staff Network had been established. It was confirmed that this group was in place but that the Network was low on numbers. The plan had been shared with members of the network, and a wider Teams group that included just under 20 members from a minority ethnic background, but no comments on the plan were received. The Board also confirmed that detailed scrutiny of the plan would be via the Workforce and Culture Committee (now retitled the People and Culture Committee).

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Overview / Summary of Observations

The Anti-Racism Action Plan was last updated in November 2025 and will be updated again in order to be submitted to the next People & Culture Committee meeting in March 2026. Work to date on the plan has largely focused on validating the current position and the reasons for it rather than introducing proactive actions to address it. However, the Health Board now has a range of training courses to educate staff in adopting an anti-racist approach, and recruitment practices and local policies have been reviewed to ensure that they are fair and inclusive. Review of the status of the specific actions within the plan did highlight some discrepancies where the status of the action was shown as on track, despite the target date for completion being apparently overdue.

As noted above, reporting of progress against the Action Plan should be to the People & Culture Committee but this only happened last in March 2025, and the plan is next due at the Committee in March 2026. The December 2025 meeting of the Committee did include a deep dive into the results of a specific piece of work linked to the plan and the situation can be complicated by a crossover with reporting against the Strategic Equality Plan and other Equality and Diversity initiatives.

Key Findings		Risk & Impact	Agreed Management Action
1	Updating of Actions 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. Powell, Bethan 05/03/2026 16:28:03	The Action Plan does not provide an accurate picture of the current position with required actions.	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.
			Expected Evidence of Implementation: Updated Action Plan
	Theme: Governance	Medium Priority Control Design	Officer: Service Lead for Welsh Language & Equalities Target Implementation Date: March 2026

Key Findings		Risk & Impact	Agreed Management Action
2	Reporting to Committee Reporting of the Action Plan should primarily be through the People & Culture Committee. The Plan was taken last to the Committee in March 2025 and is scheduled to be reviewed again in March 2026. A deep dive into a major piece of work relating to one of the actions was also received by the Committee in December 2025. Reporting on the plan is complicated by a degree of crossover with other reporting regimes – notably the Strategic Equality Plan and Workforce Futures; Theme 4 – Welsh Language, Equality, Diversity and Inclusion. In addition, the People Update Report from the Director of People & Organisational Development which is reported to each Committee, includes a section on Welsh Language and Equalities.	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.
			Expected Evidence of Implementation: People & Culture Committee Reports
		Medium Priority	Officer: Service Lead for Welsh Language & Equalities / Director of People, Culture & Transformation
	Theme: Governance	Control Design	Target Implementation Date: April 2026

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Overview / Summary of Observations

The Health Board is aware of the need to go further in embedding the Anti-Racism actions into the daily operation and culture of its work. Although the introduction of a number of training courses is recognised as a good start, work to date has largely focused on validating and investigating the reasons for any apparent discrepancies or variations in the care, treatment and career rewards and opportunities of BME staff when compared to white staff. A priority for the Health Board in the coming year is to undertake a targeted study of its BME staff’s views on their career using qualitative, in-depth interviews to best understand the experience and aspirations of BME staff, and the challenges they face.

The role of the Ethnic Group Network is fundamental to the successful embedding of the actions in the Anti-Racism Plan. Currently there are only three members of the Network and although the Network is now meeting on a reasonably regular basis, the low membership and the lack of any formality to its current arrangements restricts the opportunity to contribute to taking the actions in the Anti-Racism Action Plan forward.

Communication on the Anti-Racism Action Plan and approach to date have been largely limited to a news post on the staff intranet when first launched. One of the actions in the Action Plan is also to "Provide an ongoing program of events providing staff at all levels with opportunities to hear about the lived experience of individuals from Black, Asian and Minority Ethnic background to include for example, Equality Week, Refugee Week, Black History Month". As at November 2025 this is shown as on-track and ongoing, but our review has only identified links to events that are being delivered externally, rather than the Health Board having its own programme of events.

Key Findings		Risk & Impact	Agreed Management Action
3	Black, Asian and Minority Ethnic Staff Network Currently the Black, Asian and Minority Ethnic Staff Network has only three members and although meetings are now being held on a more regular basis, there is no formal structure to the role and remit of the Network. We acknowledge that membership of the Network is voluntary and that the BME population across the Health Board is comparatively very low. We also acknowledge that efforts have been made to promote interest in, and membership of, the Network by the Health Board. Powell, Bethan 05/03/2026 16:28:03	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.
			Expected Evidence of Implementation: Increased membership (or ability to evidence active promotion of the network) and formality of Network.
	Theme: Governance	Medium Priority	Officer: Service Lead for Welsh Language & Equalities Target Implementation Date: June 2026

Key Findings		Risk & Impact	Agreed Management Action
4	Communications and Events 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.	The Health Board is unable to demonstrate that it is actively and regularly promoting an anti-racist approach and culture.	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.
			Expected Evidence of Implementation: A plan of regular communications and programme of events (including some delivered by the Health Board).
	Theme: Governance	Medium Priority Control Design	Officer: Service Lead for Welsh Language & Equalities Target Implementation Date: June 2026

Powell Bethan
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Objective 4: The Health Board's Integrated Medium-Term Plan and other strategic documents reflect the requirements of the Anti-Racism Action Plan.

Reasonable

Overview / Summary of Observations

There is evidence of the key messages and actions from the Anti-Racism Action Plan featuring in key Health Board plans and documents. In addition, one of the specific actions in the Action Plan has been to introduce an anti-Racism Checklist which has been used to audit all local policies.

However, the degree of specific and explicit reference is limited by other plans and initiatives which target similar areas such as the Strategic Equality Plan, and also that much of the detailed work on inequalities and inclusion has focused on disabilities, neurodiversity, women and the elderly.

While these measures should benefit all staff, no matter their ethnic background, it is anticipated that as the measures in the Anti-Racism plan become better embedded across the Health Board, the read-across from the plan to other key documents should become more explicit. As this is an action that the Health Board is taking forward, we have not raised a separate finding.

Powell, Bethan
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Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
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Prioritisation of Findings

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

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Policy Management

Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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Review Reference

PTH-2526-02

Fieldwork

January - February 2026

Executive Sign Off

26 February 2026

Audit Committee

March 2026

Executive Lead

Helen Bushell Director of Corporate Governance/Board Secretary

Audit Team

Ian Virgill, Head of Internal Audit
Lucy Jugessur, Deputy Head of Internal Audit



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Executive Summary

Purpose

The review of Policy Management was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

Overview

The core element for a robust governance framework includes well-developed policies and procedures that help inform decisions by providing a structured framework, ensuring consistent application of rules and procedures across an organisation. Control documents, such as policies and procedures help to streamline processes, clearly define accountability, reduce ambiguity, and support compliance with regulations and best practices.

Policies describe the organisation's guiding principles that underpin decisions, behaviours and the actions undertaken. Procedures and other written control documents should aim to translate these principles into more detailed instructions or guidance including individual responsibilities.

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

- A large number of policies recorded on the policy database are overdue for review.
- Reviewing access to and the format of the documents saved within the clinical and non clinical libraries to ensure format consistency and documents saved.

Full details of matters arising are provided 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	Appropriate guidance and training are in place for the management of policies and procedures that includes development, approval and dissemination.		-	Substantial
2	Appropriate measures are in place to ensure policies and procedures are maintained on a central database, published in a consistent format and developed and reviewed when required and in a timely manner.		1	Reasonable
3	Health Board staff can access existing policies and procedures and are notified of new or amended policies and procedures. Relevant policies and procedures are also made available to members of the public.		2	Reasonable
4	There is an approach to manage policy changing directives from Welsh Government (WG), including All-Wales policies.		-	Substantial

Reviewed by Bethan
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Management Actions



High Priority



Medium Priority

Themes



■ Governance ■

Risk Types

Legal & Regulatory Non-Compliance

Legal & Regulatory Non-Compliance

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Findings & Agreed Action Plan

Objective 1: Appropriate guidance and training are in place for the management and review of Health Board Policies and procedures.	Substantial

Overview / Summary of Observations

There is an up-to-date policy and supporting procedure in place for the management of Health Board Policies. CGP 004 'Management of Policies and Other Written Control Documents' Policy was approved by the Board in May 2025 and published in October 2025. The policy is comprehensive and clearly sets out the standards to be set for the development and publication of health Board policies and written control documents with signposting to supporting documentation for further information on the processes to be complied with.

There is a specific 'Policies and Written Control Documents' intranet (sharepoint) page that provides guidance to staff on the development of new policies and on-going review of policies. The page also includes copies of the Policy, a Written Control Document Toolkit and the templates to be used to ensure standardisation of all policies.

All Health Board staff are able to access the information on the intranet. Whilst no formal training is provided, the information available is comprehensive and the Corporate Governance Team can be contacted to provide further advice and guidance.

There is a formal process in place for the development and approval of new policies. Information such as guidance and approval route for the process is available to all staff on the Policies & Written Control Documents intranet pages.

The testing we undertook on a sample of new policies approved in 2025/26 noted that whilst the process was not fully compliant with the new guidance in place, due to the guidance still being implemented, all policies had been formally approved by an appropriate Director/Group.

Objective 2: Appropriate measures are in place to ensure that policies and procedures are maintained on a central database, published in a consistent format and developed and reviewed when required and in a timely manner.	Reasonable

Overview / Summary of Observations

There is a database in place for recording all Health Board policies and related written control procedures. The database is maintained by the Corporate Governance team and the information recorded includes document reference, accountable Executive Director, review date and the library that the document is located within on the intranet.

As a result of the current version of the policy template only recently being published (January 2026) the format of the majority of policies that we reviewed as part of our testing did not comply with the latest guidance as they had been approved and published in accordance with previous guidance. However, our testing found that the formats of the policies were appropriate and no issues were identified.

The policy database is currently being reviewed at least weekly by the Corporate Governance team due to the ongoing implementation of the new policy management process recently approved.

Despite this weekly oversight a significant number of policies remain overdue for review. Our testing on a sample of these found that little progress has been made in reviewing and updating (if applicable) the policies.

Key Findings		Risk & Impact	Agreed Management Action
1	Policy Status Our review of the policy database as at 15 th 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.	Overdue policies may not reflect current guidance/practice.	Agreed Action. 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.
			Expected Evidence of Implementation: Email trails and reporting data as well as compliance report to Executive Committee.
	Theme: Governance	High Priority Control Operation	Officer: Deputy Board Secretary Target Implementation Date: 31 st March 2026

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Overview / Summary of Observations

With regards to public access to the Health Board’s Policies, we note that direct access is not permitted. However, the Policies page on the Health Board’s internet does provide examples of some of the policies in place. It also advises the public that they are able to obtain copies of policies by submitting a request to the contact details provided. The same page also provides a link for policies related to the NHS Wales Joint Commissioning Committee who are responsible for commissioning specialist and tertiary services. However, at the time of the audit the link was not valid.

Health Board staff can access copies of all policies via the Policies and Written Control Documents intranet pages. Our review of the documents (policies and control procedures) saved within the clinical and non-clinical libraries identified a few issues concerning the format of some of the saved documents. It was also noted that some documents could only be accessed via a link to the related department’s home page rather than copies being saved on the ‘clinical libraries’ pages. We also identified one instance where a policy recorded on the database could not be located on any of the policy libraries on the intranet.

Staff updates regarding newly approved or updated policies are included on the news update pages of the Corporate Governance Department on the intranet.

In addition, updates on policies will also be included as part of Team Focus communications issued by the Executive Team.

Key Findings	Risk & Impact	Agreed Management Action
Staff Access Our review of the information available to staff and the public regarding policies and control documents identified a number of issues: - 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	Health Board staff and general public are unable to access key documents	Agreed Action 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.

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.		Expected Evidence of Implementation: Updated website and database.
	Medium Priority Control Operation	Officer: Deputy Board Secretary Target Implementation Date: Completed
Theme: Governance		

Objective 4: There is an approach to manage policy changing directives from Welsh Government (WG), including All-Wales policies.

Substantial

Overview / Summary of Observations

The Health Board maintains a tracker to record all Welsh Health Circulars and Ministerial Directives received from Welsh Government. The tracker records the Executive Lead for the document and will also record updates on actions undertaken by the Health Board.

If the circular or directive relates to an existing policy a copy will be forwarded to the policy owner for review and to update the policy if required.

The approval of All Wales Policies follows the same process as that for Health Board policies.

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Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

Public Sector Internal Audit Standards

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Powys Teaching Health Board

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Audit Team

Lucy Jugessur, Deputy Head of Internal Audit



Executive Summary

Purpose

We have completed a follow-up review of the Deprivation of Liberties Safeguards (DoLS).

Our original DoLS audit was reported in December 2024 and identified six issues which resulted in an overall assurance rating of 'Limited Assurance'.

For 2025/26 we have revised our approach to reporting our follow-up audit work to ensure that we comply with the requirements of the new Global Internal Audit standards. As such we will no longer be providing an assurance rating as part of our follow-up reports.

The purpose of this follow up review is therefore to establish if management has now taken corrective measures to fully implement the agreed management actions and address the relevant key findings from our original report.

We note that the Audit, Risk and Assurance Committee has continued to monitor progress in implementing these actions through the internal audit tracker.

Overview

Our follow up review has confirmed that all six agreed actions have been **implemented**, as follows:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	3	3	0	0
Medium	3	3	0	0
Total	6	6	0	0

As part of our follow-up review, we met with the Mental Capacity Act and DoLS/LPS Senior Practitioner and the Safeguarding Business Support Manager to establish the progress that has been made with the implementation of the agreed actions. We then obtained and reviewed documentation and evidence to validate the stated position for each of the actions.

As noted above, this has enabled us to confirm that all the agreed management actions have been implemented. The provision of additional staff resources has provided a stable foundation for the ongoing delivery of the Supervisory role, and the development of training for ward staff will further strengthen awareness of the Managing Authority role. Strengthening of the signatory arrangements is aiding timely authorisation of DoLS applications, and the developments around the case tracker and performance reporting are improving oversight.

Whilst implementation of the agreed actions has improved the DoLS position within the Health Board, ongoing work is required to ensure that the future training for ward staff is consistently delivered as planned and the monitoring and reporting of key performance information continues to be developed.

Further detail of the work undertaken by management to implement each of the agreed actions is provided in the table below.

Appendix A: Progress of Agreed Actions

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 1	Policy and process document. <u>Finding:</u> 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. <u>Agreed Action:</u> Update DoLS Policy. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, June 2025	Medium Priority	Action Status: Implemented 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.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 2	Provision of Training on Managing Authority Responsibilities. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, March 2025 / July 2025 / September 2025	Medium Priority	Action Status: Implemented 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.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 3	BIA Contractor Qualification. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, February 2025	Medium Priority	Action Status: Implemented 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.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 4	Provision of DoLS Supervisory Body role. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, March 2025 / June 2025	High Priority	Action Status: Implemented 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 for the DoLS process until March 2027.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 5	Authorisation of DoLS Applications. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, March 2025 / June 2025	High Priority	Action Status: Implemented 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.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 6	Case tracking. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Jayne Wheeler-Sexton, March 2025 / June 2025 / June 2025	High Priority	Action Status: Implemented 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.

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Appendix B

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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Powys Teaching Health Board – Audit, Risk and Assurance Committee Update

Date issued: March 2026



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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 February 2025.

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.

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Accounts audit update

Audit of the 2024-25 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 2024-25 Health Charities Annual Report and Accounts
- **Status:** Audit has been completed and final accounts certified meeting the 31 January 2026 deadline.
- **Committee date:** January 2026

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. Some interim work to be completed December 2025 to March 2026. Final Audit to commence once draft Accounts received May – June 2026.
- **Expected committee date:** June 2026

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Performance audit update

Structured assessment 2025 – core

- **Executive Lead:** Director of Corporate Governance/Board Secretary
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review:
 - Board and committee cohesion and effectiveness;
 - Corporate systems of assurance;
 - Corporate planning arrangements; and
 - Corporate financial planning and management arrangements.
- **Status:** Final
- **Expected committee date:** March 2026

Follow up review of quality governance arrangements

- **Executive Lead:** Executive Director of Nursing, Quality, Women and Family Health
- **Focus of the work:** This work will follow up on the recommendations made in our 2021 audit. Our previous audit examined whether the health board's governance arrangements support delivery of high quality, safe and effective services.
- **Status:** Draft report with the Health Board for clearance
- **Expected committee date:** May 2026

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Review of arrangements for managing agency staff

- **Executive Lead:** Executive Director of Primary, Community Care and Mental Health
- **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:** May 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:** Draft reporting
- **Expected committee date:** May 2026

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Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Executive Director of Allied Health Professions, Health Science and Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Draft reporting
- **Expected committee date:** May 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:** July 2026

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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.

<u>Private finance – public impact. Examining decision-making for the new Velindre Cancer Centre.</u>	February 2026
<u>Checking the patients. Results from a pilot data matching exercise on GP patient lists</u>	January 2026

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

<u>Fee Scheme 2026-27</u>	January 2026
<u>Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028</u>	December 2025

There are no relevant Audit Wales consultations currently underway.

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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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Structured Assessment 2025

Powys Teaching Health Board

February 2026

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Audit snapshot

What we looked at

- 1 We looked at how well Powys Teaching Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:
 - how well its board works;
 - how it keeps track of risks, performance, service quality, and recommendations;
 - how it produces key plans and strategies; and
 - how it manages its finances.
- 2 We also looked at the Health Board's progress in implementing recommendations from:
 - previous structured assessment reports; and
 - our 2024 report on cost savings.

Why this is important

- 3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

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What we have found

- 4 The Board and its committees run effectively and transparently. Meetings are well managed, and information continues to be of a good standard. There remains a continued commitment to hearing from patients and service users and Board walkarounds have developed positively. However, the Health Board could do more to ensure the level of scrutiny at meetings remains at a consistently high standard to address the challenges the Health Board faces.
- 5 Performance reporting continues to be good and escalation arrangements have worked well for services which have been subject to them. Producing plans and strategies remains a collaborative effort and there is evidence the Health Board is mapping partnership working more effectively. However, the Health Board would benefit from ensuring the Integrated Quality Report presents a clearer narrative and ensuring greater clarity on the links between corporate plans. Although the Health Board has recently developed its risk management process, the current risk register arrangements would benefit from review to ensure a clearer distinction between strategic and operational risks.
- 6 The Health Board's financial position continues to be of concern. A substantial year-end deficit is forecast for 2025-26 and delivery of the Health Board's current savings plan remains a challenge. Both the Board and Welsh Government were unable to approve the Health Board's Annual Plan due to the financial position. The Health Board continues to have a good understanding of its cost pressures but moving to a more affordable service model is being affected by delays with the implementation of the 'Better Together' transformation model due to complexity and resource capacity.

What we recommend

- 7 We have made seven recommendations to the Health Board
 - Clarifying referrals in committee action logs;
 - Further refining the strategic and organisational risk registers;
 - Updating the format of the Integrated Quality Report;

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- More clearly linking corporate plans;
- Including actual savings to date in finance reports;
- Reporting activity and impacts of financial working groups, and
- Arranging further financial training for Independent Members.

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Key facts and figures

Under the Welsh Government's escalation and intervention arrangements, the Health Board is at Level 4 for Finance, Strategy and Planning.

The Health Board does not have a Welsh Government approved Annual Plan or Integrated Medium-Term Plan for 2025-26.

The Health Board did not meet its financial duty to break even on its revenue spend over the three-year period 2022-25, reporting a cumulative deficit of £34.7 million for 2022-25.

In 2024-25, the Health Board delivered savings of £11.7 million, against a savings target of £9.9 million. Over £6 million were recurrent.

The Health Board is forecasting a year-end deficit of £28.3 million for 2025-26, against a Welsh Government expectation of £16.5 million and a control total deficit of £12 million.

At month seven, the Health Board was forecast to deliver £18.2 million of savings against an annual target of £23.1 million

The Health Board has fully implemented seven out of 16 outstanding recommendations from past structured assessment reports. Six are partially implemented, with three where no action has been taken.

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Our findings

Board effectiveness and openness

The Board and its committees continue to work well, but more action is needed to review outdated policies and track referred actions.

Public openness of board business

- 8 The Board continues to promote openness and transparency. As in previous years, all Board meetings are livestreamed, and the public can access recordings of previous meetings via the Health Board website, promoting accessibility. Committee meetings also continue to be held virtually, and agendas and minutes are available publicly online.
- 9 Board and committee agenda papers are available to the public in advance of meetings. Agendas also invite members of the public to raise questions to the Board.
- 10 The Board conducts most business in public sessions. The Board and committees make appropriate use of private sessions, using these for confidential and sensitive matters only in line with the Board approved protocol. The Board continues to provide a high-level overview of items discussed in private, through the Director of Corporate Governance Report, at the following public Board meeting to support transparency.

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Supporting effective board conduct

- 11 The Health Board has good arrangements for monitoring and updating its core control frameworks. The Board approved a revised Scheme of Delegation in March 2025. Standing Financial Instructions are also up to date and available to the public on the Health Board's website.
- 12 Since our previous structured assessment, the Health Board has strengthened its declarations of interest arrangements. The Board approved an updated Standards of Behaviour Policy in 2025 requiring Assistant Directors, Consultants and staff members with significant budget or commissioning oversight to be included on the Declarations of Interest register. This has been actioned, and the Board received the latest copy of the Declaration and Register of Board Interests in November 2025.
- 13 The Health Board has also now made some policies and procedures available on its website. This includes the Register of Interests and the Standards of Behaviour Policy and Framework. Whilst there is a policies page on the Health Board's website, the majority of policies are available on request, rather than being directly accessible from the website. This limits public access to policies such as 'Putting Things Right' and the 'Equality, Diversity and Human Rights Policy' and is not in line with all other Health Boards in Wales. The Health Board has indicated that it will not be looking to make all policies public at this time due to capacity issues.
- 14 The Board approved its Management of Policies and Other Written Control Documents policy in May 2025. Internal Audit will assess compliance and effectiveness of this policy periodically. However, the Health Board has not presented an update either to the Board or to relevant committees regarding how many policies are out of date or which policies these relate to. This does not allow Board and relevant committees to have oversight of this important area.

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Assurance on Joint Commissioning Committee effectiveness

- 15 The Joint Commissioning Committee (JCC) was set up in April 2024 as a joint committee of the seven Health Boards in Wales. It plans and commissions a range of specialised services and other healthcare services including emergency medical services, on behalf of the seven Health Boards.
- 16 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance on JCC business, as well as on the Health Board's involvement in JCC meetings and activities. We found that the Board, Finance and Performance Committee and Patient Experience, Quality and Safety Committee routinely receive assurance on the work of the JCC. This is via a written summary provided by the Chief Executive, which also includes a link to the public JCC minutes. In January 2025, both the JCC Chair and Chief Commissioner also delivered a presentation to Board members, providing an overview of the Committee's work.

Board and committee meeting effectiveness

- 17 The Board and committees continue to use the consent agenda well, freeing up time for oversight of other more pressing agenda items. We also saw consent agenda items brought into the main agenda for discussion if required. This was the case for the committee workplan in the May 2025 Audit, Risk and Assurance Committee meeting.
- 18 Each committee revised and endorsed its terms of reference before approval at Board in May 2025. The Delivery and Performance Committee adjusted its terms of reference to update the committee's name to Finance and Performance Committee. This better reflects the activity within the workplan and the increased focus on financial management. Other updates include:
 - transferring oversight of Information Management and Technology Systems to the Audit, Risk and Assurance Committee from the Finance and Performance Committee; and

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- the Planning, Partnerships and Population Health Committee becoming the sole committee to seek assurance on compliance with the Well-being of Future Generations Act (Wales) 2015.

- 19 The Health Board updated committee membership in July 2025. This was in response to annual self-assessments and member feedback, and included the appointment of a new Audit, Risk and Assurance Committee chair to update interim Chair arrangements. The updates also considered individual skillsets and future requirements of each committee, including the size and scale of work programmes. This shows an agile approach to making best use of Independent Member capacity. We also saw some improved scrutiny as a result.
- 20 Chairs manage meetings well and include polite and consistent challenge and support. However, as the Health Board faces increasing challenges to delivery, especially financially, it will need to maintain its high levels of scrutiny. This would provide further assurance against the increasing risks the Health Board faces.
- 21 The Health Board has strengthened its escalation processes from the committees to the Board. The Committee Chairs Reports have been updated into a new Alert/Advise/Assure/Inform format. This approach ensures consistent, structured reporting and strengthens oversight by highlighting key issues, actions, and assurance levels.
- 22 Committee action logs however could be clearer. Currently, action logs are presented on spreadsheets at each committee and include dates, the relevant lead, progress updates and whether actions are on track. Action logs also note when an action is transferred to another group. However, they do not include the name of the group the action has been transferred to or what is expected of the group.

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Quality and timeliness of Board information

- 23 Board and committee information remains of a good standard and is constantly being reviewed. Reports are generally presented in a standard format and include a mix of narrative and graphic information. However, some reports remain very narrative in nature and would benefit from better summarisation.
- 24 Papers are generally distributed on time, but there are still occasions where there are late papers which the Health Board recognises could affect the Board Members ability to undertake effective challenge and scrutiny. If Independent Members receive late papers, the Health Board specifies which items will be late and when they can expect to receive them. Members are conscious of the volume of papers, particularly in the Audit, Risk and Assurance Committee, although the Health Board is addressing this. This includes giving members sight of Internal Audit reports as soon as they become available and not waiting until the next meeting.

Hearing from staff and service users

- 25 The Board continues to be committed to hearing from staff and patients. Staff have been invited to attend Board Development and Board Briefing sessions to raise Board member awareness on how services operate. Patient stories also appear on committee agendas where relevant to understand the impact of services. Patient stories now present a broader spectrum of experiences, both positive and negative, and are generally linked with other agenda items.
- 26 The People and Culture Committee¹ received one staff story in 2024 and one staff story in 2025. The Health Board should consider whether more regular information about staff experience would help the committee triangulate information and better understand staff wellbeing.

¹ Previously Workforce and Culture Committee

- 27 The People and Culture Committee receive routine updates on the Health Board's 'Great Place to Work' strategic priority, including staff retention, 'Speaking up Safely,' and the Clinical Leadership Immersive Programme. The Committee also received the results of the 2024 NHS Staff Survey in February 2025. The Health Board had the highest response rate of all health boards at 30%, although this is still low.
- 28 The Health Board recognises measuring and gathering patient and staff feedback needs more capacity. The Health Board appointed a Peoples Experience Framework Coordinator in June 2025, with the intention to strengthen its ability to gather and triangulate people's experiences and report this information to the relevant committee. The Health Board expects to see outputs from this before end of March 2026.
- 29 Since our previous structured assessment, the Health Board has made positive progress on Board member walkarounds. The Health Board has developed a forward programme for 'Out and About' visits. This covers a six-month period with a two monthly review. The programme is informed by several factors such as risk, major service change, or new areas of innovation, and visits have included the Planning Team, Therapies and Health Science Management Team and Ystradgynlais Hospital. The Chair invites Independent Members to attend based on availability and interest.
- 30 The Chair reports on the visits via the Chairs Report to Board. The Health Board has developed guidelines for walkarounds which includes governance and reporting. The Health Board will summarise and report trends and themes from walkarounds to the Patient Experience, Quality and Safety Committee on a bi-annual basis with the first report due in April 2026. An annual review of the walkaround programme will take place as part of the annual Board effectiveness evaluation.

Board cohesion and continuous improvement

- 31 The Board continues to experience some change in both Executive Director and Independent Members but manages this process well.

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- 32 The Health Board appointed two new independent members in 2025. The Vice Chair left the organisation in October 2025, and a new Vice Chair is due to take up post in early 2026. The Executive Director of Nursing, Quality, Women and Family Health retired in October 2025 after a handover period to support the new officer in this role.
- 33 The Health Board continues to undertake committee effectiveness reviews for each of its committees, with the results reported annually to Board. Following the reviews, each committee receives a Continuous Improvement Plan for the year, which includes identified actions and associated owners and timescales for completion. Agendas continue to provide opportunity for members to reflect on meetings and give feedback, which demonstrates continuous development.
- 34 However, the Health Board needs to be assured that each Independent Member is demonstrating the appropriate range of skills and scrutiny to satisfy the requirements of the role. Our observations across various committee meetings over the last 12 months has indicated that Independent Member scrutiny would benefit from being more consistent across the cohort, by offering tailored individual support where appropriate.
- 35 The Board continues to hold monthly Board Development sessions, and during our interviews we heard how these have been valuable.

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Providing board assurance

The Health Board has strengthened arrangements for oversight of performance and recommendation tracking but the current approach to risk management needs review and information regarding quality could be clearer

Managing strategic risks

- 36 In our previous structured assessment, we noted the Health Board did not identify strategic risks separately to corporate risks. As part of the work to further develop the Board Assurance Framework (BAF), the Health Board has now assessed and separated risks in an updated Risk Management Framework approved by the Board in March 2025.
- 37 The Health Board now records strategic risks on the Strategic Risk Register (SRR) and the BAF. The Board own and oversee the strategic risks, and these are reviewed and monitored by the Executive Committee in advance of Board meetings. The Executive Committee is also responsible for escalating and de-escalating risks from the SRR.
- 38 Each risk within the SRR has been allocated a committee for oversight and assurance, and each committee meeting receives an update on the relevant risk(s) in a committee risk register. The Audit, Risk and Assurance Committee also maintains effective oversight of how the revised risk management arrangements are embedding.

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- 39 The Board receives the full SRR three times per year which includes details against each strategic risk including review date, risk causes, controls, mitigations, and risk owner. It also includes the risk score and trajectory over a four-month period. Some strategic risks are however more detailed than others, with some gaps in information. The SRR also has a section to list any associated organisational risks which align with a strategic risk. This section is in development alongside the Risk Management Tool which the Health Board is currently updating.
- 40 The Board receives a Strategic Risk Summary Report at those meetings where the Health Board does not present the full SRR. This report provides summary data including the risk score and risk appetite for each strategic risk. The intention is the BAF dashboard will seek and provide assurance that actions to manage the strategic risks are both adequate and effective. This is an ongoing and developing piece of work.

Managing corporate risks

- 41 Corporate risks are now called organisational risks and held on the Organisational Risk Register (ORR). The Executive Committee oversee and monitor these risks via a comprehensive risk register document. The Health Board has set up an Operational Leadership Group consisting of the Assistant and Deputy Directors to oversee cross-organisational issues on behalf of the Executive Committee. The Group is also responsible for developing the most significant risks within the organisation for inclusion in the Organisational Risk Register. These risks include those de-escalated from the previous corporate risk register and those escalated in line with the Risk Management Framework.
- 42 The Health Board presented its first high level summary of the ORR to Board in November 2025. However, it is so high level it is unclear what assurance the Board could take from it. The terms “operational” and “organisational” are sometimes used interchangeably and consistent terminology would be helpful.

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- 48 The Health Board have also developed a summary IQPR. This useful document provides an accessible narrative summary position of performance for both services provided by the Health Board and services commissioned from others. This provides the reader assurance on these areas and strengthens oversight of commissioned services which has been a concern for Independent Members.
- 49 The summary IQPR is presented periodically to the Finance and Performance Committee. It provides dashboards to highlight performance compliance with a full version of the report presented at alternative meetings.
- 50 Going forward, the Health Board want to move to a digital system for presenting performance with Power BI dashboards but recognise the current capacity restraints in undertaking this activity.

Monitoring quality and safety

- 51 The Health Board has generally effective arrangements for maintaining oversight of quality and safety and has continued to embed arrangements to oversee the Duties of Quality and Candour. At the time of our work, we were undertaking a follow up of our 2021 Review of Quality Governance Arrangements.
- 52 The Health Board approved its Strategic Commissioning Framework (SCF) in September 2025. The SCF outlines the Health Board's approach to commissioning services including quality of commissioned services for Powys residents. The measures to accompany the SCF are still in development.
- 53 The Health Board's IQPF replaced its Clinical Quality Framework 2020-23 in March 2024. While the IQPF sets out the measures to be used to monitor quality and safety, it still does not set out the Health Board's ambitions for the quality and safety of its services and how it will go about achieving them.

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- 54 Performance is reported to the Finance and Performance Committee through the Integrated Quality and Performance Report (IQPR). A separate and standalone Integrated Quality Report (IQR) is presented quarterly to the Patient Experience, Quality and Safety Committee.
- 55 The IQR provides a more detailed picture regarding the quality and safety agenda across the Health Board. The report includes information on 'Putting Things Right,' complaints, information on compliance with the Duty of Candour (including the number of cases each quarter and trend data) and patient experience data.
- 56 The IQR is very narrative and interspersed with some useful data, but the report needs to be clearer in identifying areas of concern. It is not obvious what information in the report is part of the regular quality update and what information is reported as an exception item which requires further attention. The structure and therefore purpose of this report would benefit from being reviewed. This would ensure it is clearly and consistently presenting relevant information.
- 57 Over the last two years the Health Board placed Mental Health Services and Children's Neurodevelopmental Services into internal escalation in line with the IQPF. Relevant staff have presented regular and detailed updates of the escalated services to the Patient Experience, Quality and Safety Committee providing good oversight. Updates include action plans and progress reports including a report update when Mental Health services were deescalated.
- 58 The Health Board presented its Duty of Quality Annual Report 2024-25 to the Patient Experience, Quality and Safety Committee in July 2025 and Board in September 2025. The report is an informative mix of narrative, case studies, and data. It also updated on the de-escalation and key improvements made within Mental Health Services. However, there is no mention in the annual report of the escalation status in Children's Neurodevelopmental Services which creates an incomplete picture.

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Tracking and monitoring recommendations

- 59 The Health Board has good arrangements to monitor and track recommendations, which are continuing to develop. The Health Board continues to report progress against internal and external recommendations twice a year to the Audit, Risk and Assurance Committee via an Audit Recommendation Tracker report. But this report is extensive and can become unwieldy and difficult to navigate.
- 60 The report usefully includes a cover paper which provides a summary update of internal and external audit recommendations either completed since the last update, not due for implementation or overdue. The report also includes a breakdown of outstanding recommendations by directorate and how old the recommendation is. This provides a useful insight into directorates which may have particularly complex recommendations to address or may need help due to a capacity issue.
- 61 We previously recommended the Health Board should strengthen its approach to closing recommendations. There was limited information provided to give assurance that actions taken had adequately addressed recommendations, allowing them to be closed. The Audit Recommendation Tracker report now includes more narrative to explain why the recommendation has been marked as complete.
- 62 Despite the arrangements described above, our review of the Health Board's progress to address previous recommendations has found a mixed position, with:
- only eight out of 16 recommendations from past structured assessment reports are now complete. Five are partially complete, with three where no action has been taken; and
 - three of recommendations from our cost savings report are complete and five in progress.

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Preparing strategies and plans

The Health Board collaborates well to develop plans, and there are good processes for monitoring delivery, but links between plans could be clearer

Producing key strategies and plans

- 63 The Health Board continues to work to its long-term strategy 'The Health and Care Strategy for Powys 2017-27', developed in partnership with Powys County Council. A refresh of the strategy will be done through the Regional Partnership Board prior to the 2027 end date. The Health Board intend to report updates to the Board and the Planning, Partnerships and Population Health Committee as work progresses.
- 64 The Health Board is currently working to an Annual Plan. Due to financial challenges, the Health Board was unable to submit an approvable three-year Integrated Medium-Term Plan (IMTP). The Health Board has continued to demonstrate good engagement in development of the Annual Plan, with planning discussions taking place at Board Development sessions.
- 65 The draft Annual Plan 2025-26 was scrutinised at a joint session of the Planning, Partnerships and Population Health Committee and Finance and Performance Committee in March 2025 prior to Board approval. However, the plan did not meet the financial targets set by Welsh Government and at the time of our work, remained unapproved by Welsh Government due to the forecast deficit for 2025-26. We discuss the Health Board's financial position in paragraph 81.

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- 66 The Health Board's Annual Plan is set in the context of the five-year Integrated Plan 2024-29, which in turn supports the delivery of the long-term strategy. However, it is not clear how the Annual Plan supports the delivery of the Integrated Plan. The Health Board needs to have greater clarity about how the priorities set out in the Annual Plan supports the priorities in the Integrated Plan.
- 67 The Integrated Plan includes the Health Board's wellbeing objectives. There is a statutory requirement to review well-being objectives annually to ensure they remain appropriate. The Health Board intends to do this as part of the Regional Partnership Board workplan and communicate this to relevant Health Board committees as part of the IMTP planning process in Spring 2026.
- 68 The Integrated Plan also sets out the plans to develop a financially sustainable model for health and care with its 'Better Together' transformation model. However, the Health Board have decided to delay planned public consultations on changes to service provision until after the Senedd elections in May 2026 to give time for consultation and analysis. This delays the Health Board's ability to progress important work on development of a financially sustainable service model.

Board assurance on partnership working

- 69 The Board receives regular updates on partnership work. This includes the Regional Partnership Board and Public Services Board. Reports to Board highlight both the opportunities and challenges of working in partnership.
- 70 The Board also receives regular updates on partnership with other health boards, including the two Regional Joint Committees recently set up in Southeast and Southwest Wales.

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- 71 Updates are also received from the Mid Wales Joint Committee, which is a collaborative with Betsi Cadwaladr University, Hywel Dda University Health Board, Welsh Ambulance Services University NHS Trust and the three relevant local authorities. Whilst it is not a formal committee of the Board, it aims to strengthen the planning and delivery of health care services in mid-Wales. Priorities include urology and rheumatology services and addressing challenges like delayed pathways of care.
- 72 The Health Board has a good working partnership with Llais². The Regional Director presents a report at each Board meeting. The report includes the engagement they have had with Powys residents and any planned engagement sessions. Feedback on any health-related themes from members of the public and updates on the number of advocacy cases in the Powys region is also included.
- 73 The Health Board produced a Partnership Governance and Assurance Framework in May 2025. The framework provides a comprehensive overview of the Health Board's statutory partnerships, partnerships by choice and partnerships as a way of working. The framework includes the terms of reference, leadership, and budget information, and usefully outlines the reporting processes and cycle for each of the partnerships.

Monitoring delivery of strategies/plans

- 74 The Health Board has good arrangements for monitoring delivery of plans. Progress against the Integrated Plan 2024-29 is reported to Board through quarterly Delivery Plan updates. Overall, the updates provide a good overview of progress against strategic objectives and set out key deliverables, actions, and milestones including delivery confidence.
- 75 The Health Board recognises that producing SMART objectives has been a work in progress, but the Annual Plan 2025-26 is much more explicit. The Key Activities, Key Deliverables and Timescale sections are 'specific,' 'measurable' and 'timed.' This has produced a more focused and meaningful section for key areas of delivery.

² Llais Cymru

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- 76 During the year, the Board and committees received routine statutory updates on the delivery of wider corporate strategies and plans such as the Welsh Language Annual Report 2024-25, and Health and Safety Annual Report 2024-25. The Health Board also reports updates on enabling strategies to relevant committees. These include an update on the Capital and Estates Strategy to the Finance and Performance Committee in September 2025 and an update on the Workforce Transformation and Sustainability priority to the People and Culture Committee in December 2025.
- 77 We have previously reported that the Health Board lacked clarity about the actions it intends to take to deliver its well-being objectives and the strategic performance measures to demonstrate the long-term impact. This remains the case as noted in Recommendation 5.1 2024.

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Managing finances

Although oversight and controls are in place, the financial position is a concern, and more information is needed to strengthen scrutiny

Meeting financial objectives and duties

- 78 The Health Board did not meet all its financial duties for 2024-25. Of the three duties, it met its capital resource limit, reporting a small underspend of £50,000. However, it did not:
- spend within its revenue resource limit for the period 2022-25; and
 - have an agreed three-year Integrated-Medium Term Plan for 2024-27.
- 79 The Welsh Government set the Health Board a target deficit of £12 million for 2024-25. The Health Board did not meet this, reporting a year-end deficit of £15.8 million. This was after a further allocation by Welsh Government of £7 million. The Health Board reported a three-year cumulative deficit of £34.7 million.
- 80 The Health Board does not have a balanced financial plan for 2025-26. The Health Board submitted an annual plan to Welsh Government in March 2025 for 2025-26 which set out a predicted year-end deficit of £38.4 million. The Health Board revised its predicted year-end deficit to £28.3 million in month two. This is against a Welsh Government control total target deficit which had remained at £12 million.
- 81 At month seven, the Health Board's year end forecast position is still a deficit of £28.3 million. However, operational pressures and run rates to date are above the planned trajectory, largely due to factors affecting commissioning costs. The Health Board reported a year-to-date deficit of £19.4 million compared to a planned deficit of £16.5 million.

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- 82 The Health Board continues to forecast that it will remain within its capital resource limit of £6.5 million with a year to date spend at month seven of £1.97 million.
- 83 As a result of the Health Board's escalation status, Welsh Government gave additional funding to the Health Board to commission external support from Grant Thornton in July 2025. Grant Thornton have been working with the Health Board to assist them in three predominant areas of work: financial sustainability, commissioning, and Continuing Health Care. The Health Board received the draft report setting out the findings of the Grant Thornton work in December 2025 and was considering its findings at the point of preparation of this structured assessment report.

Financial planning arrangements

- 84 The Health Board has a clear process for developing its financial plan. Board members scrutinised the development of the plan and the plan itself prior to submission to the Welsh Government.
- 85 The 2025-26 financial plan sets out several risks which the Health Board needs to manage. As well as commissioning activity, these also include demand for agency use, and an increasing number of adult mental health and learning disability placements with private providers which are creating financial pressure for the Health Board.
- 86 The Health Board delivered its savings plans in 2024-25. It achieved £11.7 million of savings against its target of £9.9 million. However, the Health Board intended that £9.9 million were recurrent savings. Only £6.6 million were recurrent with a shortfall of £3.2 million against the target. As a result, these savings were non-sustainable, and the Health Board will need to ensure recurrent savings are achieved for longer term sustainability.

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- 87 The Health Board is currently off-track on its savings schemes for 2025-26. The Health Board's 2025-26 plan is based on a £23.1 million savings requirement. At month seven, the Health Board has identified £18.2 million of savings for 2025-26, with a gap of £4.8 million still to find. Half of the identified savings are recurrent. The biggest area for target savings is commissioning.
- 88 There continue to be risks associated with the capacity of teams to deliver the required savings. At month seven, the Health Board had delivered £8.5 million, with £14.6 million still to deliver over the remaining five months of the year.
- 89 Savings performance continues to be scrutinised by the Finance and Performance Committee and Board, but the focus is purely on the identification of savings schemes. Although the finance report sets out the planned savings targets by area, the report does not include actual savings delivered to date. Nor does the report set out where savings delivery is off track, and any mitigating actions. This means actual achieved savings are not reported until year end making it difficult to scrutinise the reality of the financial position throughout the year.
- 90 In 2024, Audit Wales reviewed the Health Board's approach to cost savings. Of the eight recommendations in that report, the Health Board has made progress but has more to do. All eight recommendations are still in progress. Areas in which further progress is required are set out in **Appendix 2**.

Financial management arrangements

- 91 The Health Board has the expected financial controls in place. The Audit, Risk and Assurance Committee regularly reviews the Standing Orders and Standing Financial Instructions. The Committee also receives assurance that appropriate financial controls are in place, and routinely reviews losses, special payments, single tender actions, and post payment verification reports. In November 2024, Internal Audit provided substantial assurance on the Health Board's treasury management as part of its four-year cycle to review the core financial systems.

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- 92 The Health Board also continues to have good counter-fraud arrangements. There is an agreed annual workplan and routine reports to the Audit, Risk and Assurance Committee show delivery against the plan.
- 93 The Health Board however continues to overspend. There continues to be enhanced reporting on key areas of expenditure at Board and committee levels. Working groups, such as the Variable Pay Reduction Group, are also in place to control spend, and deep dives on each of the groups have been provided. The most recent finance report to the November 2025 Board meeting highlights that overall agency spend is reducing.
- 94 Whilst this is positive, it is unclear what the impact of the Variable Pay Reduction Group has been. The report notes the group is implementing a detailed action plan but presents no information for assurance about what the action plan is, what difference it should make and how the Health Board will measure and report this. This is also the case for working groups focused on other areas of financial pressure such as commissioning and mental health.
- 95 The Health Board submitted draft financial statements for external audit within the required timescales. Our audit found no material misstatements but did find some areas where corrections needed to be made. Our audit also found issues with Continuing Health Care (CHC) accruals which did require additional work and resulted in the final accounts not being certified until 1 August 2025.
- 96 We issued an unqualified opinion in respect of the truth and fairness of the accounts, but a qualified regularity opinion due to the Health Board breaching its revenue resource limit over the three-year rolling period 2022-25. The Health Board has helpfully undertaken a learning exercise on the CHC accrual issue and reported the lessons learnt and actions underway to Audit, Risk and Assurance Committee in October 2025.

Monitoring financial performance

- 97 The Health Board has good arrangements for reporting financial performance, although more information is needed.

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- 98 The Health Board reports financial performance at each Board and Finance and Performance Committee meeting. Finance and performance reports are now listed together on agendas for Board meetings to ensure that any quality and performance risks are considered alongside the financial challenges. Senior officers are present at meetings to update on any relevant information regarding the financial position and to answer any queries.
- 99 In last year's structured assessment report, we commented that whilst reports to board and committee continue to highlight key financial risks to the financial position, there was a need to be clearer on the impact of mitigating actions. This continues to be the case. As highlighted in paragraph 89, the finance report also needs to include more information on the savings delivery position.
- 100 Notwithstanding the issues identified in the paragraph above, Independent Members continue to regard finance reports as clear and explanatory. Our observations found that scrutiny and challenge on the Health Board's financial performance have increased. However, we heard that Independent Members would value more training on finance to allow them to enhance scrutiny further in line with the developing financial pressures, challenges around delivering savings and managing risks.

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Recommendations

101 The following table details the recommendations arising from our work.

Recommendations

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 (paragraph 22).
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 (paragraph 43).
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 (paragraph 56).

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R4 The Health Board should make it clearer how the priorities set out in the Annual Plan supports the priorities in the Integrated Plan. **(paragraph 66).**

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. **(paragraph 89).**

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 **(paragraph 94).**

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. **(paragraph 100)**

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Appendices

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1 About our work

Scope of the audit

We looked at the following areas for the period August to November 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers;
- Model Standing Financial Instructions;

- Relevant Welsh Government health circulars and guidance; and
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes;
- Key governance documents, including Standing Orders and Standing Financial Instructions;
- Key strategies and plans, including the IMTP;
- Key risk management documents, including the Board Assurance Framework;
- Annual Report, including the Annual Governance Statement;
- Relevant policies and procedures; and
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chief Executive;
- Executive Director of Finance, Capital and Support Services and Deputy Chief Executive;
- Director of Corporate Governance/Board Secretary;
- Executive Director of Planning, Performance & Commissioning;
- Board Chair;
- Vice Chair and Chair of Patient Experience, Quality and Safety Committee;
- Chair of Audit, Risk and Assurance Committee;
- Chair of Finance and Performance Committee; and
- Chair of Planning, Partnerships and Population Health Committee.

We observed Board meetings as well as meetings of the following committees:

- Audit, Risk and Assurance Committee;

- Finance and Performance Committee;
- Planning, Partnerships and Population Health Committee; and
- Patient Experience, Quality and Safety Committee

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2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

2022 Recommendations	
R3	The Health Board does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee workplans. The Health Board needs to update its Board Assurance Framework (Complete, paragraph 37).
R4	There is currently a disconnect between directorate risk registers and the Corporate Risk Register (CRR). The Health Board needs to review all high risks on directorate risk registers to ensure the relevant ones are escalated to the CRR, and that the Board is aware of wider risks that may materialise (Complete, paragraph 41).
R5	Opportunities exist to improve public access to key Health Board documents. The Health Board should ensure that: a) policies and procedures, and the register of interest on the public website are accessible (In part, paragraph 13)

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2023 Recommendations

- R3 The Health Board should strengthen its board walkaround arrangements by:
- 3.1. Developing a forward programme which involves both Independent Members and Executive Directors and covers a broad range of Health Board services (**Complete, paragraph 29**); and
 - 3.2. Developing a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes (**Complete paragraph 30**)

- R5 The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module. (**In part, paragraph 44** - The Health Board has acknowledged that it will not be looking to address this recommendation.)

2024 Recommendations

- R1 The Health Board should require staff with significant budget oversight and/or significant influence on commissioning arrangements to provide information on any relevant interests and include this information on the Register of Interests (**Complete, paragraph 12**).

- 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 (**No action, paragraph 56**).

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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 (**Complete, paragraph 61**).

R4 The Health Board should:

- 4.1. Ensure annual reviews of its well-being objectives are clearly communicated (**In part, paragraph 67**)
- 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 (**In part, paragraph 63**)

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 (**No action, paragraph 77**); and
- 5.2. Strategic performance measures to accompany its well-being objectives that capture the long-term impact it is seeking to achieve (**No action, paragraph 77**)

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 (**Complete, paragraph 76**).

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R7 The Health Board should identify, monitor, and manage any immediate quality and performance risks that may arise because of the ongoing financial challenges (**Complete, paragraph 99**).

R8 The Health Board should provide greater assurances within finance reports on the impact of mitigating actions to address key financial risks (**In part, paragraph 99**).

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Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potential costs and savings that will arise through its introduction in order to place its finances on a more sustainable footing (In progress, paragraph 68).
R2	The Health Board should make greater use of Getting it Right First-Time (GIRFT) reviews that directly apply to the Health Board as a further source of potential intelligence to inform its savings identification arrangements (Complete)
R3	The Health Board should set challenging but realistic targets for its individual savings schemes. It should also develop robust but achievable action plans for its schemes accompanied by suitable delivery arrangements to ensure they achieve their intended aims (In progress, paragraph 89).
R4	The Health Board should broaden its assessment of capacity beyond its Finance Team to identify and develop plans to address any shortfall or gaps in available resource in its wider operational teams (In progress, paragraph 83).

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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 (**In progress, paragraph 83**).

R6 The Health Board should clearly identify savings delivery risks and mitigating actions within in its corporate and operational risk management arrangements (**In progress, paragraph 89**).

R7 The Health Board needs to prioritise how best to turn its red savings schemes into recurrent green and amber schemes that have a realistic chance of delivering the identified savings (**Complete, paragraph 87**).

R8 The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach with the aim of placing less reliance on non-recurrent savings (**Complete, paragraph 86**).

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3 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation’s strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Strategy	A Clinical Strategy is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation’s significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.

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Term	Description
Integrated Medium-Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board, and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.

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Term	Description
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation’s normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Target Control Total	A Target Control Total is a budget or deficit target set by the Welsh Government that an NHS body is expected to meet or better by year-end for the respective financial year.

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Term	Description
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

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The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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galwadau ffôn yn Gymraeg a Saesneg.

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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 Audit, Risk and Assurance 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 February 2026 is as follows: • For those WHCs received in 2022 there are <u>31 complete and 1 partially complete.</u> • For those WHCs received in 2023 there are <u>39 complete and 2 partially complete.</u> • For those WHCs received in 2024 there are <u>45 complete, 8 partially complete and 2 not yet due.</u> • For those WHCs received in 2025 there are <u>24 complete, 4 partially complete, 2 not yet due and 5 with no progress.</u> • <u>All Ministerial Directions received 2022-2023 are complete</u> • For those Ministerial Directions received in 2024 there are <u>3 complete and 1 partially complete.</u> • For those Ministerial Directions received in 2025 there are <u>19 complete and 2 partially complete.</u> Welsh Health Circulars and Ministerial Directions can be viewed here: Welsh Health Circulars and Ministerial Directions Appendix 1 - WHCs currently outstanding (not yet due, partially complete and no progress) and the progress made to action them Appendix 2 - WHCs completed since the last reporting period. Appendix 3 - MD's currently outstanding (not yet due, partially complete and no progress) and the progress made to action them Appendix 4 - MDs completed since the last report

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

Summary since the last report in: October 2025

The Table provides the committee with an overview of the WHCs and MDs that remain outstanding with no progress made. Updates will continue to be sought against these WHCs a and MDs and 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	Position
No Progress	Director of Allied Health Professions, Health Science and Digital	WHC 2025 026	The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings	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.
No Progress	Director of Nursing, Quality, Women and Family Health	WHC 2025-051	Safety netting discharge leaflets for adults and children	No update available
No Progress	Director of Primary, Community Care and Mental Health	WHC 2025 038	All-Wales NHS Accessible Communication and Information Standards	Update Jan-26: National conversations ongoing as to how to monitor compliance in the standards and contractor expectations. Local implementation will follow.

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Summary

The following table provides an overview of the progress made against the implementation of WHCs received since the last report (Audit, Risk and Assurance Committee, October 2025). The Corporate Governance team has undertaken an in-depth validation exercise to ensure accurate data is being reported and reflects the current position within the table below.

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

Actions being Taken:

- Lead Executives continue to give priority to the outstanding WHCs and MDs and provide further updates.
- Further updates will be provided to the Committee in the next report in October 2026.

Summary

The following table provides an overview of the progress made against the implementation of MDs received since the last report. (Audit, Risk and Assurance Committee, October 2024) The Corporate Governance has undertaken an in-depth validation exercise to ensure accurate data is being reported and reflects the current position within the table below. All Ministerial Directions received in 2022 and 2023 are complete.

MD's progress 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

Actions being Taken:

- Lead Executives continue to give priority to the outstanding WHCs and MDs and provide further updates.
- Further updates will be provided to the Committee in the next report in October 2025.

Following review by the Audit, Risk and Assurance Committee on 10 March 2026, the reported position will be included within the Health Board's Annual Report for 2025/26 which will be submitted to Internal Audit, Audit Wales and Welsh Government for review and scrutiny.

The Corporate Governance Team will continue to track and distribute Welsh Health Circulars and Ministerial Directions to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported on a bi-annual basis.

The next update report will be presented to the Executive Committee in September 2026 for onwards reporting to the Audit, Risk and Assurance Committee in October.



Appendices:

The following appendices provide details extracts of the WHC Tracker:

- Appendix 1 - WHCs currently outstanding (not yet due, partially complete and no progress) and the progress made to action them
- Appendix 2 - WHCs completed since the last report (ARAC, October 2025)
- Appendix 3 - MD's currently outstanding (not yet due, partially complete and no progress) and the progress made to action them
- Appendix 4 - MDs completed since the last report (ARAC, October 2025)

WHC 2022 006	Direct Paramedic referral to same day emergency care	21.04.2022		In order to reflect local service models, each health board will need to agree with WAST the mechanisms for enabling the 'clinician to clinician' discussion, which forms the basis of the acceptance of patients into SDEC services.	Director of Primary Care, Community and Mental Health	Immediate	Partially Complete
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

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 Primary Care, Community and Mental Health	N/A	Partially Complete
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	Not Yet Due

WHC 2024 011	Changes to dietary advice on feeding young children aged 1-5 years	N/A		I am writing to inform you of changes to Welsh Government dietary advice for young children aged 1 to 5 years following acceptance of recommendations made by the Scientific Advisory Committee on Nutrition (SACN) in its report on 'Feeding young children aged 1 to 5 years' . The role of SACN is to provide independent scientific advice on, and risk assessment of nutrition and related health to the 4 UK Governments. The report is based on an extensive and comprehensive review of the evidence base. It makes a number of dietary recommendations, some of which endorse existing advice, others represent a change in advice. These are summarised in the table below.	Director of Nursing, Quality, Women and Family Health	01.04.2027	Not Yet Due
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

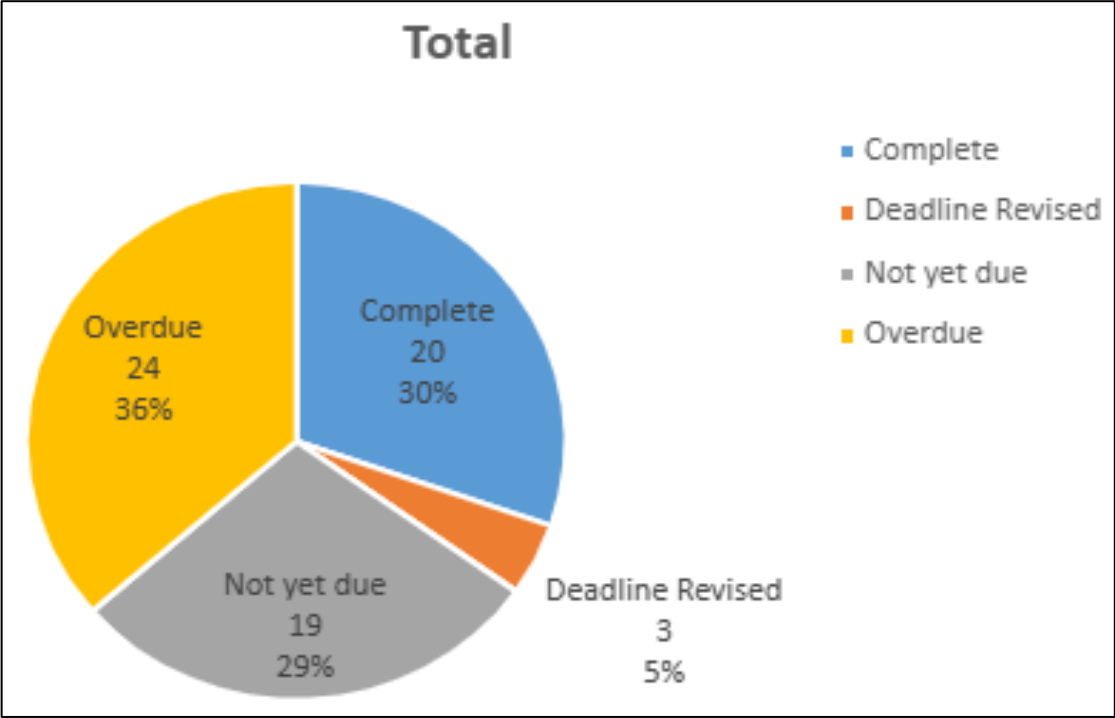
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WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status
WHC 2022 019	Non Specialised Paediatric Orthopaedic Services	21.06.2022		To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales.	Director of Nursing, Quality, Women and Family Health	01.04.2025	Complete
WHC 2022 022	Role of the Community Dental Service and Services for vulnerable people	22.08.2022		Health boards should use their professional advisory structures to review and inform the provision of dental care by all local dental services including the CDS, primary care services provided by General Dental Services (GDS), Personal Dental Services (PDS) and Hospital Dental Services (HDS), and how these relate to local authority boundaries and primary care clusters. Specialists and Consultants in Dental Public Health will provide detailed and expert assistance in needs assessment and in collaboration with others, advice on service development. The Community Dental Service should be regarded as an integrated dental service with a diverse and flexible role. It should not be regarded as a purely primary care-based service. A strong community dental service will provide all services needed for its local population and this can include both consultant, specialist, intermediate and routine general dental services. The Community Dental Service should be encouraged to work in collaboration with local hospital based dental services including oral and maxillofacial services. An effective CDS will require investment in both workforce and infrastructure, ensuring that the clinicians have access to modern equipment and robust IT systems. Poor infrastructure is seen as a barrier to recruitment and retention of staff.	Director of Primary Care, Community and Mental Health	01.08.2024	Complete

WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status

WHC No.	Name of WHC	Date Issued	Date received	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status
WG-24-01	Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05.01.2024		Each Local Health Board must prepare, for its area, an administrative list.(2) Subject to paragraph (3), the administrative list must consist of a list of the qualified practitioners who provide or assist in the provision of ophthalmic services and must contain the following information— (a) the qualified practitioner’s full name; (b) the qualified practitioner’s professional registration number; (c) the date of the qualified practitioner’s first registration in the register; (d) the date that the qualified practitioner’s name was first included in the administrative list; (e) the ophthalmic services that the qualified practitioner provides or assists with. (3) A Local Health Board is not required to include in an administrative list information about qualified (1) 2016 No. 11 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. (2) 2016 No. 10 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. practitioners who	Director of Primary Care, Community and Mental Health	N/A	Complete
WG-24-02	The National Health Service (Wales Eye Care Services) (Wales) Directions	05.01.2024		) The Eye Health Examination Service Committee (Wales) Directions 2016(2) are amended as follows. (2) In paragraph 1.1 of Schedule 1 (interpretation), at the appropriate places insert—““2023 Regulations” means the National Health Service (Ophthalmic Services) (Wales) Regulations 2023(3);”the Act” means the National Health Service (Wales) Act 2006;” ““the administrative list” means the administrative list prepared and published by a Local Health Board in accordance with the Wales Eye	Director of Primary Care, Community and Mental Health	N/A	Complete

Subject:	Audit Findings Tracking (Internal and External Audit)
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 Committee with an overview of the position relating to the implementation of Audit findings, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 04 February 2026.
Recommendations:	The Committee is asked to: • CONSIDER the current position of outstanding Audit Findings and take ASSURANCE that the organisation has an appropriate system for tracking and responding to audit recommendations. • CONSIDER and discuss the current position of all Internal and External Overdue Audit Findings with a particular focus on those findings given High Priority ratings.
Executive Summary:	The responsibility for the collation, monitoring and reporting of internal and external (Audit Wales) audit recommendations is the responsibility of the Corporate Governance Team. Information is managed throughout the year and reported to the Executive and Audit, Risk and Assurance Committee on a regular basis. The last report was received by the Audit, Risk and Assurance Committee on the 07 October 2025. The next report will be provided in October 2026. The report provides a summary of the overall position, updates to overdue findings and findings that have had their deadlines revised. The full updates for all findings are highlighted in red and are appended to this report, they include: • Internal Audit Recommendations that: • are Overdue • have been COMPLETED since the previous report • are NOT YET DUE for implementation • have had their DEADLINE REVISED • External Audit Recommendations that: • Are OVERDUE • have been COMPLETED since the previous report • are NOT YET DUE for implementation 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,



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.

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SUMMARY of OVERDUE Internal Audit Findings

Internal Audit – 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

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

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

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

Director of Allied Health Professions, Health Sciences & Digital							
PTHB Ref No	Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	No of months passed deadline
242528	Mattresses	Limited	High	R1	Specific training on the Health Board’s Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered.	February 2026: Training Programme in place. Training Record held on ESR	6
				R3	All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.	February 2026: Reports have been received regularly through Q&S process. Evidence of monthly compliance through teams channel and Q&S minutes/recordings. Evidence of correct audit template being used.	6
				R4	A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.	February 2026: Actions and escalations for ordering replacement covers/parts are captured in Ward level audits and reports through Q&S structure.	6
				R6	Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.	February 2026: Medical Devices confirmed that a process is in place to secure asset numbers on devices	5
				R7	A system which captures the information suggested, will be put in place for mattresses along with appropriate reporting within Localities. A clear mechanism for escalation of serious issues will also be established.	February 2026: 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-equip and asset numbers. Timeframe for completion Q1 26/27.	4

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

Director of Nursing, Quality, Women & Family Health

PTHB Ref No	Internal Audit Title	Audit Assurance rating	Priority Rating	Ref	Management Response	Progress of Work Underway	No of months passed deadline
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.	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.	4
				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.	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.	4
252622	Duty of Candour	Reasonable	High	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.	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 submitted 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	2

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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

Summary

3 Internal Audit Findings have had their deadlines revised all of which are partially completed.
(All three findings were presented in 2025/2026 financial year)

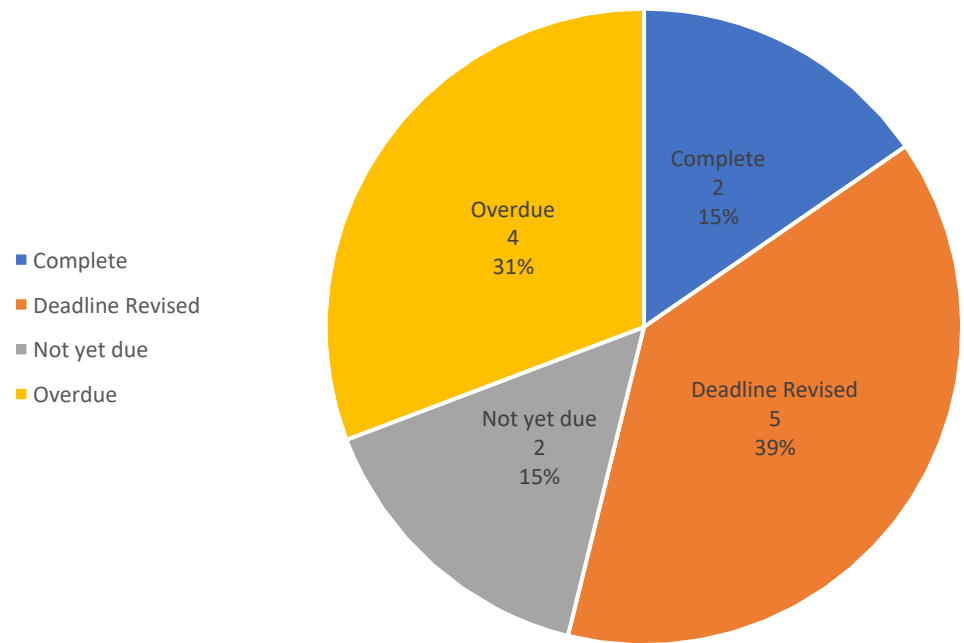
Priority and Assurance rating

- All 3 findings are medium priority and relate to Reasonable assurance reports.

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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	Continuing Health Care	Reasonable	Medium	November 2025	August 2026	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.	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.
Director of Primary, Community Care and Mental Health	Continuing Health Care	Reasonable	Medium	December 2025	August 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.	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.
Director of Finance, Capital and Support Services	Core Financial General Ledger Management and Accounts	Reasonable	Medium	January 2026	February 2026	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.	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

External Audit Findings Summary



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

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Detail of OVERDUE External Audit Findings

OVERDUE External Audit Findings by Directorate					
Directorate	External Audit Title	Finding	Progress of Work underway	Status	No of months passed deadline
Director of Nursing, Quality, Women and Family Health	Structured Assessment 2023	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	No update provided	No Progress	20
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	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.	Partially Complete	0
Director of People and Culture	Review of Cost Saving Arrangements	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potential costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	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.	Partially Complete	10
Director of People and Culture	Review of Cost Saving Arrangements	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	Feb 2026 - Organisational capacity and capability constraints have continued to be rate limiting factors. Resource plan agreed by Executive Committee 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.	Partially Complete	10

External Audit – Deadline Revised detail						
Directorate	Internal Audit Title	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline	Status
Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Tackling the Planned Care Challenges	June 2025	March 2026	The 2025/26 Annual Plan contains more detailed Planned Care objectives with broader stakeholder involvement in the Plan development. A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. “Better Together” is PTHB promise to work together with citizens to review how and where we provide services, to ensure safety, to improve quality, and to make best use of resources that we can. We want to talk to patients and service users, people and communities, health and care staff, and our partner organisations.	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.	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.	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.	Partially Complete

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External Audit – Deadline Revised detail						
Directorate	Internal Audit Title	Agreed Deadline	Revised Deadline	Management Response	Rationale to Revise Deadline	Status
Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning	Tackling the Planned Care Challenges	March 2026	May 2026	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	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.	Partially Complete
Director of Primary Care, Community and Mental Health	Primary Care follow-up review	December 2024, revised to May 2025	August 2026	Progress the development of a Primary Care Dashboard as part of Integrated Performance Report presented to Executive and Board Committees. Frequency to be agreed	January 2026: Work continues but is delayed due to other organisational priorities. Suggest deadline is revised to August 2026.	Partially Complete
Director of Primary Care, Community and Mental Health	Primary Care follow-up review	June 2024, revised to October 2025	August 2026	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.	January 2026: Suggest deadline is revised to August 2026.	Partially Complete

The following appendices are provided with more details:

- 6.3a – Internal audit - Findings Completed since last report
- 6.3b – Internal audit - Findings Not Yet Due
- 6.3c – Internal audit – Findings that are Overdue
- 6.3d – Internal audit - Findings with Revised Deadlines
- 6.3e – External audit - Findings Completed since last report
- 6.3f – External audit – Findings that are Overdue
- 6.3g – External audit - Findings with Revised Deadlines
- 6.3h- External audit – Findings Not Yet Due

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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
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R4	High	The R2G standard has been integrated into the DigifLO application and by default, all patients are categorised as red, requiring staff to manually update their status to green each day. Staff members comprehension of R2G days did not completely align with the guidance provided by Welsh Government. All patients listed on the DigifLO Whiteboards for Y Bannau Ward and Epynt Ward were indicated as having a red day. This suggests that staff may not be adequately updating	Provide clear, step-by-step guidance for staff to fully understand the "Red2 Green Process" and how to correctly apply it using both the manual and electronic whiteboards. Conduct refresher training sessions for staff to ensure they fully understand the process. Incorporate the D2RA pathway and R2G standard to the handover documentation.	01.12.2025		Complete	Complete		August 2025 - The R2G standard is being embedded through Powys DigifLO, supported by the issue of a Standard Operating Procedure (CSG 001, Sept 2024) and user-friendly "How to Guides" accessible via the intranet. Targeted face-to-face training was delivered across all sites through the Powys DigifLO Information Roadshow (Nov 2024-Feb 2025), reinforcing correct use of the R2G function and decision-making process. January 2026 - Clear step-by-step guidance has been established through the issue of the Standard Operating Procedure (CSG 001) and supporting user guides, with a further update completed in December 2025 to enhance clarity within the R2G section. Planned training has been delivered, with targeted sessions provided via the DigifLO roadshow and refresher sessions continuing across all sites from December 2025 to March 2026. These actions address the original recommendation, with ongoing monitoring and support planned through 2026/27 to ensure sustained and consistent operational embedding	August 2025 - Community hospital practices do not readily support routine R2G completion, with dependency on adapting board round and handover processes.	August 2025 - A revised board round and handover approach is being explored to support consistent R2G use.	Q3 2025	Yes - relevant SOPs	1	1512	jan-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	R5	Medium	The Hospital Discharge guidance from WG emphasises there must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub, to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway. Furthermore, once the decision of the definitive discharge pathway has been agreed, the patient and their family or unpaid carer and existing care providers must be informed and be provided with details of the decision. We could not find sufficient evidence within the existing systems to clarify how the decision regarding the D2RA Pathway was made.	Establish a standardised procedure for recording the decision-making process related to the D2RA Pathway, ensuring that the rationale and supporting evidence are clearly outlined. Additionally, document how families and caregivers have been informed about these decisions within the appropriate systems.	01.12.2025		Complete	Complete		August 2025 - D2RA is being embedded through Powys DigifLO, supported by the issue of a Standard Operating Procedure (CSG 001, Sept 2024) and user-friendly "How to Guides" accessible via the intranet, which provide information and guidance on the allocation and recording of D2RA Pathways. Targeted face-to-face training was delivered across all sites through the Powys DigifLO Information Roadshow (Nov 2024-Feb 2025), to support the correct allocation and recording of D2RA Pathway and decision-making process. January 2026 - Clear step-by-step guidance has been established through the issue of a Standard Operating Procedure (CSG 001) and supporting user guides, with a further update completed in December 2025 to enhance clarity within the R2G section. Planned training has been delivered, with targeted sessions provided via the DigifLO roadshow and refresher sessions continuing across all sites from December 2025 to March 2026. These actions address the original recommendation, with ongoing monitoring and support planned through 2026/27 to ensure sustained and consistent operational embedding	August 2025 - There is dependency on timely input from multi-disciplinary teams, which can delay consistent pathway decisions.	August 2025 - A revised board round and handover approach is being explored to strengthen MDT input and timely recording	Q3 2025	Yes - relevant SOPs	1	1512	jan-26	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Emma McGowan	R8	Medium	Use of Inpatient Notes within WNCR: Within WNCR, there is a dedicated section for Inpatient Notes that allows users to a 'note type' when updating entries, depending on the contributor or content being added. Available options include MDT Review, and Discharge discussions. The admission details and the estimated Date of Discharge (EDD) is also recorded in the system. As part of the sample testing, we examined the Nursing Notes	Establish a step-by-step guidance on what should be recorded within the Inpatient Notes under each specific 'note type' so that the information recorded is better aligned with the Hospital Discharge Guidance. The guidance should cover the following: • Highlight the key elements of the guidance that must be reflected in the Nursing Notes (e.g., indicators of R2G days, rationale for observations). • MDT Review Notes to include how the decision regarding the D2RA Pathway was made and	01.12.2025		Complete	Complete		August 2025: Work is underway to clarify the relevant documentation and requirements. Initial steps include reviewing the use of Inpatient Notes within WNCR and identifying gaps in alignment with Hospital Discharge Guidance. A step-by-step guide is being considered to support consistent documentation under each note type, including Nursing Notes, MDT Reviews, and Discharge Discussions. Further detail will be provided as this work progresses on this recommendation January 2026 - Guidance to strengthen and standardise documentation within Inpatient Notes has been established through the 'Clinical Record Keeping in Adult Inpatient Wards and Ready To Go Home Units' SOP and supporting posters, which reinforce what should be recorded under relevant note types (including Nursing Notes, MDT Reviews and Discharge Discussions) in line with Hospital Discharge Guidance.				Yes - relevant SOPs	1	1512	jan-26	
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Senior Nurse - Complex Care	R9	Medium	Patients with complex needs: Patients categorised under Pathway 3 present complex needs. Those who are either CO or Discharge Ready and require Nursing Care must undergo a DST assessment or a PAN assessment by the appropriate ward. The findings should be sent to the Complex Care Team for review and submitted to the panel as needed.	Improve documentation practices by implementing a standardised template or clear guidelines for recording and tracking key dates, such as when assessments are forwarded to the Complex Care Team and when panel approvals are granted. This will enhance transparency and traceability and help to identify themes and trends.	01.12.2025		Complete	Complete		August 2025: This action is currently being progressed through the Complex Care and Continuing HealthCare workstream, where a key focus is on Data, Metrics, and Digital Platforms. The Complex Care team is leading efforts to explore and evaluate suitable digital solutions to support individuals with complex needs, and work is actively underway to identify the most appropriate options. January 2026 - Patients identified as CO or Discharge Ready with nursing care needs undergo the appropriate DST or PAN assessment, with findings shared with the Complex Care Team and submitted to panel where required. Documentation has been strengthened. Key dates are being tracked to support transparency, traceability, and the identification of themes and trends.				TBC	1	1512	jan-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	R10	Medium	Estimated Date of Discharge (EDD) Powys Community Hospitals: As part of the sample testing, we compared the EDD recorded on the manual whiteboard to those documented in the WNCR. We identified three instances within Epynt Ward where the dates did not align. Additionally, we examined the interval between the admission date and the date when the original EDD was established. Across both wards, we discovered six cases where the EDD was set more than seven days post-admission, with the longest delay being 51 days.	Clear guidance on the management and recording of EDD needs to be established. Each patient should have an agreed-upon EDD confirmed during their initial Multidisciplinary Team (MDT) meeting or within 24 hours of admission, which must be documented and communicated to the patient and their family or caregivers. Any discussions or modifications regarding the EDD should occur and be recorded prior to the expiration of the original EDD.	01.12.2025		Complete	Complete		August 2025 - Developments have been made within Powys DigifLO to support monitoring and maintenance of Estimated Date of Discharge (EDD) records. EDD expectations are reinforced through the Standard Operating Procedure (CSG 001, Sept 2024), including that all patients should have an EDD recorded on WNCR and that EDDs should be updated in line with the most up-to-date clinical information and estimated discharge date. Within Powys DigifLO, EDDs are displayed on a colour-graded scale to indicate when they are approaching (<7 days) or highlighted in red if the date has passed or an EDD has not been entered, supporting timely review January 2026 - Clear expectations for the allocation, recording and review of Estimated Date of Discharge (EDD) are now established through updated Standard Operating Procedures, including CSG 001 and GNP042, which set out requirements for MDT involvement, timely allocation and routine review of EDDs. These expectations are supported within Powys DigifLO through visual prompts that highlight missing, overdue or approaching EDDs, enabling timely review and correction				Yes - relevant SOPs	1	1512	jan-26	
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Corporate Governance		R1	Low	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.	Agreed - The SFIs are mainly standard documents provided to the THB by Welsh Government with some minor amendments for local circumstances. The THB will put a note on the document to state that the SFIs will be internally reviewed every 2 years should a review by Welsh Government not be undertaken during that period.	31.12.2024	31.03.2026	Complete	Complete		February 2025: Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval. August 2025: Statement had been prepared for inclusion in the next SFI update, currently scheduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemented sooner if there is a need to revise the SFIs for any other reason January 2026: Action completed at PTHB Board November 2025.				Yes-Board Minutes	11	#NUM!	jan-26	10.02.2025
242512	2024/2025	Core Financial Systems – Treasury Management Final Internal Audit Report	Substantial	Director of Corporate Governance	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)	R2	Low	The Standing Financial Instructions should be updated to ensure references to the Head of Financial Services are updated to the Assistant Director of Finance (Accounting and Services).	Agreed - The change to title will be made at next update of Scheme of Delegation scheduled for late 2024.	31.01.2025	31.03.2026	Complete	Complete		February 2025: Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval. August 2025: Update has been prepared for inclusion in the next SFI update, currently scheduled for March 2026; requesting deadline be revised to align to this timetable though updates will be implemented sooner if there is a need to revise the SFIs for any other reason January 2026: Action completed at PTHB Board November 2025.				Yes-Board Minutes	11	#NUM!	jan-26	10.02.2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R1	Medium	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to	and format (spreadsheet, table, dashboard etc). Medium Agreed Management Action Target Date Responsible Officer1 Update DoLS policy.	31.01.2025		Complete	Complete		20/2/25 - DoLS policy re-draft will commence upon outcome of business case as this will determine content. Jan 2026 update: completed Re-write completed of a DoLS Practice Guidance, consultation completed. Action to be closed					11	1512	jan-26	10.02.2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R4	High	The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	01.06.2025		Complete	Complete		20/02/25 -Business case made to IBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. August 2025 update Preferred option with business case agreed by executive committee 14/5/25. 1x Best Interest Assessor recruited. Administration in place. DoLS Co-ordinator recruitment was unsuccessful m however following readvertisement further interviews set for sept 25. Interim measure for external BIA assessments in place from the 18/9/25 and agency DoLS co-ordinator identified for 12 weeks and procurement commenced for this. January 2026 update: Actions Completed, Business case agreed May 25, Positions recruited to, 2 x Best Interest assessors, DoLS Coordinator, SLA for DoLS administration from PCC completed, interim positions in place while recruitment was underway.					7	1512	jan-26	10.02.2025
242517	2024/2025	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R5	High	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	01.06.2025		Complete	Complete		20/02/25 -Business case made to IBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. Information requested from ESR to start analysis of training needs around MCA. The next MCA operational and Practice Improvement Group in March 25 has an agenda item for practice improvement action plan for MCA training. August 2025 update An increased rota is achieved through additional 5 signatories now trained and on the rota. Recruitment of DoLS Coordinator underway - interviews set for Sep 25 Jan 2026 update: Completed Signatories increased DoLS co-ordinator in post and undertaking a scrutiny, quality assurance and streamlining of processes role.					7	1512	jan-26	10.02.2025
242522	2024/2025	Cancer Services	Reasonable	Medical Director	Ruth Corbally	R1	Medium	Formalisation of the Cancer Group: We understand that the Executive Medical Director chairs the Cancer Group. Throughout our fieldwork we were unable to determine the nature of the group, its alignment within the wider governance structure for the Health Board and its decision-making abilities.	The purpose of the Cancer Group will be decided and whether it has been set up to operate as a Steering Group (Strategic oversight and focus) or a Task and Finish Group (task and objective based). Further to this, a Terms of Reference document will be documented and will be taken through the HB governance structure for scrutiny and sign off.	01.08.2025		Complete	Complete		29/07/2025 update: Arrangements underway. TOR being drawn up and first meeting planned. February 2026 update: Cancer group running with updated Terms of Reference					5	1512	jan-26	
242522	2024/2025	Cancer Services	Reasonable	Medical Director		R2	Medium	Methodology for recording action logs arising from CQPRM: Whilst action logs are kept and are being discussed at every meeting, the current methodology for documenting actions could be improved. Currently actions are logged within individual documents for each meeting. We also note that the numbering	The actions from CQPRM meetings will be documented by means of using a spreadsheet as opposed to individual word documents for each meeting. Also, target dates and revised target dates for completion of actions will be set in place.	01.08.2025		Complete	Complete		12/8/25 update: Capacity challenge currently within Commissioning Team due to retirement and vacancies. Plans in place to enact this once recruited to vacancies (Commissioning Manager x 1; Commissioning Support Officer x 1) January 2026: Action logs are recorded for each CQPRM with associated target dates. Current process reviewed and is robust for the requirements of the meetings and escalation.					5	1512	jan-26	

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242523	2024/2025	Llandrindod Wells Phase 2 Final Internal Audit Report	Reasonable	Director of Finance, Capital and Support Services	Wayne Tannail	R3	Medium	The THB noted that on the advice of their Advisers they had opted to seek a performance bond to provide assurance on delivery of the work rather than a parent company guarantee. It was confirmed that despite a request from the THB's Advisers in January 2025 the performance bond had not been provided by the SCP. The contract contained option X13 (Performance Bond) which amounted to a cost of 10% of the contracted sum. Whilst noting the contract requirement for a performance bond, at the time of reporting the	The THB will ensure deduction/reimbursement of the cost associated with the provision of a performance bond	31.05.2025		Complete	Complete		August 2025 update: Professional consultants to pursue deduction/reimbursement of the cost associated with the provision of a performance bond January 2026 Update: Professional consultants have confirmed that no financial payments have been made by PTHB in relation to the provision of a performance bond (Item removed from final account)						7	1512	jan-26	
252622	2025/2026	Duty of Candour	Reasonable	Director of Nursing, Quality, Women and Family Health	Heidi Sinclair	R5	Medium	Weekly Datix DoC reports were historically sent to CSG Service Managers and Governance Leads for review within quality meetings covering concerns, incidents, and NRIs. These reports detailed cases under review, investigation, and closure. However, distribution of the weekly reports ceased in mid-June 2025 due to uncertainty over their value, and also whether the data provided to CSG management teams was having any direct effect. Governance leads and heads of service have access to dashboards within Datix for monitoring concerns, incidents, and duty of candour cases; however, the frequency with which these dashboards are used has not been determined. A questionnaire was distributed to CSG Governance Leads, which indicated that Mental Health and Women & Children's CSGs conduct weekly safety or PTR meetings and provide monthly reports to their Quality Assurance (QA) Group or Senior Management Team (SMT); however, this information could not be independently verified during the audit based on the testing conducted under objective 3, it was identified that interim harm assessments by managers were 'blank' in 401 out of 1,775 incidents, including: • While this is attended by a core group of staff and the meetings are quorate, records of meetings from December 2024 and July 2025 indicated that several staff members listed in the Terms of Reference as required attendees were not in attendance. • The Terms of Reference is scheduled for review by December 2025. Infection Prevention and Control & Decontamination Committee. • While this is attended regularly by a core group of staff and the meetings are quorate, records of five meetings which took place between May 2024 and August 2025 indicated that there were a large number of staff who attended less frequently, and it was difficult to match attendance against the requirements set out in the Terms of Reference. • Audio recordings of the meetings are retained, but decisions taken at the meetings are not	Meetings will be scheduled with CSG management teams, and their Governance Leads to determine whether the weekly DoC reports are necessary. If required, these discussions will also establish the specific data types to be included to ensure the reports provide meaningful information. Additional analysis will also be conducted to identify current users of the Datix DoC dashboard and determine whether it is being used to support case incident review and decision-making. A standardised review process will be established to manage cases designated as 'blank,' ensuring that all cases are evaluated within the prescribed timeframes. These steps will be included into the reporting structure that has been discussed under Key Finding 1.	31.10.2025		Complete	Complete		January 2026: Fortnightly meetings are held with CSG to discuss concerns/NRIs/DOC cases and progress. DOC compliance is reported on as part of the IQR report each quarter.					2	1512	jan-26	08.01.2026	
252623	2025/2026	Decontamination	Reasonable	Director of Nursing, Quality, Women and Family Health	Gareth Thomas	R1	Medium	Decontamination Safety Group. • While this is attended by a core group of staff and the meetings are quorate, records of meetings from December 2024 and July 2025 indicated that several staff members listed in the Terms of Reference as required attendees were not in attendance. • The Terms of Reference is scheduled for review by December 2025. Infection Prevention and Control & Decontamination Committee. • While this is attended regularly by a core group of staff and the meetings are quorate, records of five meetings which took place between May 2024 and August 2025 indicated that there were a large number of staff who attended less frequently, and it was difficult to match attendance against the requirements set out in the Terms of Reference. • Audio recordings of the meetings are retained, but decisions taken at the meetings are not	The Terms of Reference for the Decontamination Safety Group and the Infection Prevention and Control & Decontamination Committee will be reviewed to ensure that they are appropriate, attendance at meetings will be matched with the Terms of Reference to evidence compliance and staff will be reminded of their responsibility to attend where necessary. • The action log will be used to record decisions taken at meetings. • SharePoint folders will be periodically reviewed to identify errors or inconsistencies such as duplicate documents	31.01.2026		Complete	Complete		03/02/2026 - The management response has now been completed. The Terms of Reference for the Decontamination Safety Group were reviewed and agreed by group members on 16/01/2026. Attendance expectations were reiterated by the EDn during the meeting on 16/01/2026, and current attendance has been checked against the membership list outlined in the Terms of Reference. The SharePoint folders have been reviewed and will continue to be monitored routinely as part of standard practice.					#NUM!	1512	jan-26	08.01.2026	
252623	2025/2026	Decontamination	Reasonable	Director of Nursing, Quality, Women and Family Health	Gareth Thomas & Alex Smith	R2	Medium	he Decontamination Safety Group Terms of Reference states that its function includes monitoring decontamination issues and updating a decontamination risk register. Furthermore, the group has discussed this and it was agreed that one risk register would be used, which would include relevant risks from CTMUHB. However, this has not currently progressed further,	A decontamination risk register will be developed and regularly presented and discussed.	31.01.2026		Complete	Complete		03/02/2026 - A comprehensive decontamination risk register has been completed and will be presented to the Infection Prevention and Control (IPC) Committee. Ongoing oversight of this register will be maintained through regular review by the Decontamination Safety Group, the Nursing Directorate, and the IPC Committee. This process will ensure that identified risks are monitored, mitigation actions are updated, and organisational governance requirements are fully met.					#NUM!	1512	jan-26	08.01.2026	
252623	2025/2026	Decontamination	Reasonable	Director of Nursing, Quality, Women and Family Health	Gareth Thomas	R4	Medium	Endoscopy weekly water testing is undertaken which forms part of the Health Board's Endoscopy validation process, which is recorded in a spreadsheet. However, while review of the spreadsheet confirms that results are generally being recorded and monitored weekly as required, we noted that no result was recorded for one machine for week	Endoscopy weekly water testing results will be promptly recorded in the monitoring spreadsheet, and any omissions or anomalies will be promptly investigated and resolved.	31.12.2025		Complete	Complete		03/02/2026 - Robust weekly water testing is fully up to date and remained consistently in place throughout the internal audit period. Weekly water test results are received directly into the IPC inbox, as well as via the Endoscopy Team, providing dual assurance and consistent oversight. This process supports strong governance, timely review of results, and professional scrutiny by the IPC Team. In addition, the associated monitoring spreadsheet has been updated to reflect the most recent testing activity and outcomes, ensuring accurate recording and continued assurance.					0	1512	jan-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	R1	Medium	Not all projects sampled fully complied with good practice in terms of all benefits defined by stakeholders and having a formal benefits realisation plan. We also note that levels of user engagement vary with some projects lacking ongoing user involvement, which can lead to a loss of service ownership of the digital product.	The Executive team approved a Benefits Framework in April 2025. It is acknowledged that many projects since that approval are still in scoping or design / testing phases, and there are national reporting templates and local reporting templates, as such there are not the clearly defined standard benefits plans in place. A standard benefits template will be developed to support this approach which will underpin the more strategic benefits framework. Digital Services project managers will utilise this template, which will be defined in collaboration with stakeholders ensuring operational service teams take ownership and accountability of their benefit realisation logs. The Digital project will oversee that benefits data is collected and tracked against an agreed stakeholder map for up to six months following implementation (Go Live), after which responsibility for ongoing benefit	31.12.2025		Complete	Complete		January 2026 update: A standardised Benefits template has been created to support the collection and ongoing monitoring of Benefits Realisation activities. Benefits are identified at the outset of each project and agreed upon by the designated SRO. Following project go-live, the project team will monitor these benefits for the initial six months, after which responsibility for the log is transferred to the operational service. The template is available upon request. A project milestone tracker for all live projects to show benefits activities has been created. Available on request	None	It is already in place and supporting all new and ongoing digital projects	01.12.2025	Yes	0	1512	jan-26	08.01.2026	
252613	2025/2026	Primary Care-Clusters Project Management Final report	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	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		January 2026: Wording within the TOR changed to meet audit recommendations - version 1.9 now current version. Same changes reflected in Mid Cluster and South Cluster TORs for consistency. TORs to be reviewed and updated again in April 2026 to reflect new 2 Cluster structure.					#NUM!	1512	jan-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	R1	Medium	The testing we undertook on a sample of 15 reversing journals found that the entries were appropriate, actioned on a timely basis and authorised prior to the upload to the general ledger. However, we did identify several occasions where the offset balance sheet financial code was incorrect resulting in income accruals being offset against a creditor accrual code and vice versa.	At financial year end all balance sheet individual transactions are reviewed to ensure the correct classification for Financial Statement Purposes. We will issue a reminder to all staff to check that they input the correct offset balance sheet financial code when actioning accruals for income and expenditure	31.01.2026		Complete	Complete		January 2026 Update: Discussed at full team meeting and communicated to all team members					#NUM!	1512	jan-26	08.01.2026	

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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				
242520	2024/2025	Patient Flow and Discharge Management Final Internal Audit Report	Reasonable	Director of Primary Care, Community and Mental Health	Clinical Change Manager	R7	Medium	Clinical Frailty Score: The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigifLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigifLO whiteboards will be updated accordingly once this new score is implemented.	Utilise the DigifLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack.	01.03.2026		Not yet due	Partially complete		August 2025 - Powys DigifLO has the ability to record Clinical Frailty Scores (CFS), with guidance provided within the Standard Operating Procedure (CSG 001, Sept 2024) and accompanying "How to Guides." Training was delivered through the Powys DigifLO Information Roadshow (Nov 2024-Feb 2025) to support staff in using this functionality. Recording of CFS is not yet consistent. The CEDAR Hospital-Acquired Deconditioning Tool is now in pilot across other Health Boards; however, as this is a manual recording tool, it cannot currently be integrated into Powys DigifLO. 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 (DEWT) 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.	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		#NUM!	1512	Jan-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.	The Health Board will continue to advocate, engage and work with providers and with DHCW/NHS Wales and NHS England to attempt to improve the current state of IT infrastructure surrounding national cancer performance data.	01.03.2026		Not yet due	No progress		29/07/2025 update: Following discussion at ARAC, further discussion to take place between 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.				#NUM!	1512	Jan-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	R1	Medium	Standard Operating Procedure: Practice Visit Report Assurance Ratings: Testing undertaken in Objective 4 identified that there is no SOP in place to clarify and formalise the process for the assessment and awarding of Practice Visit Report Assurance Ratings that underpin the potential invocation of the Framework Escalation Ladder, in absence of this approach being provided within the Framework Guidance.The Contract and Visit Governance Report includes twelve Assurance Ratings - one for each assessed Health & Care Quality Standard, and where there is an even or 'close call' split of ratings across the twelve Standards, as we identified in several of the five Reports, there is no current process to determine the final overall Assurance Rating	National guidance is due to be produced that will document and formalise the process for the assessment and awarding of Practice Contract and Visit Governance Report Assurance Ratings. Following production of the National Guidance, management will ensure that it is followed for future Practice Visits.	01.12.2025	01.04.2026	Not yet due	No progress		August 2025: Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therefore this deadline needs to be moved on to 01/04/26 January 2026: Due to revised timeline as awaiting national documentation, not yet due.	National Work	National Contract Assurance review group meetings planned	01.04.2027		1	#NUM!	Jan-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 PCGPRA is either not accepted or monitoring shows non-compliance. However, as noted within Finding 1, there is currently no process for	Following receipt of the national guidance referenced in Finding 1, the Primary Care Team will ensure that an overall assurance rating is determined and recorded for all future GMS Contract and Visit Governance Reports.	01.12.2025	01.04.2026	Not yet due	No progress		August 2025: Awaiting national guidance. Documentation currently being reviewed nationally to support the 25/26 review cycle; therefore this deadline needs to be moved on to 01/04/26 January 2026: Due to revised timeline as awaiting national documentation, not yet due.	National Work	National Contract Assurance review group meetings planned	01.04.2027		1	#NUM!	Jan-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		Not yet due	Partially 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.					0							
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	31.03.2026		Not yet due	Partially complete		January 2026: The action considers to be a key consideration and will form part of the annual review as scheduled.						0						
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 (PTB) 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 Workstream reporting progress to the Better Together Project Board. The SPOA will also formalise the reporting of Quality & Safety related governance into the QUALS meeting, which is an SMT workstream, this will be on a monthly basis.	01.02.2026		Not yet due	Partially complete		January 2026: Work underway to put together a reporting template to report into QUALS on a monthly basis, first meeting 20/1/26.						1512	Jan-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		Not yet due	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.												
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 IBC.	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		Not yet due	Partially complete		January 2026: Preparing a template for reporting at present with Quality and Safety.												

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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		Not yet due	Partially 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.	None	Digital trainers are currently in place to assist with several major projects, and the knowledge gained will be shared across further digital initiatives.	28.02.2026	Partially due to temp function arrangements	#NUM!	1512	Jan-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	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		Not yet due	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.	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.	31.03.2026		#NUM!	1512	Jan-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		Not yet due	Partially complete		January 2026 update: in Development	None	Currently available on separate documents rather than 1 tracker	31.03.2026		#NUM!	1512	Jan-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		Not yet due	Partially 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.	None	Through comms and testimonials via service lea	31.03.2026		#NUM!	1512	Jan-26	08.01.2026
252616	2025/2026	Staff Development Programme	Substantial	Director of People and Culture	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 that opportunities 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		Not yet due	No progress		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.				#NUM!	1512	Jan-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		Not yet due	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				#NUM!	1512	Jan-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		Not yet due	Partially complete		January 2026 Update: Initial discussions with Salary Sacrifice all wales team have taken place and this action is being taken forward.				#NUM!	1512	Jan-26	08.01.2026	
252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services		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		Not yet due	Partially complete		January 2026 Update: Work on this is scheduled for February 2026				#NUM!	1512	Jan-26	08.01.2026	
252604	2025/2026	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services		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 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		Not yet due	Partially complete		January 2026 Update: Work on this is scheduled for February 2026				#NUM!	1512	Jan-26	08.01.2026	
252604	2025/2027	Core Financials-General Ledger Management and Accounts Receivable	Reasonable	Director of Finance, Capital and Support Services		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.	31.03.2026		Not yet due	Partially complete		January 2026 Update: Work on this is scheduled for February 2026				#NUM!	1512	Jan-26	08.01.2026	

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PTMS 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
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Lizzi 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		Overdue	Partially complete		22.8.2025 Update: * Helen Kendrick to confirm the action of a central register - to be held on a SharePoint site for wide team access. * All CSM have received a copy of the PowerPoint update to come to every CSG Q&PE 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 reviewing 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-grip and asset numbers. Timeframe for completion Q1 26/27.					4	1512	Jan-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 AIN 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.					4	1512	Jan-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.					4	1512	Jan-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Lizzi Shone	R1	High	Lack of awareness and specific training on the Health Board's Mattress Policy. Limited specific training on the Health Board's mattress policy has been provided and so most staff have limited awareness of its requirements. Furthermore, no register is maintained which records who has received specific training and how this compares with those staff undertaking the work	Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered.	30.07.2025		Overdue	Partially complete		March 2026:					6	1512	Jan-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Lizzi Shone	R3	High	Monthly mattress audits not completed by all wards. As detailed above, monthly mattress audits are not being completed by all wards. Furthermore, the audit templates in the mattress policy were not consistently used.	All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.	30.07.2025		Overdue	Partially complete		22.8.2025 Update: * Email shared with all ward leaders by Head of Nursing (see email as unable to embed documents). * Mattress audits all undertaken for the months of July and August, with oversight of compliance of completeness by CSM team - due for reporting through Q&PE on 6th October 2025 3.2.25 Update - reports have been received regularly through Q&S process - Evidence of monthly compliance through teams channel and Q&S minutes/recordings - Evidence of correct audit template being used.					6	1512	Jan-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Pau I Sussex	R4	High	Confirmation that actions are taken to address issues identified: Where issues were identified in the mattress audits that we reviewed, there was generally no confirmation whether action had been taken to rectify the issues and if so, when it occurred. We also noted that there is currently no register in place that records the mattress audits and details any issues identified and the actions taken to address them.	A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.	30.07.2025		Overdue	Partially complete		22.8.2025 update: This action requires completion - awaiting central register to be shared by medical devices lead who is on leave. 3.2.26 Update - Actions and escalations for ordering replacement covers/parts are captured in Ward level audits and reported through Q&S structure.					6	1512	Jan-26	
242528	2024/2025	Mattresses	Limited	Director of Allied Health Professions, Health Sciences and Digital	Zoe Client/Donna Jones/Pau I Sussex	R6	High	Missing mattress audit information. Mattress identifier numbers and identifiable signatures were often missing on the mattress audits we reviewed. On some of the audits we also noted that there was no information recorded for a number of the mattresses, and the reasons for the omissions were not indicated.	Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.	30.08.2025		Overdue	Partially complete		22.8.2025 update: There was an issue that some of the identifiable information on mattresses was coming off during the process of cleaning - a request has been made to HK to ensure all information is attached to mattresses that has more permanence, this is under review. Update 3.2.26 - Medical devices confirmed that a process is in place to secure asset numbers on devices.					5	1512	Jan-26	
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 sign-off of the IMF. This will be included in the document to ensure accountability and clarity. The IMF will define and document clear responsibilities for relevant roles within the Health Board for identifying, investigating, and monitoring Duty of Candour cases. A detailed organisational structure will be developed and included within the Framework that outlines the lines of accountability for monitoring and reporting Duty of Candour. This will specify the roles and responsibilities at the Clinical Service Group, Committee, and Board levels. The IMF will be amended to show the correct timeframe for conducting the RIRMs.	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 PQOS. 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 submitted 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	Capacity of the Q&S Team				2	1512	Jan-26	08.01.2026

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PTH8 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	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.					2	#NUM!	jan-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 – 2025". 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 fullness 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	aug-26	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.					0	#NUM!	jan-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	Deadline Revised	Partially 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					#NUM!	#NUM!	jan-26	08.01.2026

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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
242501	2024/2025	Review of Workforce Planning Arrangements	Director of People and Culture		R1	To ensure service level workforce plans are consistent, for the next planning cycle, the Health Board should ensure all directorates and/or service areas develop a workforce plan using the HEIW workforce plan template	Continue to roll out training that utilises the HEIW workforce plan template. • Provide periodical updates to Executive committee of those managers who are required to undertake the training; have done so, to ensure that the competencies to complete workforce plans are embedded within the organisation. Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.	Quarter 4 2024/2025		Complete	Complete	
242501	2024/2025	Review of Workforce Planning Arrangements	Director of People and Culture		R2	The Health Board should develop an evaluation framework to measure whether the roll out of workforce planning training is achieving its intended purpose and improving service level workforce planning	• Gain feedback from attendees both immediately after training and 3 months post training to understand effectiveness. • Measure the number of workforce plans produced across the organisation.	Quarter 4 2024/2025		Complete	Complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date
Dec 24 - Workforce planning (WFP) training continues to be available for managers to access tthrough multiple modalities. such as 1-hour information and awareness session, through to more detailed training accessed via online or face to face classroom based training. 38 staff have completed the full training to date with leadership teams from across Mental Health, Womens & Childrens, Digital and Corporate Nursing receiving the 1-Hour awareness sessions. Gap analysis completed of those managers who have completed training and identified those managers with workforce planning responsibility that would benefit from the training. Identified list of managers to be shared with relevent Director/AD in Q4 for consideration. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed. HEIW have offered funding (until 31st October 2025) for a Workforce planning manager role to support the development of local MH WFP's aligned to the national strategic Mental Health WFP. The role has been advertised, interviewed and an offer made, but candidate then went on to withdraw. Role has been re-advertised again and is currently at the shortlisting stage. In order to support managers to develop WFP, WOD Business Partnering Team will share HEIW template to clinical directorates pre-populated with up-to-date workforce data - Q4. Feb 25 - Targetted discussion with Assistant Directors has taken place with an identified list of senior managers to prioritise in relation to training delivery (9 of these have booked sessions). In total, the workforce planning training in line with the HEIW template has been delivered to 39 managers (through a variety of routes/approaches). Our training approach has continued to develop based around service needs and has included the devleopmet of a bespoke awareness session and more recently, targetted practical follow up sessions to explore the 6 step toolkit in more detail. Workforce information and signposting to how to get this information has been included as part of training delivered. As we progress to practical follow up sessions as outlined above, we anticipate that we can provide more specific pre-populated workforce information sections. August 2025 - In light of the work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementaton of new emerging operatiing models. This will ensure effective use of resources and mitigate the risk of misalignment and duplication of effort. It also ensures workforce planning is co-ordinated, evidence based and aligned to the strategic priorties of the Health Board. January 2026 - This action is no longer going to be taken forward, and is recommended for closure, based on the redirection of resource to the delivery of Better Together and the need to develop workforce plans for new and emerging workforce models.	Capacity of managers with WFP responsibility to complete WFP training and subsequent WFPs. Unclear what future demand is until Route Map to Sustainability work has been defined/completed. Difficulties in recruitment to WFP Manager role.	People & Culture WFP Lead continues to develop organisational level WFPs	2025/26				jul-25
Dec 24 - P&C Business Partnering Team have developed an evaluation framework which gathers feedback from attendees following the training delivery. Refreshed evaluation questionnaire due to be sent to all those that have attended training to date to understand current utilisation of WFP knowledge and skills. Feb 25 - An evaluation form has been developed and it is anticipated this will be finalised and sent to attendees by end of March 2025. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed. August 25 - In light of the work work on the Better Together programme, the recommendation has been superseded by the development of workforce plans to support the implementation of new emerging operating models. This will ensure effective use of resources and mitigate the risk of misalignment and duplication of effort. It also ensures workforce planning is co-orindated, evidence based and aligns with the strategic priorities of the Health Board. January 2026 - This action is no longer going to be taken forward, and is recommended for closure, based on the redirection of resources to the support the delivery of Better Together and the need to focus training to support new and emerging workforce models.	Percentage of those attendees completing evaluation questionnaire.		Q4 2024/25				jul-25

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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	Structure Assessment 2023	Director of Nursing, Quality, Women and Family Health		R3	Develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	mai-24		Overdue	No progress	
232401	2023/2024	Structure Assessment 2023	Director of Corporate Governance/Director of Nursing, Quality, Women and Family Health		R5	The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	jul-25	jan-26	Overdue	Partially complete	
242503	2024/2025	Review of Cost Saving Arrangements	Director of People and Culture	Director of Improvement and Transformation	R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potention costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	Agreed – The Health Board has established a programme of work around future sustainability with programme and workstream structure: - ‘Task force’ in place to examine three areas: • the future model (building on existing work) • options and decisions around when to achieve financial breakeven. • new opportunities based on analysis of data and benchmarking. Identified timeline in place with initial engagement planned for 24/25.	okt-24	mar-25	Overdue	Partially complete	
242503	2024/2025	Review of Cost Saving Arrangements	Director of People and Culture	Director of Improvement and Transformation	R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the Accelerated Sustainable Model.	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	okt-24	mar-25	Overdue	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
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.							jul-25	mar-24
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	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					jan-26	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 qualification 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	Capacity in key roles/teams to work at pace on options development.	Ongoing mitigation through existing operational measures.	TBC				jul-25	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 Committee 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.	Capacity in key roles/teams to identify additional resource requirements	Ongoing mitigation through existing team deployment to areas of highest priority	TBC				jul-25	

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	Deadline Revised	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	Deadline Revised	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	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 involvement in the Plan development. A Strategic Assessment of Provided and Commissioned Planned Care will be undertaken as part of the Better Together Transformation Programme. "Better Together" is PTHB promise to work together with citizens to review how and where we provide services, to ensure safety, to improve quality, and to make best use of resources that we can. We want to talk to patients and service users, people and communities, health and care staff, and our partner organisations.	jun-26	mar-26	Deadline Revised	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	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	des-25	mar-26	Deadline Revised	Partially complete	

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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
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	Deadline Revised	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
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.							jul-25	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.							jul-25	jul-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.	None identified.		mar-26	Yes				13.02.2026
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.			mar-26					13.02.2026

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Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
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.								13.02.2026

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 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	mar-25	mar-26	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	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		Not yet due	Partially complete	

Progress of Work underway	Barriers to implementation including any interdependices	How is the risk identified being pending implementation	When is implementaiton expected to be acheived.	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
August 2025: Delays with establishment of Professional Nursing Collaborative. Unlikley to be implemented this financial year. Strengthening 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.							jul-25	jul-24
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.	None identified.		mar-26	Yes				13.02.2026



GIG
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Health Board

Agenda item: 5.8

Audit, Risk and Assurance Committee		10 March 2026
Subject:	POWYS TEACHING HEALTH BOARD (PTHB) BOARD MEMBERS DECLARATION OF INTERESTS, GIFTS and HOSPITALITY 2025/2026	
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary	
Prepared by:	Corporate Governance Business Officer	
Other Committees and meetings considered at:	Executive Committee – 18 February 2026	
PURPOSE:		
This paper presents the position as of 02 February 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 02 February 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.

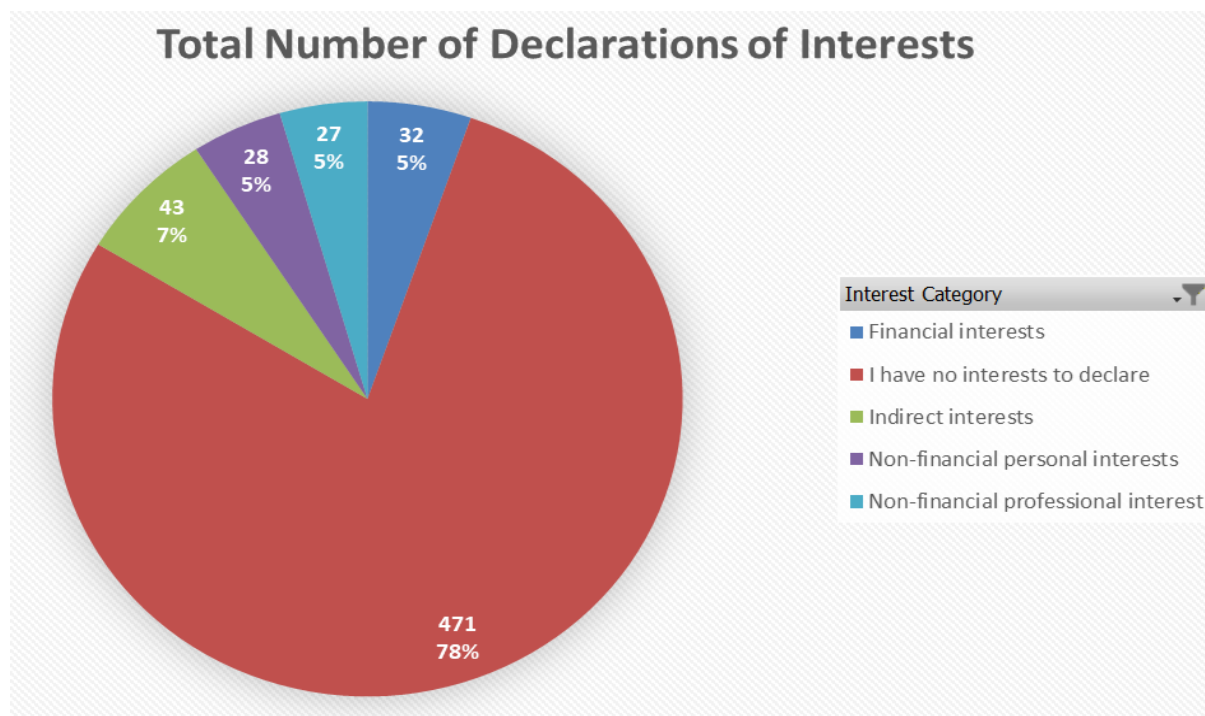
In March 2025 the Board approved the revised Standards of Behaviour Policy. The key fundamental change within the revised policy was the addition of recording and maintaining a record of declarations of interests submitted by those staff with responsibility of budget oversight within the organisation.

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 Director of Corporate Governance with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests and any gifts and hospitality received or declined.

The chart below provides a summary position of the Declarations of Interest submissions received for 2025/26. The register for Declaration of Interests 2025/26 is attached at **Appendix A**.



The previous report in September 2025 showed a total of 145 Declarations of interest submissions received. As of 02 February 2026, a total of 601 Declarations had been declared, providing a significant increase of submissions received in year.

As of 02 February 2026, a total of 6 Gifts, Hospitality and Honoria had been declared within the register for 2025/2026. This showed a 100% increase in comparison to the previous year, 2024/2025. The register for Declaration of Gifts and Hospitality in 2025/26 is attached at **Appendix B**.

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

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 2025/2026 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.

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Employee Name	Employee Number	Position Title	Consent Flag	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Independent Monitoring Authority - Non-executive Director. Remuneration £7250.00 per Annum		18/03/2021	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Lay Observer to HEW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	01/10/2018	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Outside employment	Member of Finance, Risk and Audit Committee - Hafod-Hendre Housing Association.	Hafod does not undertake functions in Powys Small annual payment only - £2500.00 per anum.	31/12/2017	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Shareholdings and other ownership interests	Director of RA and CJ Consulting Ltd	Dividend payment only	31/08/2012	14/04/2025
Alexander, Mr. Ronnie Joseph	29746249	Board Non Officer	Y	Y	Indirect interests	Shareholdings and other ownership interests	Partner - Director of RA and CJ Consulting Ltd	Dividend payment only	06/08/2017	14/04/2025
Ashman, Mrs. Zoe Kate	30321709	Assistant Director of Quality & Safety	Y	N	I have no interests to declare				05/06/2025	
Barnes, Mrs. Sarah	31363315	Head of Service: Public Health Programmes and Projects	Y	N	I have no interests to declare				30/06/2025	
Beavan, Mr. Paul	10601945	Digital Technology Lead	Y	N	I have no interests to declare				05/06/2025	
Beavan, Mr. Paul	10601945	Bank Digital Technology Lead	Y	N	I have no interests to declare				05/06/2025	
Bennett, Mrs. Jacqueline Helen	10602133	Senior Area Dental Nurse	Y	N	I have no interests to declare				10/06/2025	
Bertie, Mrs. Hannah Mae	29169740	Senior Communication and Engagement Manager	Y	N	I have no interests to declare				13/06/2025	
Bocking, Mrs. Karen Jean	20458005	Facilities Co-ordinator	Y	N	I have no interests to declare				26/08/2025	
Bowley, Mrs. Shan Mererid (Mezz)	30743956	Director of Public Health	Y	Y	Financial interests	Shareholdings and other ownership interests	Husband employed by Mitie Engineering as estimating manager, who holds contracts / work with some NHS Bodies/Organisations. Shares held by husband & myself in Mitie. Jointly hold share certificates Royal Mail.	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	14/05/2025	
Bowley, Mrs. Shan Mererid (Mezz)	30743956	Director of Public Health	Y	Y	Non-financial professional interest	Loyalty interests	Fellowship membership of the 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). Unclear which situation option to select as this is professional membership.	14/05/2025	
Brown, Mrs. Amanda Jane	10604787	Admin & Patient Services Manager	Y	N	I have no interests to declare				04/06/2025	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Indirect interests	Outside employment	My partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Last worked for the organisation in October 2024.	01/06/2024	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Indirect interests	Outside employment	My partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Chair since June 2023, Board member since August 2016. Newydd/Cadarn Housing Group	01/08/2016	
Bushell, Miss Helen	31173260	Board Secretary	Y	Y	Non-financial personal interests	Outside employment	Governor - Llangynwyl primary School (Bridgend)	Current term runs to November 2027	01/11/2023	
Cooper, Dr Carl	31039601	Board Chair	Y	Y	Indirect interests	Loyalty interests	Family Member Employment	Pharmaceutical Control Analyst. Cardiff & Vale UHB.	02/02/2025	
Cooper, Dr Carl	31039601	Board Chair	Y	Y	Indirect interests	Loyalty interests	Spouse's Employment	Sole Trader - Mandy Williams Consulting	02/04/2025	
Cooper, Mrs. Vicki Andrea	28462424	Chief Digital Data Officer	Y	N	I have no interests to declare		No further comment	no further comment	30/04/2025	
Crawley, Mr. Duncan Neil	31968897	Professional Lead for Catering and Environmental Cleanliness	Y	N	I have no interests to declare				11/06/2025	
Davies, Mr. Geraint William	28434855	Head of Estates	Y	N	I have no interests to declare		I have no declarations to declare	I have no declarations to declare	26/08/2025	
Davies, Mrs. Catrin Ann	30675100	Lead Advanced Nurse Practitioner for Children	Y	Y	Financial interests	Outside employment	Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies. Spouse / Partner or other Relative. – Yes Director of Owen Davies Consulting Ltd and Gwaggle Space Ltd	Ongoing for both companies owned by spouse.	01/08/2013	
Day, Mrs. Wendy Jane	31520037	Assistant Head of Childrens Public Health Nursing	Y	N	I have no interests to declare				07/05/2025	
Deacon, Mrs. Tracey Elizabeth	31598575	Head of Service: Public Health Programmes and Projects	Y	N	I have no interests to declare				05/06/2025	
Deakins, Mrs. Victoria Louise	10604327	Lead Therapist North Locality	Y	N	I have no interests to declare				06/05/2025	
Edwards, Mrs. Amanda Jane	25429509	Assistant Director of Improvement and Innovation	Y	N	I have no interests to declare				10/06/2025	
Elliot, Mr. Stephen Richard	32535276	Board Non Officer	Y	Y	Non-financial professional interest	Outside employment	Spouse Directorship of Osh's World Private Limited Company and a Trustee of Osh's World Charity		17/04/2024	
Evans, Mrs. Caroline	27784514	Research, Innovation & Improvement Manager	Y	N	I have no interests to declare				19/08/2025	
Falvey, Mr. Aled Joseph	27086017	Professional Head of Physiotherapy	Y	N	I have no interests to declare				18/08/2025	
Falvey, Mrs. Katelyn Emma	21187975	Head of Workforce Transformation, Planning & Resourcing	Y	N	I have no interests to declare				18/08/2025	
Falvey, Mrs. Katelyn Emma	21187975	Assistant Director or Workforce and OD	Y	N	I have no interests to declare				18/08/2025	
Farnsworth, Mr. David Mark	30692747	Assistant Director of Community Services	Y	Y	Non-financial personal interests	Loyalty interests	My spouse works as a clinical practitioner in dementia for St Michael's Hospice, Hereford.	I have no direct involvement in the commissioning of any services with this provider.	09/05/2025	
Giannasi, Mr. Michael Anthony (Nick)	32493172	Board Non Officer	Y	Y	Indirect interests	Outside employment	I am currently the Chair of Social Care Wales which is a Welsh Government Sponsored Body.	The Health Board has no direct contractual or financial relationship with Social Care Wales. However, as the regulator for the social care workforce in Wales, it is part of the wider health and care system and as such, matters may arise in the course off the Board's business which could be perceived by others to amount to a conflict.	01/08/2019	31/07/2027
Gwynne, Mrs. Stella Elizabeth	27926256	Assist. Dir. Corporate Governance/Deputy Board Secretary	Y	N	I have no interests to declare				22/04/2025	
Gwyther, Mrs. Tracey Louise	32884839	Head of Commissioning	Y	N	I have no interests to declare				14/05/2025	

Harris, Mrs. Susan Dorothy	25348800	Facilities Co-ordinator	Y	N	I have no interests to declare				05/06/2025	
Hartwright, Dr Christopher Gerald (Chris)	28862934	Head of Psychology	Y	N	I have no interests to declare				05/06/2025	
Hill, Mrs. Alex Jayne	23105814	National Head of Researcher Development	Y	N	I have no interests to declare				13/06/2025	
Hobbs, Ms. Rhannon Catrin	32797600	Principal Public Health Practitioner	Y	N	I have no interests to declare				10/06/2025	
Hopgood, Mr. Peter Lewis (Pete)	27376161	Deputy CEO & Director of Finance	Y	Y	Non-financial personal interests	Loyalty interests	Wife/Partner is a Finance Manager in Swansea Bay UHB.	Wife/Partner is currently employed as a Finance Manager in Swansea Bay UHB.	18/06/2018	
Hughes, Mr. Owen	10604720	Head of Pain & Fatigue Management	Y	Y	Financial interests	Clinical private practice	I am a director of a limited company called psych45 ltd. I use this company to run training events, clinical private practice and expert witness work		05/04/2010	
Hymers, Mrs. Louise	28527252	Macmillan Lead Nurse for Cancer and Palliative Care	Y	Y	Indirect interests	Loyalty interests	My husband is employed by RNIB as one of the Eye Care Liaison Officers covering PTHB - this is a commissioned service via an SLA between PTHB and RNIB - I have no interaction with the commissioning process of his role, or his role within the health board.		20/06/2025	
Ingram-Jones, Mrs. Jayne Elizabeth	30965037	Business Support Manager	Y	N	I have no interests to declare				29/07/2025	
Jamieson, Mrs. Judith Rosemary	10601981	Senior Nurse Mgr - Outpatients	Y	N	I have no interests to declare			I have no conflicts of interest to declare	01/06/2011	01/06/2029
Jamieson, Mrs. Judith Rosemary	10601981	Senior Nurse Mgr - Outpatients	Y	N	I have no interests to declare				05/06/2025	
Johnson, Mrs. Nicola	32833200	Director of Planning	Y	N	I have no interests to declare				30/04/2025	
Jones, Mrs. Donna Leela	32147098	Integrated Clinical Team Manager	Y	N	I have no interests to declare				05/06/2025	05/06/2026
Kelly, Miss Nicola Jane	26623607	Head of Planned Care	Y	N	I have no interests to declare				18/08/2025	
Kelly, Mrs. Vivien Maria	25599815	Senior Clinical/Counselling Psychologist - Older Adult	Y	Y	Non-financial professional interest	Clinical private practice	I have a private practice providing clinical supervision	I have in the past also provided consultancy and training to third sector organisations, local authorities, educational institutions and the NHS (under the name 'People Skills Wales'). I have also had a private practice as a therapist. At the moment I only offer a limited supervision provision	11/06/2025	
Kirkham, Mrs. Michelle	24909224	Professional Head of Radiography	Y	N	I have no interests to declare				13/06/2025	
Lawrence, Mrs. Jayne Louise	10604680	Assistant Director of Primary Care Services	Y	N	I have no interests to declare				16/07/2025	
Lewis, Dr Rhobert	27442212	Board Non Officer	Y	Y	Indirect interests	Outside employment	External member Cross-party STEMM Group Welsh Government	Unsure of exact date. No payment involved. Continuing.	01/01/2020	15/04/2025
Lewis, Dr Rhobert	27442212	Board Non Officer	Y	Y	Non-financial professional interest	Outside employment	Chair NPfC Group of Colleges	And continuing No payment involved	17/11/2021	15/04/2025
Lines, Mrs. Clare Peace	10603301	Assistant Director Partnership Development	Y	Y	Indirect interests	Outside employment	My husband is; "A trustee of the Wales Council for Voluntary Action * The Chair of the Gateway Dental Practice * The Chair of Social Investment Cymru Committee (WCVA) * Member of Cares Trust Wales Advisory Board	Update May 2025 - positions have been held for longer	07/05/2025	07/05/2027
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Financial interests	Outside employment	Independent Member - ateb housing associate		01/04/2024	
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Indirect interests	Outside employment	Daughter works for Aneurin Bevan University Health Board		01/08/2023	
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Indirect interests	Outside employment	Husband works for Hywel Dda University Health Board		02/06/2025	
Lorton, Mrs. Elaine Linda	32852996	Executive Director of Primary Care,Community & Mental Health	Y	Y	Non-financial professional interest	Outside employment	Chair of West Wales Care & Repair Board	Voluntary Board Member	01/11/2019	
Madsen, Mrs. Claire Louise	28421856	Director of Therapies and Health Sciences	Y	Y	Financial interests	Outside employment		I sometimes do visiting lecturer work ad hoc for the University of the West of England	30/04/2025	20/04/2027
Madsen, Mrs. Claire Louise	28421856	Director of Therapies and Health Sciences	Y	Y	Non-financial professional interest	Loyalty interests		Member of the Chartered Society of Physiotherapy	02/06/2025	01/06/2027
McGowan, Mrs. Emma Jayne	20904349	Clinical Informatics Lead Nursing	Y	N	I have no interests to declare				05/06/2025	
McGowan, Mrs. Emma Jayne	20904349	N&M Bank Staff Qualified AFC	Y	N	I have no interests to declare				05/06/2025	
McIntyre, Mr. Mark Edward	26581555	Deputy Director of People & Culture	Y	N	I have no interests to declare				18/08/2025	
Morris, Miss Louise Marie	26846132	Head of Capital	Y	N	I have no interests to declare				14/04/2025	
Moss, Mr. Christopher	32035998	Assistant Director of Performance & Commissioning	Y	N	I have no interests to declare				05/06/2025	
Osborne, Mr. Adrian	26873573	Deputy Director of Communication, Engagement & Corporate Gov	Y	Y	Non-financial personal interests	Outside employment	I am a volunteer Trustee of Powys Citizens Advice which is in receipt of grant funding from the health board and other partner bodies.		01/04/2025	
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Brother is Senior Manager Freedom Leisure South Powys & Swansea		01/01/2020	31/12/2030
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Chair PSB Scrutiny Committee		01/04/2024	01/04/2027
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Coopted member PAVO		01/09/2024	01/06/2028
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Member (not a NEI) Glas Cymru		01/06/2016	10/06/2027
Owen Adams, Mrs. Jennifer	31013528	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Vice Chair PAVO		07/02/2025	09/02/2028
Owen, Mr. David Michael	31289889	Assistant Director of Digital Technology and Data Operations	Y	N	I have no interests to declare				04/06/2025	
Parry, Miss Jane	26944865	Library Services Manager	Y	N	I have no interests to declare				25/06/2025	
Pearce, Dr Adam Hugh	30005784	Service Improvement Manager Welsh Language & Equalities	Y	Y	Financial interests	Outside employment	I run a small independent publisher called Melin Bapur books (www.melinbapur.cymru) as an additional (part time) employment. I have also previously delivered Equality training, including to NHS Wales organisations, on a freelance basis; I have and will not solicit any such work through my NHS Wales role.	I have previously received a payment from Public Health Wales in my capacity as Melin Bapur CEO for delivering a speaking engagement. This engagement was not solicited by myself and was totally coincidental to my employment by NHS Wales, and was carried out on my own time.	01/03/2023	

Phillips, Ms. Justine	10604523	Specialist Continence Service Lead	Y	N	I have no interests to declare				05/06/2025	
Powell, Mrs. Sarah	27544342	Assistant Director of People & Culture, OD & Wellbeing	Y	N	I have no interests to declare				09/06/2025	
Poynton, Ms. Catherine	10606185	UNISON Branch Secretary	Y	N	I have no interests to declare				11/04/2025	
Price, Dr Fiona Catherine Mary	31511062	Head of Clinical Education	Y	N	I have no interests to declare				05/06/2025	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Outside employment	Husband Interests Husband Ó Pharmacist consultant providing support to Pharmacy departments in NHS England and Wales. Husband Ó working as a pharmacy and medicines consultant providing advisory and expert services to: Bain & Co. Global consultancy. Input to specific pharmacy and medicines projects		03/04/2023	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Shareholdings and other	Brother in law owns building in Welshpool currently rented by Rowlands Pharmacy. I have no interest or gain in this.		03/06/2018	
Price, Miss Jayne Elizabeth	20731798	Principal Pharmacist	Y	Y	Indirect interests	Shareholdings and other	Second cousin is senior GP partner for Newtown Medical Practice		01/06/2017	
Pritchard, Mrs. Sarah Elizabeth	10601943	Assistant Director of Finance	Y	Y	Indirect interests	Loyalty interests	My son is a planning officer with Bannau Brycheiniog National Parks to which the HB will submit planning applications for construction works on its land and buildings.	I will not be making any planning applications directly but may be required to facilitate payment for such applications but based on budget holder approval.	23/07/2025	
Pritchard, Mrs. Sarah Elizabeth	10601943	Assistant Director of Finance	Y	Y	Indirect interests	Shareholdings and other	My brother owns a petrol station in Senybridge where THB fleet fuel cards may be used.	I have no personal/owner interest in this business but declaring family relationship as this business may have possible transactions with the THB via third party vendor for fuel cards	23/06/2025	
Pullen, Mr. Hywel Richard	31291840	Deputy Director of Finance	Y	N	I have no interests to declare				01/02/2023	
Quarrell, Miss Catherine Linda	10602220	Corporate Services Manager	Y	N	I have no interests to declare				05/06/2025	
Quarrell, Mr. Andrew Phillip	27519808	Non Emergency Patient Transport	Y	N	I have no interests to declare				11/06/2025	11/06/2026
Randell, Mrs. Rebecca Claire	10604591	AHPs Head of Paeds Physiotherapy	Y	N	I have no interests to declare				04/08/2000	
Rosche, Mrs. Claire Louise	30400027	Director of Nursing	Y	N	I have no interests to declare				29/05/2025	
Ruthven-Hill, Miss Samantha (Sam)	27190725	Assistant Director of Planning	Y	N	I have no interests to declare				05/06/2025	
Shone, Mrs. Lini Ann	21597775	Prof Head of Nursing	Y	N	I have no interests to declare				06/05/2025	
Shooter, Dr Ben Michael	26229116	Consultant in Adult Mental Health	Y	N	I have no interests to declare				03/05/2022	
Shooter, Dr Ben Michael	26229116	Consultant in Adult Mental Health	Y	N	I have no interests to declare				06/05/2025	
Sinclair, Mrs. Heidi Marie	31366346	Head of Quality and Safety	Y	N	I have no interests to declare				29/04/2025	
Smart, Mrs. Amanda Louise	10601949	Head of Information Governance, Records & Data Protection	Y	N	I have no interests to declare				30/07/2025	
Summerfield, Mrs. Tanya Maria	10604108	Business Manager Online CBT	Y	N	I have no interests to declare				05/06/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal interests	Clinical private practice	Director of BEST KEPT SECRET AESTHETICS WALES LTD.	Joint Director of this Ltd company undertaking private clinical practice in aesthetics. No direct or relationship with NHS activity.	22/08/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal interests	Outside employment	Director of LLAMORS LTD.	Joint director with my husband, working in the construction of new residential dwellings. No direct or related interest in public service.	22/08/2025	
Symes, Mrs. Amie Louise	25790311	Director or Midwifery, Women and Family Health	Y	Y	Non-financial personal interests	Shareholdings and other	Registered Landlord - rental of residential dwellings	I am joint owner of a portfolio of residential dwellings with my husband. I am the RentSmart Wales registered landlord undertaking activities in line with legislative obligations. No affiliation with NHS activity, property located outside the county of Powys.	22/08/2025	
Tannahill, Mr. Wayne Robert (Wayne)	25129663	Associate Director of Capital, Estates & Property	Y	N	I have no interests to declare				02/07/2025	
Taylor, Mr. Peter Martin Henry	28858271	AHPs Head of Podiatry	Y	N	I have no interests to declare				06/07/2020	
Taylor, Mr. Peter Martin Henry	28858271	AHPs Head of Podiatry	Y	N	I have no interests to declare				18/08/2025	
Thomas, Mr. Christian Delfryn	10604706	Assistant Director of Finance	Y	N	I have no interests to declare		No interest to Declare		05/06/2025	
Thomas, Mr. Ian	33136771	Board Non Officer	Y	Y	Non-financial personal interests	Outside employment	I have worked with a team of consultants as an independent associate in the past	I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	09/04/2025	
Thomas, Mrs. Christina Marie	24460992	Senior Manager - Unscheduled Care	Y	N	I have no interests to declare				01/09/2025	
Thomas, Mrs. Hayley	23581771	CEO Chief Executive	Y	N	I have no interests to declare				09/05/2025	
Thomas, Mrs. Tanya Marie	28323968	Transformation Manager - Mental Health Renewal	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Transformation Manager - Mental Health Renewal	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Mental Health Team Bank	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	Mental Health Team Bank	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	CAMHS Primary Mental Health Worker	Y	N	I have no interests to declare				05/06/2025	
Thomas, Mrs. Tanya Marie	28323968	CAMHS Primary Mental Health Worker	Y	N	I have no interests to declare				05/06/2025	
Tolley, Dr Warren	10604274	Associate Dental Director	Y	N	I have no interests to declare		I have no interests to declare	I have no interests to declare	18/08/2025	

Toy, Mrs. Julia Anne	10602270	Strategic Workforce Lead for Health, Care and Partnership	Y	N	I have no interests to declare				05/06/2025	
Vitolo, Miss Lydia	23757448	National Lead Commercial Research Delivery Wales	Y	N	I have no interests to declare			I have no declarations to declare and am happy for this to be published	27/08/2025	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Associate Member of the Association of Genealogists and Registered Archivists		08/05/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Elected Member Powys County Council		05/05/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Sole Trader/Owner of Celebratory Gifts Heraldic Names		01/06/2003	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Financial interests	Outside employment	Sole Trader/Owner CTW Genealogy Research		01/06/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Indirect interests	Loyalty interests	Trustee/Chair: Brecon University Scholarship Fund		01/07/2022	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Indirect interests	Outside employment	Brecon Town Council Elected Member		10/08/1995	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Governor of Priory Church in Wales School		22/05/2017	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Labour Party Member		01/12/1988	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel		25/09/2017	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member of Community Speed Watch Group		01/06/2010	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Loyalty interests	Member of Society Genealogists		01/01/2019	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial personal interests	Shareholdings and other ownership interests	Owner of Property in the County of Powys		01/06/1988	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Member of Royal College of Nursing		01/01/1986	
Walsh, Mr. Christopher Timothy	31171724	Board Non Officer	Y	Y	Non-financial professional interest	Loyalty interests	Registered Member of Nursing and Midwifery Council		31/03/1988	
Walters, Mrs. Amanda Jayne	29825659	Head of Primary Care	Y	N	I have no interests to declare				18/08/2025	
Waters, Mrs. Felicity Jayne	28227441	Communication and Engagement Manager	Y	N	I have no interests to declare				16/06/2025	14/06/2026
Wheeler Sexton, Mrs. Jayne	28484260	Assistant Director of Nursing	Y	N	I have no interests to declare				08/04/2025	
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Outside employment	Magistrate	Gwent Bench	01/03/2016	
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Outside employment	Private work as a sole trader - delivering coaching, training and marking services. Associate at TPC Leadership and TPC Health Other clients include Macmillan UK, NHSE/I, Personalised Care Institute (England), Welsh Government, HDUHB Changed to Ltd company in Feb 2022	Previously submitted declarations by email to Med Dirs office/HR	04/01/2016	03/02/2027
Williams, Dr Nicola Louise	25665710	National Director of Support & Delivery	Y	Y	Non-financial professional interest	Shareholdings and other ownership interests	Founder/Director of Williams Creative Consultancy Ltd -T/A Mynd Leadership. Registration number 13938853		22/02/2022	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Indirect interests	Outside employment	Chair of the GCRE Community Liaison Committee		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Indirect interests	Outside employment	Commissioner South Wales Fire and Rescue Service		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Co Director Powys Samaritans		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Director of ILEP Ltd a subsidiary of Cardiff University		22/04/2025	
Williams, Ms. Victoria Kirsty	30361342	Board Vice Chair	Y	Y	Non-financial personal interests	Loyalty interests	Vice Chair Brecknock YFC Board of Management		22/04/2025	
Wood-Lawson, Ms. Debra	31521670	Director of Workforce and Organisational Development	Y	Y	Indirect interests	Outside employment	Non Executive Director of Cadam Housing Association	I am a non Executive Director of a Housing Association and a member of their Group Board and Governance Committee The 'group' is a zonal partner with Powys for the provision of housing stock	01/11/2024	01/11/2027
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Financial interests	Outside employment	I am employed as Academic Registrar at Cardiff University which delivers a number of health care programmes		03/03/2015	18/06/2025
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Financial interests	Outside employment	My wife is employed as a District Nurse for Cardiff and Vale Health Board		18/06/2025	
Wright, Mr. Simon	30982939	Board Non Officer	Y	Y	Indirect interests	Loyalty interests	My sister is a Senior Operations Manager, Milestone Trust Bristol		18/06/2025	

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Powys Teaching Health Board Register of Gifts and Hospitality 2025/2026.

Date of Gift	Donor/Contact Name	Item Donated	Organisation	Channel received	Notes	Value likely to exceed £25	Accepted/Declined
19.06.2025	Unknown	£100 Spa Voucher	Public	Email	Gift voucher emailed directly to a Midwife for providign maternity care	yes	Declined- Emailed directly back to Spa
09.10.20205	NHS Procurement Framework Partner	Winner of a prize draw: £100 Gift Voucher	Welsh Procurement Alliance	Email	Winner of a Prize draw of £100 voucher. This has been declined and asked that a donation to be made to the Powys Health Chairty on behalf of the department	yes	Declined - donation to be made to the Powys Health Chairty
10.10.2025	Tesco	Shower Gel and Soap	Tesco	Post	Accepted and used for patients that have no families	No	Accepted
24.10.2025	Corporate Governance Conference - Digital Health and Care Wales	Notebook, Pen, Pin, Keyring, Sticker and Chocolate Bar	Digital Health and Care Wales	In person	Gifted as part of a Conference attended.	No. Less than £15	Accepted
24.10.2025	Corporate Governance Conference - Digital Health and Care Wales	Notebook, Pen, Pin, Keyring, Sticker and Chocolate Bar	Digital Health and Care Wales	In person	Gifted as part of a Conference attended.	No. Less than £15	Accepted
29.12.2025	Patient	£50 Gift voucher	Public	In person	Gifted as part of a Retirement gift.	Yes	Declined

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.9

Audit, Risk and Assurance Committee		Date: 10 MARCH 2026
Subject:	STRATEGIC RISK REGISTER and BOARD ASSURANCE FRAMEWORK (BAF) DASHBOARD	
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary	
Prepared by:	Deputy Board Secretary	
Other Committees and meetings considered at:	Executive Committee – 04 March 2026	
PURPOSE:		
To provide the Committee with the March 2026 version of the Strategic Risk Register and BAF Dashboard as a source of assurance that both the Risk Management Framework and Board Assurance Framework are in active operation.		
RECOMMENDATION:		
The Committee is asked to:		
• RECEIVE the ○ March 2026 Strategic Risk Register update, included at Appendix A ○ March 2026 BAF Dashboard update, included at Appendix B ○ Annual detailed analysis of Strategic Risks at Appendix C • TAKE ASSURANCE that the above elements of the Risk Management Framework and Board Assurance Framework are in active operation.		
Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Corporate Risk Register covers all of the strategic objectives and risks could impact on more than one objective.
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	
EXECUTIVE SUMMARY:		

The Strategic Risk Register (SRR) is a cornerstone of the Board Assurance Framework (BAF) and is the central repository for risks to the delivery of PTHB's strategic priorities. The SRR was created following the approval of a revised Risk Management Framework in March 2025 and was developed in alignment to the Health Board's Strategic Priorities and was first report to the Board in November 2025.

There are 12 risks on the register. Following review and consideration by Executive Leads, there have been no changes suggested to risk descriptions or scores to those risks reported in the Strategic Risk Register on the 26 November 2025 to the Board.

Appendix A includes a summary of the risks, the heatmap of risk ratings and the detail for each strategic risk.

The Board Assurance Framework (BAF) Dashboard was newly developed and first reported to the Board on 26 November 2025. This dashboard supports the Strategic Risk Register by seeking/providing assurance that the actions deployed by the Board to manage/mitigate its key risks are adequate and effective, and presenting an opportunity to undertake further scrutiny and identify actions where gaps or weaknesses are identified. The BAF Dashboard is attached to this paper as **Appendix B**.

Appendix C provides a more detailed analysis of each strategic risk. This is the first time the report has been developed and will be provided to the Committee annually with the opportunity to consider whether controls and assurance are effective, adequate and well balanced, as well as the opportunity to assess the level of gaps on control and assurance.

NEXT STEPS:

Executive Committee will continue to seek assurance on the ongoing development and management of all organisational and strategic risks. Responsibility is allocated, as per Committee terms of reference against the current strategic risk register as follows:

Committee	Risk Number and Summary
Audit, Risk and Assurance	SRR 011 (Digital and Electrical Infrastructure)
Finance and Performance	- SRR 001 (Financial sustainability) - SRR 007 (Estate) - SRR 009 (Continuing Health Care) - SRR 012 (Public Confidence)
Patient Experience, Quality and Safety	- CRR003 (Commissioning) - CRR004 (Provided Services)
People and Culture	SRR 006 (Workforce)

Planning, Partnerships and Population Health	• SRR 002 (Transformation) • SRR 005 (Primary Care) • SRR 008 (Prevention) • SRR 010 (Major/Critical Incident)
The Board Assurance Framework (appendix B) will continue to be produced to the Board bi-annually. The detailed analysis of strategic risk (appendix C) will continue to be refined based on learning and feedback and will be presented annually.	

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Powys Teaching
Health Board

Strategic Risk Register

March 2026

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Strategic Risk Register

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Agenda Item:5.9a Appendix A

STRATEGIC RISK DASHBOARD

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

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Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/✗	Lead Board Committee	Link to Strategic Priorities:
EDP&C	SRR 006	Workforce	The Health Board is unable to recruit and retain an appropriate workforce.	4 x 4 = 16	→	Cautious	✗	People and Culture	Cross-cutting (All SPs and WBOs)
EDoFC &E	SRR 007	Quality	The care provided in some areas is compromised due to the health board's estate being not fit for purpose.	4 x 4 = 16	→	Minimal	✗	Finance and Performance	SP 09 and WBOs 1 and 4
EDPH	SRR 008	Innovation and Strategic Change	The Health Board is unable to shift to a primary prevention focused health care system	4 x 4 = 16	→	Eager	✗	Planning, Partnerships and Population Health	SP 1 and WBO 1
EDPCC MH	SRR 009	Performance and Service Sustainability	The Health Board is unable to stabilise the growing implications of Continuing Health Care	4 x 4 = 16	→	Open	✗	Finance and Performance	SP 6 and WBO 4
EDPH	SRR 010	Safety	The Health Board is unable to respond in a timely, efficient, and effective way to a major incident, or critical incident	3 x 4 = 12	→	Averse	✗	Planning, Partnerships and Population Health	Cross-cutting (All SPs and WBOs)
EDAHP HS&D	SRR 011	Performance and Service Sustainability	Failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.	3 x 5 = 15	→	Open	✗	Audit, Risk and Assurance	Cross-cutting (All SPs and WBOs)

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Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/✗	Lead Board Committee	Link to Strategic Priorities:
DCG	SRR 012	Reputation and Public Confidence	The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.	3 x 5 = 15	→	Open	✗	Finance and Performance	Cross-cutting (All SPs and WBOs)

The details for SRR011 has been removed from the in-public papers due to the sensitivity of data contained.

KEY:

Executive Lead	
EDoFC&E	Executive Director of Finance, Capital and Estates
EDP&C	Executive Director of People and Culture
EDPP&C	Executive Director of Planning, Performance and Commissioning
EDPCCMH	Executive Director of Primary Care, Community and Mental Health
EDPH	Executive Director of Public Health
EDAHPHS&D	Executive Director of Allied Health Professionals, Health Sciences and Digital
DCG	Director of Corporate Governance/Board Secretary
CEO	Chief Executive

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Trend	
*	New risk
→	Risk score unchanged since last report
↓	Risk score decreased since last report
↑	Risk score increased since last report

RISK HEAT MAP

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

SRR 001	There is a risk that: The Health Board is unable to achieve its duty to achieve financial breakeven (and therefore sustainability).																						
Current Risk Score: 20	Risk rating detail: (likelihood x impact) Current: L4 x I5 = 20 Inherent: L4 x I5 = 20 Target: L2 x I4 = 8	Risk Category: Financial Sustainability																					
		Boards Risk Appetite: Cautious																					
Executive Lead: Executive Director of Finance, Capital and Support Services		Assuring Committee: Finance and Performance Committee																					
Latest review date: February 2026 Added to register: June 2024 Link to Strategic Priorities and Wellbeing Objectives: Cross-cutting risk relevant to all SPs and WBOs	 <table border="1"><caption>Risk Score Trajectory</caption><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 24</td><td>8</td><td>16</td></tr><tr><td>Nov 24</td><td>8</td><td>16</td></tr><tr><td>Jan 25</td><td>8</td><td>20</td></tr><tr><td>July 25</td><td>8</td><td>20</td></tr><tr><td>Nov 25</td><td>8</td><td>20</td></tr><tr><td>Mar 26</td><td>8</td><td>20</td></tr></tbody></table>	Month	Target Score	Risk Score	July 24	8	16	Nov 24	8	16	Jan 25	8	20	July 25	8	20	Nov 25	8	20	Mar 26	8	20	Cause/source of risk: The Health Board reported a £15.8m deficit in 2024/25 It has a Plan for a £28.3m deficit in 2025/26, but due to unforeseen cost pressures, it is forecasting a £28.3m deficit in 2025/26. Savings programme of £23.1m Planned underlying deficit of £42.1m has been revised to £44.7m due to the impact of the unforeseen cost pressures, off-set by some recurrent mitigating actions Risk materialising would result in: Failure to achieve the statutory duty to breakeven
Month	Target Score	Risk Score																					
July 24	8	16																					
Nov 24	8	16																					
Jan 25	8	20																					
July 25	8	20																					
Nov 25	8	20																					
Mar 26	8	20																					

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

Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
Executive Directors are focussed on delivery of £23.1m savings targeted for 2025/26.	DFC&SS	Reported regularly to Board and F&P and to Exec Committee. Month 106 £17.7m £20m savings forecast.	Ongoing	Ongoing
Executive Team workshops focussed on actions to reduce expenditure in 2025/26.	DFC&SS	Workshops held w/c 7 July. Outcome to be reported to Board in July. Has led to greater value of recurrent savings than initially planned.	Ongoing	Ongoing
An external review has been commissioned, which is focusing on the financial position of the Health Board and its arrangements for commissioning secondary healthcare services and CHC.	DFC&SS	Grant Thornton has been appointed. Interim findings are due to be reported at the end of October and draft Final report at the end of November.	End of November	Met
		Final report February with GT led Board Development session. Findings to inform 2026/27 Annual Plan.	Submit Plan end of March	Ongoing
Additional information:				
Rationale for current score:				
• The Plan includes a £23.1m savings target. This is not currently being achieved.				

- The Health Board is experiencing greater cost pressures than its recurrent mitigating actions and additional funding can contain. This is leading to an increase in its underlying deficit. Assessed as ~~£42.1m~~ **£44.7m**.
- The scale of this deficit against annual expenditure of circa **£500m** ~~£480m~~ makes it probable that the organisation will not be able to comply with its statutory duty to breakeven for some time.

SRR 002	There is a risk that: The Health Board is unable to successfully deliver and realise the benefits of transformation													
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: 4 x 4 = 16 Inherent: 4 x 4 = 16 Target: 2 x 4 = 8	Risk Category: Innovation and Strategic Change												
		Boards Risk Appetite: Eager												
Executive Lead: Executive Director of People and Culture		Assuring Committee: Planning, Partnerships and Population Health												
Latest review date: February 2026 Added to register: July 2025 Link to Strategic Priorities and Wellbeing Objectives: Cross-cutting risk relevant to all SPs and WBOs	 <table border="1"><caption>Risk Score Trajectory Data</caption><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 25</td><td>8</td><td>12</td></tr><tr><td>Nov 25</td><td>8</td><td>16</td></tr><tr><td>Mar 26</td><td>8</td><td>16</td></tr></tbody></table>	Month	Target Score	Risk Score	July 25	8	12	Nov 25	8	16	Mar 26	8	16	Risk cause/source: • Insufficient capacity to deliver across the Better Together Portfolio • Insufficient cognition and capability to deliver the level of transformational change across the Better Together Portfolio • Lack of organisational and public readiness for change • Timescales are too challenging to deliver • Inability to invest in estate and infrastructure required to deliver level of transformational change across the Portfolio • Financial recovery plan FY25/26 and FY26/27 impacts on ability to deliver the Better Together portfolio • Unable to access reliable data and/ or deliver digital transformation and infrastructure to support change • Misalignment with key dependencies both external and internal to the portfolio
Month	Target Score	Risk Score												
July 25	8	12												
Nov 25	8	16												
Mar 26	8	16												

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

		Wellbeing Programme, Frailty & Community Model incorporating the Six Goals for Urgent & Emergency Care Programme, Planned Care & Diagnostics Programme, Mental Health Transformation Programme, Business Efficiencies Programme and Temporary Service Change Programme		
2.2	Better Together Portfolio Board established as a Sub—Group of the Executive Committee	Regular reporting to the Executive Committee	Substantial	Executive Committee
2.3	Oversight of Better Together and Transformation integrated into Terms of Reference of F&P, P&C and PPPH Committees	Regular reporting to Board Committees and onwards assurance provided to Board	Substantial	Multiple Board Committees
2.4	Better Together Stage 2 engagement programme has been developed and commenced ~~concluded~~ including staff roadshows and workshops as well as several public events across Powys. The Stage 2 engagement report has been published with Board papers. Continuous engagement activity is underway.	Review and report on outcomes arising from engagement	Reasonable	Better Together Portfolio Board
2.5	Monthly informal Planning update meetings with WG including Better Together update	Regular informal discussion with WG leads	Substantial	N/A

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2.6	Wider stakeholder engagement plan in place with regular Primary Care, PCC, PAVO and Llais interface.	- Inputs and reporting from primary care workshops and meetings. - Inputs and outputs from wider stakeholder engagement meetings.	Reasonable	Better Together Portfolio Board
2.7	Ongoing assessment of delivery capacity as portfolio plan develops. Monitored through Portfolio Board and reported to Executive Committee	Portfolio Board reporting to Executive Committee	Reasonable	Better Together Portfolio Board

Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
Revised timeline in development, including consideration of alignment for future phases and resourcing plan to strengthen delivery confidence	DI&T	NEW	Complete End Nov 2025	Complete On track
Continued implementation of transformational programmes aligned to the PTHB Strategic Priorities to deliver agreed benefits and deliverables	DI&T	This continues	Ongoing	On track
Implementation of Strategic Change deliverables to support achieving financial sustainability	DI&T; Executive Director Programme Leads; Programme SROs	Approved Temporary Changes implemented for 6 month period and further decision making aligned with Better Together.	Ongoing	Aligned to extension of Better Together timeline
Ongoing public, staff and stakeholder communication & engagement	DI&T; Director of Corporate Governance	ODEC workstream established to oversee delivery of Comms	Ongoing	On track

		& Engagement activity to support portfolio delivery Resource plan supported and in implementation.		
Map dependencies within portfolio and external to portfolio including strategic change being enacted on PTHB borders and assess impact and areas for close monitoring	DSI&T; Director of Planning, Performance & Commissioning	This continues	Ongoing	On track
Development of Estates Strategy	Associate Director of Capital, Estates & Property	Close working with Better Together programme to support strategy development	Ongoing	On track
Assess dependencies with digital work plan	DSI&T; Director of AHPs, Health Science and Digital	Dependencies and interdependencies under ongoing assessment	Ongoing	On track
Additional information:				
N/A				

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SRR 003		There is a risk that the Health Board is unable to respond to the demand for commissioned services																									
Current Risk Score: 20	Risk rating detail: (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	Risk Category: Performance and Service Sustainability																									
		Boards Risk Appetite: Open																									
Executive Lead: Executive Director of Planning, Performance & Commissioning		Assuring Committee: Patient Experience, Quality & Safety Committee																									
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Month	Risk Score	Target Score																									
July 24	20	12																									
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Mar 26	20	12																									
Added to register: July 2024	Link to Strategic Priorities and Wellbeing Objectives:																										

SP 11 and WBO 8		weeks but continuing to report patients >52 weeks (178). RJAH remains most challenged provider for long waiters. 78131 > 104 weeks reported in July November. Very long waits exceed 200 weeks, especially for complex spinal. - The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality. Risk materialising could result in: - Poorer outcomes and experience for the citizens of Powys - Difficulty in balancing performance and financial plan		
Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
3.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers. Low assurance currently due to robustness of referral data. Exploring alternative data sources (e.g. activity) whilst working through improved data set for GP referrals. Intention to review further in context of Commissioning Intentions for 2026/27; and SCF implementation plan.	Limited	Executive Director

3.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers <i>Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.</i>	Reasonable	Executive Director
3.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans <i>Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.</i>	Reasonable	Executive Director
3.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data. <i>Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.</i>	Limited	Executive Director
3.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the	Various data sources including operational & performance data. Qualitative information	Limited	Executive Director

	Finance and Performance Committee and Board as well as future planning	from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.		
Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> - Continue regular meetings with commissioned service providers. - Secure performance improvement trajectories from providers. - Insourcing contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. - Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Quality and Performance Report. - Continuing to work to obtain robust data for referrals from NHSW and NHSE GPs for Powys residents.	Executive Director of Planning, Performance and Commissioning (supported by DPCCMH)	Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand expected performance 2025/26 and to be reviewed and discussed through CQPRMs. Planned Care Insourced provision tender exercise ~~delayed~~ cancelled pending outcome of GIRFT assessment of planned care. Temporary extension of medinet to end of	April 2025 and ongoing	Delayed (Procurement)

▪ GIRFT strategic assessment of planned care. ▪ Commissioning Intentions 2026/27 for NHSW and NHSE providers. ▪ Recommendations from GT review – to be included in SCF implementation plan.		March 2026. Mitigating actions put in place to ensure continuity of service provision whilst tender exercise undertaken. Paper presented to Executive Committee for decision. Established Commissioning Oversight and Assurance Group (COAG), chaired by Exec DPPC, to provide a forum for internal oversight and escalation of performance monitoring of commissioned non-specialist services. Additional actions to be taken: ▪ Strategic Commissioning Framework implementation plan for 2026/27 (to reflect outcomes of GIRFT assessment of planned care and GT recommendations). ▪ Refresh of IQPR to include additional detail particularly on quality metrics.	

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		Increased scrutiny on performance through Commissioning Oversight and Assurance Group and planned Commissioned Services Performance Report.		
Cancer	MD (supported by DPPC)	Added to this version of the risk register. Actions to be agreed. Cancer Working Group chaired by Medical Director. CQPRMs and COAG cover all specialties with commissioned providers. Cancer Deep Dive to be presented to F&P Committee October 2025.	TBA	TBC
<u>Urgent and Emergency Care</u> - CQPRMS cover all specialties with commissioned providers including UEC. - Continued work on 6 Goals plan to reduce admissions and secure timely discharge.	DPPC (supported by DPCCMH)	CQPRMS and COAG cover all specialties including urgent and emergency care. Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient	April 2025 and ongoing	On track

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

Commented [NJ2R1]: Also COAG will cover all specialities

▪ Strengthening arrangements for admissions to community beds in NHSE. ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissioning Committee ▪ Secure performance improvement trajectories and improvement plans from providers. ▪ NHSW and NHSE commissioning intentions 2026/27.		experience, incidents and resultant investigations, clinical indicators. ~~Several recent ICAP meetings have been cancelled.~~ Regular attendance at CCLG and sub- committee structure including Ambulance and 111 Commissioning Group, NEPTS Commissioning Assurance Group. ~~New governance structure developed by the JCC with establishment of Ambulance Services and 111 Collaborative Commissioning Integration Group.~~ Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.		
All indicators There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will	DPPC	Integrated Quality and Performance Framework (IQPF) has been reviewed and refreshed for 2025/26. As part of the IQPF, the Integrated	April 2025 and ongoing	On track

develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.		Quality and Performance Report will continue to provide information across the NHS Wales Performance Framework measures including Cancer and 4 hour ED waits. IPQF annual review planned for March 2026 to inform IQPF refresh for 2026/27.		
Additional information:				
Rationale for current score: <u>Planned Care</u> NHS Wales Latest validated position to month 8 5 as per IQPR month 5-8 report presented to Executive Committee. ~~15th October 2025.~~ (April 2025)÷ Update including impact of actions to date on current risk score: ~~Improved~~ Performance being maintained across NHSW and NHSE providers, still challenges in compliance with patients waiting >52 and 104 weeks. performance experienced within NHS England commissioned service providers; expected improvement in NHS Wales expected following issue of additional planned care monies in 2025/26, and national procurement process for outpatients and treatments. Continued inequity of access for PTHB residents accessing NHSW services in comparison with NHSE.				

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SRR 004	There is a risk that the Health Board is unable to respond to the demand for provided services																									
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	Risk Category: Performance and Service Sustainability																								
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Month	Target Score	Risk Score																								
July 24	12	16																								
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Several SPs and WBO 4 and 8				
Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
4.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services. Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer. Maximising insourcing offer to ensure optimal performance standards are achieved. Implement as many Optimisation frameworks and 5 Goals for Planned Care as appropriate for a community-based provider	- Referral data into services from commissioning data sets and supplementary reports received from commissioned providers - Best practice guidance from GIRFT and Welsh Government / NHS Exec	Reasonable	Finance & Performance
4.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Finance & Performance
4.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Finance & Performance
4.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Reasonable	Finance & Performance
4.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to the reliance on agency staff (particularly	Various workforce and financial reports recording agency usage at ward and service level	Reasonable	Finance & Performance

	higher cost agency providers) and deliver expected cessation.			
4.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections	Reasonable	Finance & Performance
4.7	Development and implementation of integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and the expansion of Powys DigiFLO—to enhance system resilience and operational efficiency. This control supports delivery of the PTHB Six Goals for Urgent and Emergency Care, contributes to the NHS Wales People’s Experience Framework, and enables a shift toward a prevention-based, value-driven model of care.	Task & Finish Group reports, baseline assessment against National SPoA Framework, operational data (Package of Care Delays, PoCD), pilot evaluations and implementation monitoring reports	Reasonable	Finance & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> - Continue series of regular meetings with service providers - Monitor and manage delivery against performance improvement trajectories for our own services. - On track for delivery of national OPD recovery plan and secondary validation of RTT position.	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed. GIRFT review underway	September 2026	On track

Medinet contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report. External review of elective care commissioned from GIRFT for Q4 25/26				
<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. A number of service reviews are being undertaken with several 'cases for change' having been approved by the Health Board and stakeholders.	Executive Director PCCMH	Overall case for change now available for second phase engagement, with options development completed and available for future engagement and consultation. Further work ongoing to develop and implement service change that falls below threshold for consultation.	April 2026	On track
There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made	Executive Director PCCMH	A number of sub-indicator performance targets have been identified. These have been built into the IQPR and actions in train to further reduce risk	December 2025 April 2026	On track

towards achievement of the overall target.				
Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to mitigate delays, improve patient flow, and support timely discharge across the system.	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for December 2025. PoCD: Daily tracking and escalation in place; overall delays reduced, recognising seasonal variation. Daily 'huddle' to review patients in place. DigiFlo: Implemented on community hospital wards, expansion into MH has been progressed. Trusted Assessment: Pilot completed in collaboration with PCC with early findings indicating positive impact.	March 2026	On Track
Additional information:				
Rationale for Current Score: Mitigation actions are ongoing, including further actions relating to planned care but some underlying challenges remain, so the current risk score remains unchanged at this review. Collaborative efforts through the <i>Better Together</i> programme are expected to provide further support in addressing this strategic risk alongside mitigating actions listed above.				

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SRR 005	There is a risk that Primary Care is unable to respond to demand																									
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	Risk Category: Performance and Service Sustainability																								
		Boards Risk Appetite: Open																								
Executive Lead: Executive Director of Primary Care, Community and Mental Health		Assuring Committee: Planning, Partnerships and Population Health Committee																								
Latest review date: February 2026 Added to register: July 2024 Link to Strategic Priorities and Wellbeing Objectives:	Risk Score Trajectory <table><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr><tr><td>July 24</td><td>8</td><td>16</td></tr><tr><td>Nov 24</td><td>8</td><td>16</td></tr><tr><td>Jan 25</td><td>8</td><td>16</td></tr><tr><td>Mar 25</td><td>12</td><td>20</td></tr><tr><td>July 25</td><td>12</td><td>16</td></tr><tr><td>Nov 25</td><td>12</td><td>16</td></tr><tr><td>Mar 26</td><td>12</td><td>16</td></tr></table>	Month	Target Score	Risk Score	July 24	8	16	Nov 24	8	16	Jan 25	8	16	Mar 25	12	20	July 25	12	16	Nov 25	12	16	Mar 26	12	16	Drivers/causes of risk: - Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures Risk materialising would result in: - Related workforce challenges may lead to services becoming unsustainable
	Month	Target Score	Risk Score																							
July 24	8	16																								
Nov 24	8	16																								
Jan 25	8	16																								
Mar 25	12	20																								
July 25	12	16																								
Nov 25	12	16																								
Mar 26	12	16																								

SP 4 and WBO 8				
Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
5.1	Monitoring and liaison with GP practices to offer support including weekly review of the escalation tool, reviewing the sustainability matrix, and considering sustainability funding applications. Regular discussions with Cluster Lead and LMC regarding ongoing demands and additional actions to manage peaks. 25/26 negotiation agreed in December 2025, confirming additional national investment. Includes 4% DDRB uplift and additional 5.8% recurrent uplift supporting a Workforce Fund, Change Fund and Resilience Fund. These new additional funding streams will provide practices with financial certainty to invest in resources needed for ongoing reform, including workforce expansion, service redesign and administrative support as part of the Community by Design transformation programme. The detail around access to these funds is being worked through in readiness for 26/27 Sustainability Assessment Panels being held following practice application submission. Targets discussions and action plans and support packages in place with specific practices. National 25/26 negotiations have been delayed; however the expectation is additional national investment will be	- Escalation Tool - Sustainability matrix score - National Sustainability Assessment Framework - Primary Care Information Portal – access standards	Reasonable	Executive Committee

	announced. Sustainability Assessment Panels being held following practice application submission. Targets discussions and action plans and support packages in place with specific practices. 3 non-recurrent ortho contracts completed as of September 2025. Crickhowell contract award, approved by the Board in November 2025.			
5.2	National Contract Assurance Framework embedded to support contract assurance. 24/25 Practice reviews ongoing. 5 practice visits currently being undertaken and 11 practices progressing practice improvement plans. evidence reviews commenced, including a comparison of clinical indicators across the 2 years for consistency/improvement assurance. Outstanding actions from 23/24 being followed up as part of the 24/25 review process GMS Contracts Management Group confirming practice action plan requirements or targeted practice visits required as part of the 24/25 cycle. GDS End of year review visits with all contract holders completed in August 2025.	- Contract Assurance Framework - Annual Return - Supplementary Service Audits - Prescribing Data - Practice Declarations - GP Clinical Governance Self-Assessment Tool - Information Governance Toolkit	Reasonable	Executive Committee / Finance & Performance
5.3	Implementation and maturity of Accelerated Cluster Development Programme and associated cluster projects of local pathways will support practice sustainability.	Cluster Plan progress reported to RPB Executive Group	Reasonable	Executive Committee /

	26/27 Cluster IMTP plans currently being progressed, for presentation to RPB Executive Group by end of Q3 completed and agreed at RPB Executive Group. The mid and south cluster will merge from 1st April 2026. Newly formed cluster currently working in shadow form and developed a joint 26/27 IMTP			Finance & Performance
5.4	OOH APMS contract is in place with Shropdoc from 01/04/25 to 05/06/26 (including extensions). PTHB Board have approved Direct Award to continue with current specification from 01/07/26 to 30/09/27. Direct Award being progressed. SBUHB 25/26 SLA signed, with ongoing discussions to resolve outstanding issues in readiness for 26/27. Conversations being led at Director level between PTHB and SBUHB. SBUHB continue to provide a service. ~~Resolve and secure current commissioning arrangements with SBUHB for 25/26 to ensure ongoing provision of OOH cover for Ystradgynlais patients and Ystradgynlais Community Hospital. Conversations being led at Director level between PTHB and SBUHB. SBUHB continue to provide a service.~~ ~~GMS out of hours review and future model appraisal group with multiple stakeholder representation set up, to consider various options for the future OOH GMS service delivery and model across Powys was approved by the Board in September 2025.~~	- Weekly Rota (triage & base cover) - Monthly achievement against OOH Performance Standards - Quarterly Performance Review Commissioning Assurance Framework	Reasonable	Executive Committee / Finance & Performance

	GMS out of hours multi stakeholder workshop undertaken in January 2026 to consider the future OOH clinical model. This work is moving at pace to develop a revised specification to commence an open market tender in Q3/Q4 26/27. Quarterly Performance Reviews continue to monitor out of hours services.			
5.5	Allocating patients from the Dental Access Portal is in place. DAP is fluid with regular 'on and offs'. List is currently at circa 4000 patients due to recent terminations of Llandrindod, Knighton and Crickhowell GDS contracts. Patient urgent access demand has sufficient capacity in the system to address patient need and this is monitored very closely on a weekly basis. Urgent access pathways in place in all contract reform practices, further supported by the Community Dental Service pathway when needed. Mobile Dental provision, salaried PTHB service working well. Pathways in place to support patients following completion of course of treatment. Current location is Bronllys. Potential purchase of an additional Mobile Dental Unit to support GDS access in areas of need. Procurement underway to recommission general dental services in Crickhowell and Knighton. Successful Contract award for Crickhowell GDS. Crickhowell GDS contract award.	• Dental Access Portal • Contract Reform new patient and historic patient metrics. • GDS monitoring Group	Limited	Executive Committee / Finance & Performance

Procurement underway to recommission general dental services in Knighton and Llandrindod. A PTHB salaried service for both these areas is being progressed to offer access through a hybrid model, this will add resilience and sustainability to both areas. New Dental Contract being implemented from 01/04/27. National model contract not yet published; therefore, it is difficult to quantify how many practices will sign up to the new contract or terminate NHS services. This is a national risk.				
Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
To complete GP Practice visits following outcome of Desktop Reviews. These will take place in Q4	Assistant Director Primary Care (ADPC)	Desk top reviews completed and follow/up actions being progressed. 5 practice visits to be undertaken and 11 practice improvement plans to be progressed ~~Desk top reviews to commence in July~~	March 2026 ~~November 2025~~	On track Commenced
Review and assess completion of General Practice Improvement Plans	ADPC	~~Linked to the above.~~ ~~Not yet commenced - linked to desktop reviews above.~~	March 26	On track
Undertake GDS Mid-Year Review visits	ADPC	All required visits undertaken in October/November 2025	November 25	Completed On track

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		~~Will be undertaken in October/November 2025~~		
Review of GMS sustainability matrix	ADPC	To be undertaken in Q4 2	~~March 26~~ November 25	On track Commenced
Procure additional recurrent GDS access in mid Powys	ADPC/ Dental Director	Knighton and Llandrindod contract procurement commenced	March 26	On track
Complete Procurement of direct award for future provision of GMS OOH services	EDPCCMH/ADPC	Commenced and linking in with NHSSSP Procurement Services ~~Will commence following Board approval in September to proceed.~~	March 26	On track
Ensure future provision of general medical services for patients registered at Rhayader Medical Practice post 30 th September 2025	EDPCCMH/ADPC	Procurement process concluded and APMS contract award issued. To be implemented on 01/01/26	January 2026	Completed On track

Additional information:

Rationale for current score:

- Sustainability assessment and escalation tool of GP Practices identifying consistently high-risk practices across Powys. Practices may not be able to provide sustainable GMS services. Approx. 50% of GP Practices reporting level 3/level 4 currently confirming the ongoing pressure. Appointment/contact activity data confirms continued high patient demand.
- Practice Sustainability support in place for Llanfyllin and Knighton
- ~~Practice Sustainability applications for support being considered Llanidloes and Welshpool.~~
- Financial sustainability of practices may influence the termination of Local Supplementary Services

- Dental access continues to be challenging in areas with recruitment and workforce challenges. Mid cluster particularly affected currently.
- **DAP waiting list currently increasing due to loss of 3 contracts in mid/south Powys.**
- ~~DAP waiting list currently at 3,500 patients on the waiting list.~~
- Orthodontic demand continues to exceed capacity across Powys.
- **Implementation of WGOS4 challenging due to complex secondary care pathways and implementation is further compromised by information governance complexities.**
- ~~New Optometry Regulations and implementation of WGOS4 challenging due to complex secondary care pathways and implementation is further compromised by information governance complexities~~

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Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8	Risk Category: Workforce																								
		Boards Risk Appetite: Cautious																								
Executive Lead: Executive Director People & Culture		Assuring Committee: People & Culture Committee																								
Latest review date: February 2026 Added to register: July 2024 Link to Strategic Priorities and Wellbeing Objectives: Cross-cutting risk relevant to all SPs and WBOs	 <table><caption>Risk Score Trajectory Data</caption><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr><tr><td>July 24</td><td>8</td><td>16</td></tr><tr><td>Nov 24</td><td>8</td><td>16</td></tr><tr><td>Jan 25</td><td>8</td><td>16</td></tr><tr><td>Mar 25</td><td>8</td><td>16</td></tr><tr><td>July 25</td><td>8</td><td>16</td></tr><tr><td>Nov 25</td><td>8</td><td>16</td></tr><tr><td>Mar 26</td><td>8</td><td>16</td></tr></table>	Month	Target Score	Risk Score	July 24	8	16	Nov 24	8	16	Jan 25	8	16	Mar 25	8	16	July 25	8	16	Nov 25	8	16	Mar 26	8	16	Drivers/causes of risk: • Demographics of the workforce and within our communities leading to challenging labour market. • No university within the Powys footprint to provide regular supply of newly qualifying clinicians. • Rurality and commutability of sites. Risk materialising would result in: • Higher agency costs associate with variable pay spend • Inability to sustain high quality services and patient safety
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Controls (What are we currently doing about the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
6.1	Safecare has been implemented to support and monitor safe staffing levels on wards.	Briefing at daily huddle between Community Service Managers and TSU.	Reasonable	Assistant Directors
6.2	A programmed schedule of staffing huddle meetings take place during the week between the TSU and services to plan and review rosters for the week ahead and prioritise areas requiring additional staffing.	Routine schedule published to include all relevant staff. It is managed by the resourcing team with a rota in place of TSU staff to attend.	Reasonable	Assistant Directors
6.3	A Variable Pay Group has been established and meets twice monthly. A range of performance measures have been developed to monitor variable pay levels. Agency Operationalising Meetings schedule now completed and workstreams incorporated into this group.	Minutes and papers from meetings. Escalation of current vacancies within areas of high variable pay spend. Adult and MH Ward managers have been engaged to fully understand and agree existing vacancies and encouraged to actively advertise vacant posts. Wider vacancy 'deep dive' investigation completed and presented to variable pay group.	Reasonable	Deputy CEO
6.4	Workforce projections have been developed for all clinical staff groups with a detailed focus on Nursing (both Registered and HCSWs) across Adult Wards and Community teams and Mental Health Wards and	Workforce performance reports produced routinely and shared appropriately.	Substantial	Lead Executive Directors

	Community Teams, projecting future staffing levels against known recruitment pipelines, such as Grow our own and international recruitment.	Deep Dive Reports developed annually, or as required.		
6.5	Regular reporting of 'Time to Hire' and recruitment KPI's included within Workforce Performance Reports.	Workforce performance reports produced routinely and shared appropriately.	Substantial	Workforce & Culture Committee
6.6	Monthly vacancy reporting in place identifying vacant posts against the financial ledger.	Workforce performance reports produced routinely and shared appropriately.	Substantial	Workforce & Culture Committee
6.7	Workforce planning training delivered and an ongoing offer available.	38 staff have completed the full training to date with staff from MH, W&C, Digital and Corporate nursing receiving a 1-hour overview session.	Reasonable	Deputy Director People & Culture
6.8	Intranet page with information on Workforce Planning set up for managers.	SharePoint site: Workforce Planning (sharepoint.com)	Substantial	N/A
6.9	Wage stream available for Bank staff.	System in place and usage report included within the Workforce Performance Report. Programme recently re-publicised across ward areas, and reminded staff of availability of the service.	Substantial	Executive Committee
Mitigating Actions (What more will we do?)				
Action		Lead	Action update	Deadline
Workforce Planning: Roll out the organisationally agreed workforce planning model by delivering		tbc	Ongoing support available to service leads in the	November 2025 Ongoing
				On track

training which supports services to develop their resource plans.		development of workforce plans. HEIW funded role currently advertised – Workforce Planning Manager, to operationally support service areas in the development of workforce plans. Advert unsuccessful over two campaigns so tasking subsumed within existing resource.		
Candidate Journey application to induction Review the end-to-end candidate journey from application to induction, identifying changes or omissions within the current process that are required to improve the candidate journey. To be extended to include local KPIs for recruitment to the Bank.	tbc	Heavily involved with All-Wales recruitment modernisation group, applying any learning to improve PTHB processes. End to End journey being reviewed to identify opportunities. No activity from NWSSP over this period. Recruitment Modernisation group, renamed as Recruitment Improvement and first meeting held in June 25. Recruitment Improvement Board continues to work through different elements of the Recruitment journey on an	31/09/2025 Ongoing	On Track

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		all-Wales basis, meeting quarterly.		
		End-to-end review of Bank recruitment complete with changes immediately implemented. Weekly monitoring and escalation process in place.		
Increase bank supply: Targeted Recruitment Open days taking place at all Hospitals and will continue throughout the year. Rolling adverts and targeted Bank adverts for Registered Nurses and HCSW posts.	tbc	5 Open Days held over June and July 2024 across Powys with multiple members recruited to the bank at each event. A further 5 held in August and September 2024. Work continues to onboard the applicants successfully. Further targeted bank recruitment Open Days planned for Q4 2024-25. Specialist Bank Mental Health services Open Day held in February, with successful interviews held on the day. Rolling adverts out each week and shortlisting against applicants each Friday,	Ongoing	On Track

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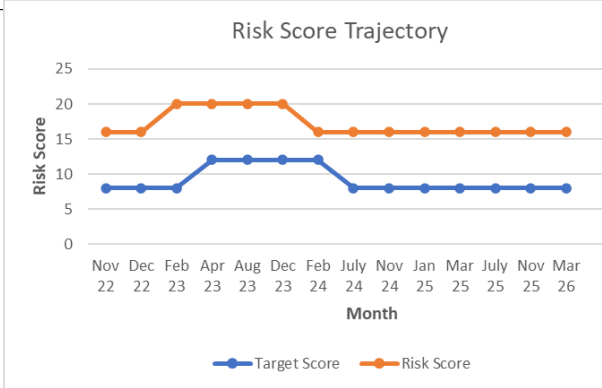
		alternating between RNs, HCSWs and both General and Mental Health fields. Further adverts created to target areas of high agency spend, such as 111#2 service.		
International Recruitment Continue international nurse recruitment to a target of 18 Adult nurses and 46 Mental Health Nurses for the FY 25/26.	tbc	18 international nurse offers have been made, first cohort of 6 arrived in Newtown in August 2024, have now all passed their OSCE exam and have their NMC PINs. A further 6 arrived into Machynlleth on 20 November and are undergoing their OSCE training. Final FY 24/25 General Nurse cohort of 6 staff arrived into Bronllys on 3 Feb, and will work across both Brecon hospital wards. In addition, 6 RMNs are expected in country by end of Q4. 24/25 International recruitment plan complete, totalling 18 Adult RNs and 6 RMNs, who have all now passed their OSCE exam.	Ongoing	On Track

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		25/26 International recruitment programme commenced, with 8 RNs having arrived in the country, 4 of whom have already completed OSCE and gained their NMC PIN, the remaining 4 are currently undertaking their training. 4 RMNs ~~are due to be~~ were interviewed in November 2025 and intended to arrive in approx. ~~January~~ February 2026, undertaking OSCE training in Cardiff before travelling to Powys in March 2026. This brings us to a total of 45 Internationally Educated Nurses recruited.		
Additional information:				
Rationale for current score: • The risk has been fully reviewed and assessed as a new risk in July 2024. • As of 31st January 2026, the Health Board contracted vs budgeted establishment showed a vacancy rate of 11.48%. After the use of overtime, additional hours, agency, and Bank this fell to 7.29%. • The challenges in recruitment are more pronounced in clinical roles with vacancies running at 10.36% for registered Nursing and Midwifery, 23.89% for Healthcare Scientists, 8.95% for Allied Health Professionals, 12.88% for Additional Clinical Services, 17.72% for Medical and Dental and 7.96% for Add Prof Scientific & Technic.				

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- To support safe staffing levels there continues to be a need for reliance on agency staffing with the following WTE agency staff deployed in January 2026 from information held on the Health Roster/TSU systems:
 - Add Prof Scientific & Tech : 4.33 WTE
 - Additional Clinical Services: 2.90 WTE
 - Nursing & Midwifery Registered: 17.61 WTE
 - Healthcare Scientists: 1.25 WTE
 - Allied Health Professionals: 14.57 WTE
 - Medical & Dental: 6.23 WTE
- ~~As of 30th September 2025, the Health Board contracted vs budgeted establishment showed a vacancy rate of 11.55%. After the use of overtime, additional hours, agency, and Bank this fell to 5.71%.~~
- ~~The challenges in recruitment are more pronounced in clinical roles with vacancies running at 12.26% for registered Nursing and Midwifery, 23.32% for Healthcare Scientists, 15.28% for Allied Health Professionals, 12.19% for Additional Clinical Services, 16.50% for Medical and Dental and 3.10% for Add Prof Scientific & Technic.~~
- ~~To support safe staffing levels there continues to be a need for reliance on agency staffing with the following WTE agency staff deployed in September 2025 from information held on the Health Roster/TSU systems:~~
 - ~~Additional Clinical Services: 8.55 WTE~~
 - ~~Nursing & Midwifery Registered: 17.61 WTE~~
 - ~~Allied Health Professionals: 5.93 WTE~~

SRR 007		There is a risk that the care provided in some areas is compromised due to the health board's estate being not fit for purpose.																																																																																																																															
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8	Risk Category: Quality																																																																																																																															
		Boards Risk Appetite: Minimal																																																																																																																															
Executive Lead: Executive Director of Finance, Capital, and Support Services		Assuring Committee: Finance and Performance Committee																																																																																																																															
Latest review date: February 2026 Added to register: January 2017 Link to Strategic Priorities and Wellbeing Objectives: SP 9 and WBOs 1 and 4	 Risk Score Trajectory <table><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr><tr><td>Nov 22</td><td>8</td><td>16</td></tr><tr><td>Dec 22</td><td>8</td><td>16</td></tr><tr><td>Jan 23</td><td>8</td><td>20</td></tr><tr><td>Feb 23</td><td>12</td><td>20</td></tr><tr><td>Mar 23</td><td>12</td><td>20</td></tr><tr><td>Apr 23</td><td>12</td><td>20</td></tr><tr><td>May 23</td><td>12</td><td>20</td></tr><tr><td>Jun 23</td><td>12</td><td>20</td></tr><tr><td>Jul 23</td><td>12</td><td>16</td></tr><tr><td>Aug 23</td><td>12</td><td>16</td></tr><tr><td>Sep 23</td><td>12</td><td>16</td></tr><tr><td>Oct 23</td><td>12</td><td>16</td></tr><tr><td>Nov 23</td><td>12</td><td>16</td></tr><tr><td>Dec 23</td><td>12</td><td>16</td></tr><tr><td>Jan 24</td><td>12</td><td>16</td></tr><tr><td>Feb 24</td><td>12</td><td>16</td></tr><tr><td>Mar 24</td><td>12</td><td>16</td></tr><tr><td>Apr 24</td><td>12</td><td>16</td></tr><tr><td>May 24</td><td>12</td><td>16</td></tr><tr><td>Jun 24</td><td>12</td><td>16</td></tr><tr><td>Jul 24</td><td>12</td><td>16</td></tr><tr><td>Aug 24</td><td>12</td><td>16</td></tr><tr><td>Sep 24</td><td>12</td><td>16</td></tr><tr><td>Oct 24</td><td>12</td><td>16</td></tr><tr><td>Nov 24</td><td>12</td><td>16</td></tr><tr><td>Dec 24</td><td>12</td><td>16</td></tr><tr><td>Jan 25</td><td>12</td><td>16</td></tr><tr><td>Feb 25</td><td>12</td><td>16</td></tr><tr><td>Mar 25</td><td>12</td><td>16</td></tr><tr><td>Apr 25</td><td>12</td><td>16</td></tr><tr><td>May 25</td><td>12</td><td>16</td></tr><tr><td>Jun 25</td><td>12</td><td>16</td></tr><tr><td>Jul 25</td><td>12</td><td>16</td></tr><tr><td>Aug 25</td><td>12</td><td>16</td></tr><tr><td>Sep 25</td><td>12</td><td>16</td></tr><tr><td>Oct 25</td><td>12</td><td>16</td></tr><tr><td>Nov 25</td><td>12</td><td>16</td></tr><tr><td>Dec 25</td><td>12</td><td>16</td></tr><tr><td>Jan 26</td><td>12</td><td>16</td></tr><tr><td>Feb 26</td><td>12</td><td>16</td></tr><tr><td>Mar 26</td><td>12</td><td>16</td></tr></table>		Month	Target Score	Risk Score	Nov 22	8	16	Dec 22	8	16	Jan 23	8	20	Feb 23	12	20	Mar 23	12	20	Apr 23	12	20	May 23	12	20	Jun 23	12	20	Jul 23	12	16	Aug 23	12	16	Sep 23	12	16	Oct 23	12	16	Nov 23	12	16	Dec 23	12	16	Jan 24	12	16	Feb 24	12	16	Mar 24	12	16	Apr 24	12	16	May 24	12	16	Jun 24	12	16	Jul 24	12	16	Aug 24	12	16	Sep 24	12	16	Oct 24	12	16	Nov 24	12	16	Dec 24	12	16	Jan 25	12	16	Feb 25	12	16	Mar 25	12	16	Apr 25	12	16	May 25	12	16	Jun 25	12	16	Jul 25	12	16	Aug 25	12	16	Sep 25	12	16	Oct 25	12	16	Nov 25	12	16	Dec 25	12	16	Jan 26	12	16	Feb 26	12	16	Mar 26	12	16	Drivers/causes of risk: Estates Compliance: (Risk Driver: Ageing Infrastructure, Underinvestment, Compliance Demands) • Powys has the oldest estate in NHS Wales with 38% of the estate infrastructure was built pre-1948, and only 5% post-2005, leading to higher maintenance needs and outdated systems. • Years of underinvestment have compounded deterioration and compliance risks across key areas (fire safety, water hygiene, electrical systems, medical gases, ventilation, etc.). • Backlog Maintenance stands at approximately £70M, significantly exceeding available budgets. • Revenue pressures due to rising energy costs and mandated cost savings are limiting the ability to invest in maintenance or modernisation.
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		- Internal Audit (March 2024) issued a 'Limited Assurance' report citing the critical condition of the estate and shortfall in funding to address backlog and support future transformation plans. - Powys has the oldest estate in NHS Wales, compounding these issues. Capital: (Risk Driver: National Funding Constraints, Affordability, Prioritisation Pressures) - NHS Wales faces significant capital funding constraints which has seen the introduction of a new Capital Business Case Prioritisation Process from April 2024. This process will re-assess all current and planned projects against criteria for benefits and affordability, potentially impacting the PTHB capital programme / transformation agenda. - NWSSP-SSU audit (February 2024) reported a Limited Assurance rating, identifying a shortfall in WG Capital against backlog maintenance across the NHS estate. - Affordability challenges due to high overheads for contractors operating in rural areas like Powys are impacting the viability and attractiveness of capital schemes. Environment & Sustainability: (Risk Driver: Policy Ambition vs. Resource Gap) - The NHS Wales Decarbonisation Strategic Delivery Plan (2021) sets out ambitious targets to reduce carbon emissions. However, delivery capacity is limited due to limited funding/resource allocation.

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		• The aging estate infrastructure is not well-suited to low-carbon adaptations without significant retrofit investment (Re:fit), further widening the gap between policy ambition and practical delivery. Risk materialising would result in: • Inability to sustain high quality services • Adverse impact on achievement of WBO 1 & 4 • Increased likelihood of infrastructure failure, non-compliance with statutory regulations, potential harm to patients and staff, and inability to deliver safe, modern healthcare services. • Escalating backlog costs may also lead to reputational damage and regulatory scrutiny. • Delayed or cancelled capital projects, inability to modernise or expand services, and failure to address critical infrastructure needs. • Possible impact on transformation goals, reduce service quality, and compromise long-term estate sustainability. • Failure to meet decarbonisation targets, missed national sustainability commitments, and rising operational costs due to inefficiencies. Also leading to reputational harm and reduced eligibility for future Environment and Sustainability funding streams.	
Controls (What has been implemented to manage the risk?)	Sources of Assurance	Level of Assurance	Highest Assurance provided to:
ESTATES			

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7.1	Specialist sub-groups for each compliance discipline	Structured meetings, risk-based approach, clear escalations lines	Reasonable	Estates Compliance Group
7.2	Risk-based improvement plans introduced	Highlight reports identifying and tracking risk mitigations, clear escalation lines	Reasonable	Estates Compliance Group
7.3	Specialist leads identified for key compliance areas	Authorised Persons independently appointed by NWSSP-SES	Reasonable	Estates Compliance Group
7.4	Estates Compliance Group and Capital Control Group established	Minutes, papers & work plans from meetings	Reasonable	Innovative Environments Group
7.5	Medical Gases Governance Group; Fire Safety Group; Water Safety Group; Electrical Safety Group; Asbestos Safety Group; Ventilation Safety Group convened with cross organisation & NWSSP-SES membership.	- Minutes and papers from meetings - Audits undertaken by NWSSP	Reasonable	Estates Compliance Group, Health & Safety Committee
7.6	Capital Programme developed for Compliance and approved capital programme	Paper to Executive level meeting	Substantial	Delivery & Performance
7.7	Capital and Estates set as a specific organisational priority in the Health Board's Annual Plan	Annual Plan	Substantial	Board
7.8	Address (on an ongoing basis) maintenance and compliance issues	Compliance Highlight Reports, Audit plans, notes and papers from meetings	Reasonable	Delivery & Performance Group
7.9	Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards	Compliance Highlight Reports, Audit plans,	Reasonable	Delivery & Performance Group

		notes and papers from meetings		
7.10	30+ Specialist Maintenance Contracts in place to ensure appropriate specialist service provision over 3-5 year contract periods	Contracts let via NWSSP-Procurement and contain Key Performance Indicator regime	Reasonable	Estates Compliance Group
CAPITAL				
7.11	Capital Procedures for project activity	- Capital Procedures CP/D/1.00 document - Annual Capital Systems Audit reports from NWSSP	Reasonable	Innovative Environments Group
7.12	Routine oversight / meetings with NWSSP Procurement	- Notes from meetings - Annual Procurement Report	Substantial	Innovative Environments Group / Finance & Performance
7.13	Specialist advice, support and audit from NWSSP Specialist Estates Services / Authorising Engineers	- Notes from meetings - Designated Director role	Substantial	Innovative Environments Group
7.14	Audit reviews by NWSSP Audit and Assurance	Audit reports and Action Plans	Reasonable	Audit and Assurance Group
7.15	Close liaison with Welsh Government, Capital Function	Regular Capital Review Meetings. Notes and papers from meetings	Substantial	Innovative Environments Group

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7.16	Reporting routinely to Finance & Performance Committee	Notes and papers from meetings	Reasonable	Finance & Performance Committee
7.17	Capital Programme developed and approved	Paper to Executive level meeting	Substantial	Delivery & Performance / Board
7.18	Detailed Strategic, Outline and Full Business Cases defining risk	BJC, SOC, OBC, FBC documents / governance	Substantial	Executive Committee / Board
7.19	Capital and Estates set as a specific Organisational Priority	Annual Plan	Substantial	Board
7.20	Capital projects developed for consideration for Welsh Government slippage in order to take advantage of any available funding	Capital proposals sheets Project sheets SBARs	Substantial	Capital Control Group /Innovative Environments Group
ENVIRONMENT				
7.21	ISO 14001 accreditation	SGS external body certification	Substantial	Finance & Performance
7.22	Environment & Sustainability Group	Notes and papers from meetings	Reasonable	Innovative Environmental Group
7.23	NWSSP-Specialist Estates Services (Environment) support and oversight	Meetings with Director NWSSP-SES	Reasonable	Innovative Environments Group
7.24	Welsh Government support and advice to identify and fund decarbonisation project initiatives	Presence on WG groups such as Community of Experts, etc.	Reasonable	Innovative Environments Group

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7.25	Welsh Government Energy Service / Re:fit energy programme of works complete in Q2. Investment Grade Proposal (IGP) published to illustrate invest to save projects	WG Salix Framework arrangement	Substantial	Innovative Environments Group
Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
Implement the in-year Capital Programme and develop the long-term capital programme which is responsive to changes in funding availability and funding sources.	Associate Director for Capital, Estates and Facilities	Fluid nature of NHS All Wales Capital allocations and current WG/NHS funding challenges make future capital investment uncertain. All-Wales NHS Capital Prioritisation Review has 3 key schemes on 'green' list. Pressure on programme to divert capital to Transformation activity at short notice.	In line with Annual Plan for 2025-26	On Track
Continue to seek Welsh Government capital funding to underpin investment to improve the estate / support Transformation.	Associate Director for Capital, Estates and Facilities	Consider alternative funding opportunities such as RPB IRCF, Targeted Estates Funding, etc. and have schemes 'on the shelf' in anticipation of Welsh Government 'end of year' capital slippage.	In line with Annual Plan for 2025-26	On Track

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Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address establishment staff numbers in Works Team and recruitment challenges. Resource review undertaken by IEG in 2023 with proposal limited by financial position.	Associate Director for Capital, Estates and Facilities	Due to financial challenges within the Health Board, this item is on hold.	TBC	At risk

Additional information:

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

Capital: Discretionary capital budget for 2026/27 has been increased to £3.032M. This will mean an extra 632k for PTHB which will be utilised on improving the estate. A total of 16 of the 17 Targeted Estates Funding (TEF) bids were approved for expenditure over 2025/26/27 at a value of £3.550M This includes a 30% health board contribution which equates to £634.5k in 2025/26 and £430k in 2026/27.

Estates: Estates compliance – team continues to support core statutory compliance and limited Reactive job requests using risk-based approach due to age of estate. Workforce challenges for recruitment and staff resource establishment level being reviewed at Innovative Environments Group. Organisational recruitment freeze ongoing. Contract awarded to provide new CAFM (Helpdesk) system, this will replace the previous system, which is over 20 years old. Embracing new technologies allowing better reporting and improving access and information to service users. As part of the agreed PTHB savings plan, the Estates team were requested to decommission the Vacuum Insulated Evaporators (VIEs) that were installed during the COVID-19 pandemic at Brecon, Llandrindod Wells, and Welshpool Hospitals. The VIE units were hired from BOC at a cost £38,040 per annum. To decommission the VIE's and revert from liquid oxygen back to oxygen cylinder, the team had to reinstate the manifolds and ancillary pipework. It's estimated that by undertaking the work and returning to oxygen cylinders, PTHB will see a minimum saving of £27K per annum. NWSSP-SES has issued a Building Resilience Survey on behalf of the Welsh Government across the NHS Wales estate. The survey provides a consistent, evidence-based assessment of how NHS sites withstand, respond to, and recover from disruptions

such as system failures, adverse weather, and other operational challenges. Estates teams have completed the surveys for PTHB sites to enable this comprehensive evaluation.

Fire: Work to improve operational fire structure has been positive, but significant infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented but are dependent on capital funding. **Annual Fire Assurance Report 2025** documents that Fire safety remains a significant risk for PTHB due to the complexity of patient evacuation, but continued improvements were observed in 2025. Fire Awareness Training strengthened post-pandemic, achieving an 82% completion rate, supported by increased face-to-face sessions. All fire risk assessments were completed, identifying 553 actions, a significant reduction from over 2,000 prior to 2018, reflecting progress in infrastructure and compliance. Unwanted Fire Signals have been effectively reduced through a data-driven programme, targeted upgrades to detection systems, and Welsh Government funding. Only two minor fire incidents were reported in 2025, and inspections by Mid and West Wales Fire and Rescue Service resulted in no enforcement notices. Capital investment of £832,000 supported major fire safety enhancements. The draft Building Safety (Wales) Bill is under review, with particular consideration for the management of Residential Units, while fire induction programmes for residents have been positively received.

Property: significant pressure on space with expanding staff numbers alongside implementation of new agile working approach. Rationalisation of space of health board and other public sector bodies underway. International Recruitment has introduced significant extra workload, which is affecting output of core activity. Better Together may have significant impact.

Finance: significant cost pressures related to energy and inflation are acting to increase pressure on Estates Revenue and Capital projects outturn costs and material / Supplier availability. Estates related pressure on revenue due to reactive failures of key building fabric and infrastructure.

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SRR 008	There is a risk that: The Health Board is unable to shift to a primary prevention focused health care system													
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L5 x I4 = 20 Target: L2 x 3I = 6	Risk Category: Innovation and Strategic Change												
		Boards Risk Appetite: Eager												
Executive Lead: Executive Director of Public Health		Assuring Committee: Planning, Partnerships and Population Health												
Latest review date: February 2026 Added to register: July 2025 Risk source: SP 1 and WBO 1	Risk Score Trajectory <table border="1"><caption>Risk Score Trajectory Data</caption><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 25</td><td>6</td><td>16</td></tr><tr><td>Nov 25</td><td>6</td><td>16</td></tr><tr><td>Mar 26</td><td>6</td><td>16</td></tr></tbody></table>	Month	Target Score	Risk Score	July 25	6	16	Nov 25	6	16	Mar 26	6	16	Cause of risk and rational for current score: • NHS historically structured around acute and reactive care. • The NHS is under immense pressure with escalating acute care demand; means it's a challenge to 'shift left' to reallocate resources to redesign care models around primary care and prevention. • NHS Wales priorities and performance measures respond to rising health care pressures and are predominantly focused on activity and acute care rather than broader system change and population health outcomes. • Predominately community-based prevention services undertaken by the Health Board for tobacco control/smoking cessation and preventing childhood obesity is currently reliant on external grant funding.
Month	Target Score	Risk Score												
July 25	6	16												
Nov 25	6	16												
Mar 26	6	16												

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

8.4	PTHB is required to report against vaccination uptake and smoking cessation targets contained in the <i>NHS Wales Performance Framework 2025-26</i> .	NHS Wales Planning Framework reporting procedures.		
8.5	A Population Health Framework for Powys (DPH Annual Report) was approved and published by the Board in September 2025.	PTHB Annual Plan internal performance reporting procedures.		
Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
The <i>Better Together</i> consultation on adult physical and mental health community services in Powys contains the ambition that 'Together we want to create a future that helps people to stay healthy'.	Director of Improvement and Transformation	Detailed work is underway to make sure the right timeline is in place for the work ahead	To be confirmed	On track
The 2026/27 planning process in the Health Board will be used to take forward actions in the Population Health Framework.	Executive Director of Public Health	Work is underway to understand the 2026/27 planning process and how actions in the Framework can be included. Proposed set of actions to take forward the framework in year 1 identified for Board consideration on choices on inclusion ded in the draft PTHB Annual Integrated Plan 2026/27.	March'26.	On track.

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Implement Welsh Government's <i>Community by Design</i> healthcare transformation programme with the stated aim of making population health management and prevention business as usual, systematically embedded into every contact.	Executive Directors	First meeting of Welsh Government's Community by Design Transformation Programme Board on 10/12/25. National Draft delivery plan for phase 1 published. National Draft Delivery plan (Phase 2) to be agreed by end of March'26.	Timeline to be confirmed.	On track.
Additional information:				
Rationale for current score: The controls currently in place are considered sufficient to reduce the inherent score to a current score of 16.				

SRR 009		There is a risk that: The Health Board is unable to stabilise the growing implications of Continuing Health Care													
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I3 = 9	Risk Category: Performance and Sustainability													
		Boards Risk Appetite: Open													
Executive Lead: Executive Director of Primary, Community Care and Mental Health		Assuring Committee: Finance and Performance Committee													
Latest review date: February 2026 Added to register: July 2025 Link to Strategic Priorities and Wellbeing Objectives: SP 6 and WBO 4	 <table><caption>Risk Score Trajectory</caption><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 25</td><td>9</td><td>16</td></tr><tr><td>Nov 25</td><td>9</td><td>16</td></tr><tr><td>Mar 26</td><td>9</td><td>16</td></tr></tbody></table>	Month	Target Score	Risk Score	July 25	9	16	Nov 25	9	16	Mar 26	9	16	Cause of risk and rational for current score: - Demand is greater than available resource Risk materialising would result in: - The service is unable to remain within allocated budget - Failure to meet needs of vulnerable patients who are eligible for health services	
		Month	Target Score	Risk Score											
July 25	9	16													
Nov 25	9	16													
Mar 26	9	16													

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

9.5	Deep Dive Report on EMI numbers and costs and Private Provider Report identifying new governance processes in place presented to appropriate Committee of the Board	Reports presented to Finance and Performance Committee in June and September 2025		F&P	
Mitigating Actions (What more will we do?)					
Action		Lead	Action update	Deadline	Action on Target
Recruitment to additional post to support MH Adults of Working Age with provision of commissioning support to Acute Care Pathway		Head of Mental Health Complex and Unscheduled Care	Draft JD is submitted to Workforce for job matching Action not taken forward, subject to external review. See further actions.		On track Closed
Complex Care Operational Management Group		Assistant Director of Complex Care Community Services Group	This bi-monthly meeting has a financial component. This is in addition to other regular meetings with finance to review budget changes/rationale. Monitoring continues regularly. Meeting last on 24/10/25. Slightly improved CHC position. Meeting continues to review operational performance including further consideration of mitigation for increased risk. Noted deterioration in trajectory for end of year, with significant pressure in EMI.	October 2025 2026	On track

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		Actions now aligned to outputs of external review.		
To undertake an external Subject Matter Expert review, with a view to optimising the service and outcomes, including financial position	Assistant Director Community Services Group	UB Healthcare, partnered with Clarity Consulting Associates Ltd and Grant Thornton, were commissioned to undertake a detailed, evidence led and systematic service review across Continuing Healthcare (CHC) and complex care functions in December 2025. This report is now being shared with the governance of the Health Board and is expected to make recommendations around governance, commissioning and contracting, data and organisational capacity. This is also expected to identify opportunities to further reduce costs for the future.	February 2026	On Track
National Digital System delays	Assistant Director of Complex Care	~~There is no clear timeline for when a national system will be agreed.~~ Welsh Government (WG) has agreed to fund the initial procurement cost of a digital	~~October 2025~~ March 2026	~~Delayed~~ On Track

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		system only but will not cover ongoing costs such as licensing and other system-related expenses. Health Boards will need to plan financially for future costs. The Health Board has submitted a business case to WG as part of a national procurement plan. Outcome expected by end of financial year. There is a national business case in pace. Team has engaged in several product demonstrations.		
Additional information:				
Rationale for current score: It is early on in the financial year and full year demand is unknown, with continued work locally and nationally. End of year forecast looks to indicate continued growth which risks further financial pressure but risk score has remained the same. Update including impact of actions to date on current risk score: Remains the same as no significant change in position since last review. benefit realised since previous review				

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SRR 010		There is a risk that: The Health Board is unable to respond in a timely, efficient, and effective way to a major incident, or critical incident													
Current Risk Score: 12	Risk rating detail: (likelihood x impact) Current: 3 x 4 = 12 Inherent: 4 x 4 = 16 Target: 2 x 3 = 6	Risk Category: Safety													
		Boards Risk Appetite: Averse													
Executive Lead: Executive Director of Public Health		Assuring Committee: Planning, Partnerships and Population Health Committee													
Latest review date: February 2026	 <table><caption>Risk Score Trajectory</caption><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 25</td><td>12</td><td>16</td></tr><tr><td>Nov 25</td><td>6</td><td>12</td></tr><tr><td>Mar 26</td><td>6</td><td>12</td></tr></tbody></table>	Month	Target Score	Risk Score	July 25	12	16	Nov 25	6	12	Mar 26	6	12	Cause of risk and rational for current score: Due to emergency planning arrangements at both the corporate level and operational level not being sufficiently robust to respond to the incident or emergency.	
Month		Target Score	Risk Score												
July 25	12	16													
Nov 25	6	12													
Mar 26	6	12													
Added to register: July 2025		Risk materialising would result in: - Adverse impacts on delivery of care to patients - Inability to respond to a major incident to meet needs of those affected - Harm or injury to population, patients and/or staff - Health Board breaches statutory duties under the Civil Contingencies Act 2004 - Litigation & financial penalties - Reputational damage and loss of public confidence - Staff absence (injury, wellbeing)													
Link to Strategic Priorities and Wellbeing															
Objectives: Cross-cutting risk relevant to all SPs and WBOs															

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Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
10.1	Major Incident and Emergency Response Plan and Corporate Business Continuity Plan are in place and updated on an annual basis.	- Plan approved by Executive Committee - Civil Contingency Annual Report	Substantial	Executive Committee
10.2	Business Continuity Policy in place, with supporting 'Business Continuity Toolkit' available for operational services to develop service level business continuity plans.	Policy approved by Executive Committee	Substantial	Executive Committee
10.3	PTHB Pandemic Framework is in place to guide the Health Board's response to a new or emerging pandemic. The Health Board is currently awaiting the publication of updated UK Pandemic Guidance, prior to completing a further review of the Framework.	Framework approved by Executive Committee	Substantial	Executive Committee
10.4	PTHB Adverse Weather Arrangements is in place and is updated on an annual basis.	Arrangements approved by Executive Committee	Substantial	Executive Committee
10.5	Internal protocols are in place for the management of patients self-presenting with a suspected High Consequence Infectious Diseases (HCID) are in place and are subject to regular review.	Protocols in place	Substantial	Executive Director

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10.6	PTHB Civil Contingencies Training Plan in place and updated on an annual basis.	Plan approved by Executive Committee	Substantial	Executive Committee
10.7	Corporate level Business Continuity arrangements subject to internal audit 2023/24.	Audit Report – substantial assurance (Dec 2023)	Substantial	Audit Committee
10.8	Operational level Business Continuity arrangements subject to internal audit 2024/2025.	Audit Report – substantial assurance (May 2025)	Substantial	Audit Committee
10.9	The Health Board is fully engaged in Dyfed Powys Local Resilience Forum's planning and response structures.	- Minutes of meetings - Training and exercise records	Substantial	Executive Director
10.10	The Health Board is fully engaged in the NHS Wales Emergency Preparedness, Resilience and Response planning structures.	- Minutes of meetings - Training and exercise records	Substantial	Executive Director
10.11	The Health Board has participated in a variety of exercises. Examples of these exercises are included below (not inclusive): - Exercise Mighty Oak (National Power Outage) - Exercise Pen Y Darren (Mass Casualty) - Exercise CYD (Communicable Disease) - Exercise Fad Fellin (Mpox/HCID)	Exercise Reports	Substantial	Executive Director

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	- Exercise Solaris (Pandemic) - Exercise Redstreak (Water disruption) - Exercise Wales Connect (Regular Pan Wales Response Plan activation test) - Walkthroughs of the operational response to major incidents/Mpox arrangements - Exercise Pegasus (Pandemic Response)				
10.12	Testing of internal major incident and business continuity response plans through response to incidents, including: Powys Train Collision (October 2024) Storm Darragh (December 2024)	Debriefs from internal responses to incidents	Substantial	Executive Committee	
10.13	Internal repository in place for all internal Response Plans	Internal repository	Substantial	Executive Director	
10.14	Strengthened cross-border multi-agency working through the establishment of regular meetings to share information on identified areas of risks, preparedness activities and response.	Six monthly meetings in place	Substantial	Executive Director	
Mitigating Actions (What more will we do?)					
Action		Lead	Action update	Deadline	Action on Target
Deliver programme of work in place to strengthen identified areas of risk.		Civil Contingencies Manager		31 st March 2026	On Track

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Complete cycle of work to ensure that PTHB internal response plans remain up to date.	Civil Contingencies Manager		31 st March 2026	On Track
Continue to provide regular update reports to the Executive Committee on programmes of work in place to strengthen identified areas of risk	Civil Contingencies	Regular updates on Exercise Pegasus (pre and during Exercise) to Executive Committee during August/September/October 2025. Debrief learning report will be incorporated into update report.	February 2025	On Track
Complete internal operational review of clinical governance arrangements for operational major incident response arrangements	Civil Contingencies Manager/ Urgent and Emergency Care Clinical Transformation Lead	~~Mass Casualty Incident Arrangements for Wales updated and approved at NHS Wales Executive Civil Contingencies Group (October 2025). This is informing update of HB review of arrangements underway.~~ Recommendations following the review of the operational major incident arrangements to be presented to the Executive Committee for approval by the 31 st March 2025, with	~~30th April 2026~~ ~~December 2025~~	On Track

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		plans to undertake an early review of the PTHB Major Incident and Emergency Response Plan to incorporate the changes included within the updated <i>Mass Casualty Arrangements for NHS Wales</i> to be completed by 30th April 2026		
Additional training and exercise opportunities to support PTHB's staff preparedness in response to an incident or emergency to be made available	Civil Contingencies Manager		31 st March 2026	On Track
Continue to engage in, and actively promote preparedness activities (including planning, training, exercising) taking place with multi-agency partners, including NHS Wales Emergency Preparedness, Resilience and Response networks and Dyfed Powys Local Resilience Forum	Civil Contingencies Manager		31 st March 2026	On Track
Continue to incorporate lessons identified from other incidents and exercises into internal plans and procedures to strengthen the Health Board's future response to incidents	Civil Contingencies Manager	PTHB's Pandemic Framework will be updated to incorporate internal lessons identified following PTHB's participation in Exercise Pegasus.	31 st March 2026	On Track
Additional information:				

The Executive Director of Public Health holds the overall responsibility for Civil Contingencies Planning within PTHB, however all Executive Directors are responsible for ensuring business continuity for the services that sit within their portfolio areas, as outlined within the PTHB Business Continuity Policy. Cyber resilience and response sits within the responsibility of the Executive Director of Allied Health Professions, Health Sciences and Digital
Rationale for current score: There are a number of control measures in place, however further work is required to strengthen identified areas of risk and test internal response capabilities.

CONFIDENTIAL APPENDIX – Agenda Item 8.9

(SRR 011) failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.

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SRR 012		There is a risk that: The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.												
Current Risk Score: 15	Risk rating detail: (likelihood x impact) Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 2 x 4 = 8	Risk Category: Reputation and Public Confidence												
		Boards Risk Appetite: Open												
Executive Lead: Director of Corporate Governance / Board Secretary		Assuring Committee: Finance and Performance Committee												
Latest review date: February 2026 Added to register: July 2025 Link to Strategic Priorities and Wellbeing Objectives: Cross-cutting risk relevant to all SPs and WBOs	Cause of risk and rationale for current score: The NHS is facing a very challenging period, including the waiting list backlog arising from COVID, the delays in strategic transformation exacerbated by the pandemic period, significant inflationary pressures. This is compounded locally by the challenges of service delivery in a rural area including for recruitment and retention, the need to take action to transform the model of health care so that it is safe and sustainable for the future, and the need for immediate action in response to the financial position. In this context there is a need for challenging decisions, sometimes short term in nature (e.g. waiting list measures). Given the comparatively small organisational leadership infrastructure in PTHB it is highly complex to engage meaningfully at a hyperlocal level with the													
	Risk Score Trajectory <table><thead><tr><th>Month</th><th>Target Score</th><th>Risk Score</th></tr></thead><tbody><tr><td>July 25</td><td>8</td><td>15</td></tr><tr><td>Nov 25</td><td>8</td><td>15</td></tr><tr><td>Mar 26</td><td>8</td><td>15</td></tr></tbody></table>			Month	Target Score	Risk Score	July 25	8	15	Nov 25	8	15	Mar 26	8
Month	Target Score	Risk Score												
July 25	8	15												
Nov 25	8	15												
Mar 26	8	15												

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		many different community needs and expectations across our large county, particularly to contextual this to multiple secondary and tertiary care pathways. Risk materialising would result in: • Lack of public confidence could lead to erosion of trust; reduced engagement and discretionary effort by patients, public, staff and stakeholders; leadership and administrative burden in relation to responding to complaints, correspondence, FOI, enquiries, Senedd questions etc.; adverse impact on staff morale, recruitment and retention; potential loss of strategic momentum and/or financial inefficiencies due to delays, rework or crisis communications.		
Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
12.1	Better Together programme in place in order to make lasting decisions about the permanent future shape of safe and sustainable health services, with Stage One engagement completed and Stage Two engagement nearing completion	Better Together Programme	Reasonable	Board
12.2	Communication and engagement team in place (substantive team = 4.0wte, additional temporary posts) with active management of priorities aligned with organisational priorities and risks	Quarterly E&C Team reports Directorate Review	Reasonable	Director / Chief Executive

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12.3	Weekly informal communications report to Board including reputation risk portfolio to support internal review and scrutiny	Copies of The Week	Reasonable	Chair / whole Board
12.4	Twice Yearly Engagement and Communication Report supports ongoing review of capacity against opportunities and risks	Twice yearly E&C Team reports Directorate Review	Reasonable	Board Committees (x2 per annum)
12.5	Temporary strengthening of communications and engagement function including non-pay resources to support Better Together programme	Minutes of Executive Committee	Reasonable	Executive Committee
12.6	Procurement of additional engagement delivery and analysis support to Stage Two Better Together engagement	Contract in place. Reports to Portfolio Board and Executive Committee	Reasonable	Board
12.7	Procurement of additional consultation delivery and analysis support to Stage Three Better Together	Contract in place. Reports to Portfolio Board and Executive Committee	Reasonable	Board
12.8	Stakeholder Map in place	Stakeholder Map	Reasonable	Executive Committee
12.9	Priority stakeholder engagement mechanisms in place (e.g. regular MS/MP briefings, Board to Cabinet meetings with PCC, Joint Leadership Team meetings with PCC, RPB and sub-structures, PSB and sub-structures)	Notes from meetings	Reasonable	Board
12.10	OD programme in place linked to Better Together transformational change programme	Notes of ODEC and Portfolio Board	Reasonable	Executive Committee

12.11	Channel strategy in place and kept under review (web, govDelivery, Facebook, NextDoor etc.)	Quarterly E&C Team reports	Reasonable	Executive Committee
12.12	Out of hours media protocol in place via Gold On Call but currently insufficient team capacity for on call comms	Major Incident and Business Continuity Plan arrangements	Limited	Executive Committee
12.13	Powys Engagement and Insight Network in place to support pan-organisational co-ordination of engagement and insight (joint sub-group of RPB and PSB)	Minutes 6-monthly insight reports	Reasonable	Executive Committee
12.14	Programme of continuous engagement in place as of October 2025 following strengthening of the engagement team.	Minutes Event materials Update reports	Reasonable	Portfolio Board
Mitigating Actions (What more will we do?)				
Action	Lead	Action update	Deadline	Action on Target
Stakeholder engagement assurance included within TI support framework	DCG	Procurement process under way Oct 2025 – procurement complete, report due Dec 2025. Jan 2026 – procurement complete	08/25	On track Complete

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Identification of named Locality leads for each of the 13 Powys localities	DCG	Arrangements being finalised for implementation Oct 2025 – In final draft, will be complete end Nov 2025	08/25	~~Delayed rescheduled 30/11/25~~ Complete
Establish annual Insight Report from community engagement activities for Board review and to inform annual planning	DCG	Pilot report created 2024/25 with aim to fully establish from 2025/26	31/03/26	On track

Additional information:

Rationale for current score:

Significant challenges to public confidence remain possible, particularly given the pressing need for significant transformation of health services to ensure that they are fit for the future. The scope for managing these challenges is reduced due to the highly complex environment in which the health board operates (very large rural geography, hyperlocal needs and expectations, complex cross-border commissioned pathways with both England and Wales). Trust has been further challenged by decisions the health board has needed to make in the context of in-year financial challenges (e.g. waiting list measures) and to address risks to safety and sustainability (e.g. temporary service changes).

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

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

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Board Assurance Framework (BAF) Dashboard

*Audit, Risk and Assurance Committee
- 10 March 2026*

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Board Assurance Framework Dashboard: Key

Key:

Adequacy of Controls	Effectiveness of Controls	Control Assurance
<i>Are we doing enough to manage the risk?</i>	<i>Is what we're doing working?</i>	<i>Based on what evidence?</i>
GREEN: Multiple controls	GREEN: Controls largely effective	GREEN: Assurance largely substantial
AMBER: Some controls	AMBER: Some control weaknesses	AMBER: Assurance largely reasonable
RED: Limited/no controls	RED: Significant control weaknesses	RED: Assurance largely limited
		GREY: Insufficient assurance available



Risk outside Board appetite

Board Assurance Framework Dashboard

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

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

Summary Position

- 9 of the 12 risks are operating within the Board's Risk Appetite
- None of the 12 risks are at target score
- **3 of 12 risks received are operating outside of the Board's Risk Appetite**
 - **SRR 001 – Financial Balance**
 - **SRR 007 – Estate**
 - **SRR 010 - Emergency Preparedness/Incident Response**
- *Is the Board willing to tolerate the current position outside of appetite or is action to identify and implement further controls needed to mitigate risks?*
- **8 of the 12 risks received have Inherent Scores the same as the Current Score, suggesting a need to review the effectiveness of controls and/or risk scoring.**

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Scoring Matrix

Likelihood x Impact = Risk Score

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

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Risk Appetite Summary

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

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Risk Appetite Summary Cont.

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

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Annual Review of Strategic Risk Assurance

Audit, Risk and Assurance Committee

10 March 2026

Annual Review of Strategic Risk Assurance – Purpose and Definitions

In accordance with the UK Government’s Orange Book (2023), “Assurance mapping is a mechanism for linking assurance from various sources to the risks that threaten the achievement of an organisation’s outcomes and objectives. They can be at various levels, dependent upon the scope of the mapping” – HMT “Assurance Frameworks” (2012). Assurance mapping should be undertaken to ensure appropriate nature, coverage and depth of assurance being planned, which typically relates directly to the degree of confidence organisations can have in their control environment.

Good (effective and efficient) assurance mapping helps improve the effectiveness and efficiency of risk management more broadly. The approach utilised by Powys Teaching Health Board in the development of this report is a combination of risk and control based assurance mapping. The purpose of the Board Assurance Framework (BAF) is a structured means of identifying and mapping the main sources of assurance in the organisation, and co-ordinating them to best effect. It is intended that through appropriate utilisation of the BAF, the Board can have confidence that it is providing thorough scrutiny of its role and is able to identify any gaps in assurance and take appropriate action as a result.

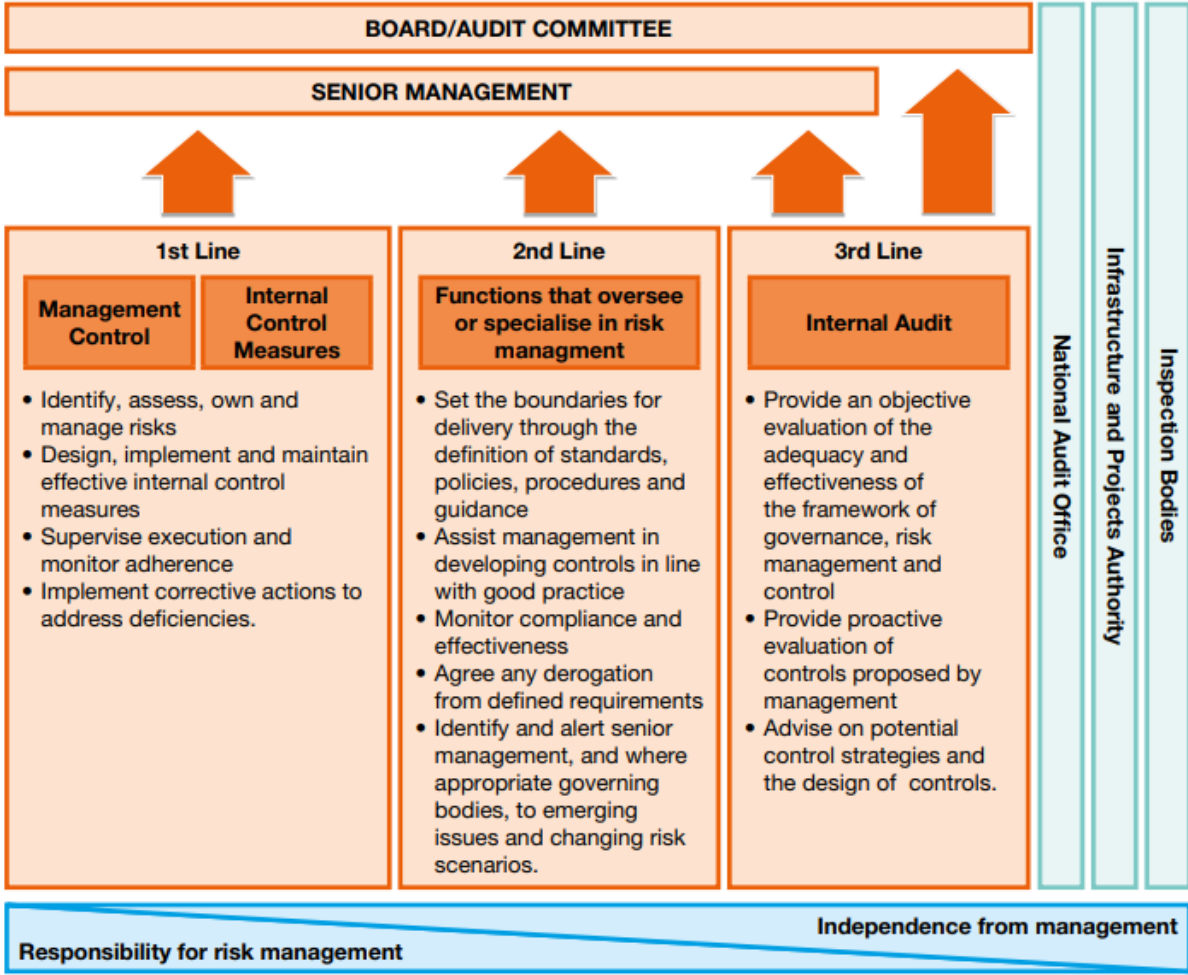
This report will be provided to the Audit, Risk and Assurance Committee annually with the opportunity to consider whether controls and assurance are effective, adequate and well balanced however also the opportunity to assess the level of gaps on control and assurance and whether they are comfortable with the level of control improvement actions or whether more or less should be done, thus providing a clear steer to the organisation. This report will also be shared with the Executive Committee. The control data utilised in the report will be drawn from the most recent Strategic Risk Register and Board Assurance Framework Dashboard updates.

Effective risk controls should be adequate, effective and well balanced, the BAF Dashboard reports provides an analysis of control adequacy and effectiveness, this report also draws out the balance of controls, utilising the below categorisations provided within the Orange Book and assigning a category to each control:

- Preventative Controls: seek to prevent the risk from materialising, reducing the likelihood
- Corrective Controls: seek to mitigate the risk when it has materialised, reducing impact
- Detective Controls: seek to identify a risk or issue

An analysis of assurance is also produced for each risk, analysing the assurance available against the Three Lines Model (Orange Book ,2023)as depicted below, to aid in simplicity of analysis for the purposes of this report Board and Committee oversight will be included in Line 2 (L2) Risk Oversight, and all external assurance, including of internal audit will be categorised as L3 – Audit and External Assurance:

Effective assurance should be balanced across the three lines, whilst recognising that it is entirely appropriate that the availability assurance decreases from lines 1 to 3. Management generated assurance is more plentiful than oversight function assurance, which in turn is more plentiful than external assurance. It is worth noting that there are several iteration of the Three Lines Model from various sources, the application of the model is based on the Health Board’s interpretation of the approach.



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SRR 001		There is a risk that: The Health Board is unable to achieve its duty to achieve financial breakeven (and therefore sustainability).							
Current Risk Score: 20	Risk rating detail: (likelihood x impact) Current: L4 x I5 = 20 Inherent: L4 x I5 = 20 Target: L2 x I4 = 8				Risk Category: Financial Sustainability				
					Boards Risk Appetite: Cautious				
Executive Lead: Executive Director of Finance, Capital and Support Services					Assuring Committee: Finance and Performance Committee				
BAF Dashboard Assurance Rating:									
		Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>
		SRR 001: Financial Balance <i>EDoFC&E</i>	20	20	8	Cautious 	Multiple Controls	Some control weaknesses	Assurance largely reasonable
	Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
1.1	Financial Plan approved by Board. Subsequent AO letters set out savings target of £23.1m.					Preventative	- The Health Board has a planned deficit in year, not achieving the key 1st duty to attain break-even. This presents a current unmitigated risk to balancing financial allocations with spending in year. - Integration of financial planning with transformation, performance and risk management processes		
1.2	Additional control - Introduced joint CEO and ED Finance only focussed meetings with each Exec Director individually.					Preventative /Detective			
1.3	Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.					Preventative			
1.4	Group established for Variable Pay, identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. Variable Pay, CHC and Commissioning regular deep dive areas of focus at F&P Committee to track actions to improve.					Detective			
1.5	Investment Benefits Group - focus on benefits realisation of previous investments, including consideration of dis-investment.					Preventative /Detective			

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1.6	Regular communication and reporting to Welsh Government and NHS Wales Performance and Improvement (Financial Planning and Delivery Directorate) regarding the impact of pressures on Financial Plan and underlying position.	Preventative		
	Control Improvement Actions:			
	Action	Owner	Status	Due Date
	External support contract had been awarded to Grant Thornton providing support with partners, clarity consultant associates and UB Healthcare. The key work streams are to improve financial sustainability, commissioning contracting and Continuing Health Care (CHC) including mental health providers, final report is due for imminent publication.	DoFC&SS	Underway	02/01/2026
	Key sources of assurance	Associated Line (Three Lines Model)	Gaps in assurance	
	Monthly financial reporting and reporting on financial control	L1 – Management	- Annual Plan unapproved by Welsh Government as of November 2025 - Qualification of Accounts in 2024/25 due to breach of resource limit in the three year period 2022-23 – 2024-25 which constitutes irregular expenditure.	
	Oversight of financial reports by the Executive Committee, Finance and Performance Committee and the Board	L2 – Risk Oversight		
	All Directorates undergo regular performance reviews which include a review of financial control	L1 – Management		
	Internal Audit of Core Financial Systems (Substantial Assurance, 2024-25)	L3 – Audit and External Assurance		
	Monthly oversight of financial performance by Welsh Government	L3 – Audit and External Assurance		
	Head of Internal Audit Opinions 2024/25 articulated Reasonable Assurance over systems of internal control	L3 – Audit and External Assurance		

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Summary Position:

- Controls largely balanced between preventative and detective, no corrective controls identified should the risk materialise
- Gaps in control are recognised
- Control improvement action identified and underway, with finalisation imminent
- Assurance is balanced across the Three Lines, with the majority sat in L1 or 3
- Some recognised gaps in assurance

SRR 002		There is a risk that: The Health Board is unable to successfully deliver and realise the benefits of transformation																					
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: 4 x 4 = 16 Inherent: 4 x 4 = 16 Target: 2 x 4 = 8				Risk Category: Innovation and Strategic Change																		
					Boards Risk Appetite: Eager																		
Executive Lead: Executive Director of People and Culture					Assuring Committee: Planning, Partnerships and Population Health																		
BAF Dashboard Assurance Rating:																							
<table><tr><th>Strategic Risk</th><th>Inherent Score</th><th>Current Score</th><th>Target Score</th><th>Within Appetite</th><th>Adequacy of Controls <i>Are we doing enough to manage the risk?</i></th><th>Effectiveness of Controls <i>Is what we're doing having the desired impact?</i></th><th>Associated Assurance <i>Based on what evidence?</i></th></tr><tr><td>SRR 002: Transformation EDP&C</td><td>16</td><td>16</td><td>8</td><td>Eager <i>In appetite</i></td><td>Multiple Controls</td><td>Some control weaknesses</td><td>Assurance largely reasonable</td></tr></table>								Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>	SRR 002: Transformation EDP&C	16	16	8	Eager <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable
Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>																
SRR 002: Transformation EDP&C	16	16	8	Eager <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable																
	Key Risk Controls:				Preventative, Corrective or Detective	Gaps in Control																	
2.1	Transformation programmes in place under the Better Together Portfolio, in line with PTHB Strategic Priorities, to provide the capacity to deliver the transformational deliverables required to support delivery of a balanced financial plan within 3-5 years.				Preventative	- Further planning is underway to determine the future timeline for Better Together which includes phase 1, adult physical and mental health community services, and the additional phases of Planned Care and Women, Children and Families services. The earliest date for public consultation on Phase 1 will now be following conclusion of the Senedd elections and establishment of a Programme for Government. - capacity and capability across the organisation and partner organisations to deliver Better Together																	
2.2	Better Together Portfolio Board established as a Sub—Group of the Executive Committee				Preventative/Detective																		
2.3	Oversight of Better Together and Transformation integrated into Terms of Reference of F&P, P&C and PPPH Committees				Preventative																		
2.4	Better Together Stage 2 engagement programme has been concluded including staff roadshows and workshops as well as several public events across Powys. The Stage 2 engagement report has been published with Board papers. Continuous engagement activity is underway.				Detective																		
2.5	Monthly informal Planning update meetings with WG including Better Together update				Preventative/Detective																		

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2.6	Wider stakeholder engagement plan in place with regular Primary Care, PCC, PAVO and Llais interface.	Preventative		
2.7	Ongoing assessment of delivery capacity as portfolio plan develops. Monitored through Portfolio Board and reported to Executive Committee	Detective		
	Control Improvement Actions:			
	Action	Owner	Status	Due Date
	Revised timeline in development, including consideration of alignment for future phases and resourcing plan to strengthen delivery confidence	DP&C	Underway	March 2026
	Key sources of assurance	Associated Line (Three Lines Model)	Gaps in assurance	
	Inputs and reporting from primary care workshops and meetings.	L1 – Management	No external assurance available as of November 2025, several elements of the Better Together programme were reviewed as part of the external Grant Thornton review, the final report is due imminently.	
	Inputs and outputs from wider stakeholder engagement meetings.	L1 – Management		
	Regular reporting to Executive Committee, Board, Planning Partnerships and Population Health Committee and Local Partnership Forum	L2 – Risk oversight		
	Strategic Risk (SRR 002) in place and reported to Executive Committee and Board x3 per year.	L2 – Risk oversight		
	Portfolio Programme Risk Register developed, and reports escalated issues to the Executive Committee for oversight regularly.	L2 – Risk oversight		
Summary position: - Controls largely balanced between preventative and detective, no corrective controls identified should the risk materialise - Gaps in control are recognised - Control improvement action identified and underway - No current assurance derived from L3, though it’s recognised that this is imminent				

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SRR 003		There is a risk that the Health Board is unable to respond to the demand for commissioned services							
Current Risk Score: 20	Risk rating detail: (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12				Risk Category: Innovation and Strategic Change				
					Boards Risk Appetite: Eager				
Executive Lead: Executive Director of Planning, Performance & Commissioning					Assuring Committee: Planning, Partnerships and Population Health				
BAF Dashboard Assurance Rating:									
		Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>
		SRR 003: Commissioning EDPP&C	20	20	12	Open <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable/limited
	Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
3.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services					Preventative/Detective	Shift from transactional contracting with individual providers to a more strategic approach underway based on the health needs of the population, improving outcomes and supporting the recovery and sustainability of the Health Board under the Strategic Commissioning Framework approved by the Board in September 2025.		
3.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes					Preventative/Detective			
3.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process					Preventative			
3.4	Reviewing where services do not meet clinical and operational standards					Corrective			
3.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the Finance and Performance Committee and Board as well as future planning					Preventative			

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	Control Improvement Actions:			
	Action	Owner	Status	Due Date
	External support contract had been awarded to Grant Thornton providing support with partners, clarity consultant associates and UB Healthcare. The key work streams are to improve financial sustainability, commissioning contracting and Continuing Health Care (CHC) including mental health providers.	DoFC&SS	Underway	March 2026
	Implementation of the Strategic Commissioning Framework aligned to the delivery of the Annual Plan 2025/26, development of the Annual Plan 2026/27, Strategic Commissioning Intentions 2026/27 and Better Together.	DPP&C	Underway	Q4 2026/27
	Key sources of assurance	Associated Line (Three Lines Model)	Gaps in assurance	
	Integrated Quality and Performance Report, Commissioned Services Performance Report and Integrated Performance Dashboard produced monthly	L1 – Management	- Low assurance currently regarding robustness of referral data. Exploring alternative data sources (e.g. activity) whilst working through improved data set for GP referrals. - There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target. - Ongoing data retrieval issues with Shrewsbury and Telford Hospitals NHS Trust (SaTH).	
	System for review and assurance in place, including reporting to each Board meeting, bi-monthly reporting to the Patient Experience Quality and Safety Committee and Finance and Performance Committee.	L2 – Risk Oversight		
	Regular oversight by Welsh Government including 6 monthly JET meetings and Monthly IQPD presentations.	L3 – Audit and External Assurance		
Summary position:				
- Controls largely balanced between preventative and detective - Gaps in control are recognised - Control improvement action identified and underway - Singular source of assurance from each line				

SRR 004		There is a risk that the Health Board is unable to respond to the demand for provided services						
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12				Risk Category: Performance and Service Sustainability			
					Boards Risk Appetite: Open			
Executive Lead: Executive Director of Primary Care, Community and Mental Health (PCCMH)					Assuring Committee: Patient Experience, Quality & Safety Committee			
BAF Dashboard Assurance Rating:								
Strategic Risk		Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>
SRR 004: Provided Services EDPCCMH		16	16	12	Open <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable
	Key Risk Controls:				Preventative, Corrective or Detective	Gaps in Control		
4.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services. Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer. Maximising insourcing offer to ensure optimal performance standards are achieved. Implement as many Optimisation frameworks and 5 Goals for Planned Care as appropriate for a community-based provider				Preventative/Detective	- Aging estate unable to meet service needs - Challenges in workforce recruitment and retention resulting in gaps in critical roles affecting service delivery - Limitations of digital infrastructure and minimum viable product systems - Clinical variations and lack of standardised operational processes across the Health Board		
4.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes				Detective			
4.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county				Corrective			
4.4	Reviewing where services do not meet clinical and operational standards				Corrective			

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4.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to the reliance on agency staff (particularly higher cost agency providers) and deliver expected cessation.	Detective		
4.6	Improving the outcomes and experience data capture to inform future planning	Preventative		
4.7	Development and implementation of integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and the expansion of Powys DigiFLO—to enhance system resilience and operational efficiency. This control supports delivery of the PTHB Six Goals for Urgent and Emergency Care, contributes to the NHS Wales People’s Experience Framework, and enables a shift toward a prevention-based, value-driven model of care.	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	A comprehensive options development and appraisal process is in progress for adult physical and mental health community services, aligned with NHS Wales planning guidance and quality standards. The process has been informed by extensive engagement (Stages 1 and 2), clinical input, and multi-agency collaboration.	DPPCMH/DP&C	Underway	Timeline under development
	Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to mitigate delays, improve patient flow, and support timely discharge across the system.	DPPCMH	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	Integrated Quality and Performance Report, Commissioned Services Performance Report and Integrated Performance Dashboard produced monthly	L1 – Management	There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	
	Patient-reported outcome measures (PROMs) and Patient reported experience measures (PREMs)	L1 – Management		

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	System for review and assurance in place, including reporting to each Board meeting, bi-monthly reporting to the Patient Experience Quality and Safety Committee and Finance and Performance Committee.	L2 – Risk Oversight	- Limited Assurance Internal Audit Report received in June 2025 regarding Mattresses. - Underdeveloped assurance reporting of Healthcare Inspectorate Wales outcome reports.
	Regular oversight by Welsh Government including 6 monthly JET meetings and Monthly IQPD presentations.	L3 – Audit and External Assurance	
	2025-26 Internal Audits delivered include; Cancer Services (Reasonable), Pharmacy Stores (Reasonable).	L3 – Audit and External Assurance	
	Clinical Audit Programme in place and monitored through Patient Experience, Quality and Safety Committee. Health Inspectorate Wales Programme.	L3 – Audit and External Assurance	
Summary Position: - Controls largely balanced between preventative, detective and corrective - Gaps in control are recognised - Multiple control improvement actions identified and underway - Assurance is balanced across the Three Lines, with the majority sat in L1 or 3 - Some recognised gaps in assurance			

SRR 005		There is a risk that Primary Care is unable to respond to demand						
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12				Risk Category: Performance and Service Sustainability			
					Boards Risk Appetite: Open			
Executive Lead: Executive Director of Primary Care, Community and Mental Health					Assuring Committee: Planning, Partnerships and Population Health Committee			
BAF Dashboard Assurance Rating:								
Strategic Risk		Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>
SRR 005: Primary Care EDPCCMH		16	16	12	Open <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable
	Key Risk Controls:				Preventative, Corrective or Detective	Gaps in Control		
5.1	Monitoring and liaison with GP practices to offer support including weekly review of the escalation tool, reviewing the sustainability matrix, and considering sustainability funding applications. 25/26 negotiation agreed in December 2025, confirming additional national investment. Includes 4% DDRB uplift and additional 5.8% recurrent uplift supporting a Workforce Fund, Change Fund and Resilience Fund. These new additional funding streams will provide practices with financial certainty to invest in resources needed for ongoing reform, including workforce expansion, service redesign and administrative support as part of the Community by Design transformation programme. The detail around access to these funds is being worked through in readiness for 26/27					• 11 GMS Practices had an underperformance recorded against their contracts with 2 breach notices issued as of EOY 2024/25. Access to general dental services continues to be a local and national challenge. • As of 31 March 2024, 4 practices (25%) were reporting Level 4 escalation. • Vacancies and sickness are an ongoing challenge for practices. Across some disciplines, Powys Practice absences are consistently higher than the all-Wales average.		

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	Sustainability Assessment Panels being held following practice application submission. Targets discussions and action plans and support packages in place with specific practices.		- DAP waiting list currently increasing due to loss of 3 contracts in mid/south Powys. - Implementation of WGOS4 challenging due to complex secondary care pathways and implementation is further compromised by information governance complexities.
5.2	National Contract Assurance Framework embedded to support contract assurance. 24/25 Practice reviews ongoing. 5 practice visits currently being undertaken and 11 practices progressing practice improvement plans. Outstanding actions from 23/24 being followed up as part of the 24/25 review process GMS Contracts Management Group currently confirming practice action plan requirements or targeted practice visits required as part of the 24/25 cycle. GDS End of year review visits with all contract holders completed in August 2025.		
5.3	Implementation and maturity of Accelerated Cluster Development Programme and associated cluster projects of local pathways will support practice sustainability. 26/27 Cluster IMTP completed and agreed at RPB Executive Group. The mid and south cluster will merge from 1st April 2026. Newly formed cluster currently working in shadow form and developed a joint 26/27 IMTP.		
5.4	OOH APMS contract is in place with Shropdoc from 01/04/25 to 05/06/26 (including extensions). PTHB Board have approved Direct Award to continue with current specification from 01/07/26 to 30/09/27. Direct Award being progressed. SBUHB 25/26 SLA signed, with ongoing discussions to resolve outstanding issues in readiness for 26/27. Conversations being led at Director level between PTHB and SBUHB. SBUHB continue to provide a service. GMS out of hours multi stakeholder workshop undertaken in January 2026 to consider the future OOH clinical model. This work is moving at pace to develop a revised specification to commence an open market tender in Q3/Q4 26/27. Quarterly Performance Reviews continue to monitor out of hours services.		

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5.5	Allocating patients from the Dental Access Portal is in place. DAP is fluid with regular 'on and offs'. List is currently at circa 4000 patients due to recent terminations of Llandrindod, Knighton and Crickhowell GDS contracts. Patient urgent access demand has sufficient capacity in the system to address patient need and this is monitored very closely on a weekly basis. Urgent access pathways in place in all contract reform practices, further supported by the Community Dental Service pathway when needed. Mobile Dental provision, salaried PTHB service working well. Pathways in place to support patients following completion of course of treatment. Current location is Bronllys. Potential purchase of an additional Mobile Dental Unit to support GDS access in areas of need. Successful Contract award for Crickhowell GDS. Procurement underway to recommission general dental services in Knighton and Llandrindod. A PTHB salaried service for both these areas is being progressed to offer access through a hybrid model, this will add resilience and sustainability to both areas. New Dental Contract being implemented from 01/04/27. National model contract not yet published; therefore, it is difficult to quantify how many practices will sign up to the new contract or terminate NHS services. This is a national risk.			
	Control Improvement Actions:			
	Action	Owner	Status	Due Date
	Procurement of additional recurrent GDS access opportunities across Powys	DPPCMH	Underway - procurement commenced for Knighton and Crickhowell	March 2026
	Complete Procurement of direct award for future provision of GMS OOH services	EDPCCMH	Underway	March 2026
	Key sources of assurance	Associated Line (Three Lines Model)	Gaps in assurance	
	- Contract Assurance Frameworks - Primary Care Information Portal	L1 – Management		

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	• Dental Access Portal • Escalation Tool • Sustainability matrix score • National Sustainability Assessment Framework • Annual Return • Supplementary Service Audits • Prescribing Data • Practice Declarations • GP Clinical Governance Self-Assessment Tool		
	Bi-Annual assurance reporting to the Executive Committee, Patient Experience, Quality and Safety Committee and Finance and Performance Committee.	L2 – Risk Oversight	
	Cluster Plan progress reported to RPG Executive Group	L3 – Audit and External Assurance	
	Substantial GMS Unified Contract Assurance Framework Internal Audit Report in 2025/26	L3 – Audit and External Assurance	
Summary Position: • Controls largely balanced between preventative, detective and corrective • Gaps in control are recognised • Multiple control improvement actions identified and underway • Assurance is balanced across the Three Lines, with the majority sat in L1 or 3 • No identified gaps in assurance			

SRR 006		There is a risk that the Health Board is unable to recruit and retain an appropriate workforce						
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8				Risk Category: Workforce			
					Boards Risk Appetite: Cautious			
Executive Lead: Executive Director People & Culture					Assuring Committee: People & Culture Committee			
BAF Dashboard Assurance Rating								
Strategic Risk		Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are we doing enough to manage the risk?</i>	Effectiveness of Controls <i>Is what we're doing having the desired impact?</i>	Associated Assurance <i>Based on what evidence?</i>
SRR 005: Primary Care EDPCCMH		16	16	12	Open <i>In appetite</i>	Multiple Controls	Some control weaknesses	Assurance largely reasonable
Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
6.1	Safecare has been implemented to support and monitor safe staffing levels on wards.				Detective	- Critical vacancies in some clinical areas - Ongoing implementation of plans to reduce agency usage and increase bank supply - Further embedding of growing our own initiatives		
6.2	A programmed schedule of staffing huddle meetings take place during the week between the TSU and services to plan and review rosters for the week ahead and prioritise areas requiring additional staffing.				Preventative/Corrective			
6.3	A Variable Pay Group has been established and meets twice monthly. A range of performance measures have been developed to monitor variable pay levels.				Preventative/Detective			
6.4	Workforce projections have been developed for all clinical staff groups with a detailed focus on Nursing (both Registered and HCSWs) across Adult Wards and Community teams and Mental Health Wards and Community Teams, projecting future staffing				Preventative			

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	levels against known recruitment pipelines, such as Grow our own and international recruitment.			
6.5	Regular reporting of 'Time to Hire' and recruitment KPI's included within Workforce Performance Reports.	Detective		
6.6	Monthly vacancy reporting in place identifying vacant posts against the financial ledger.	Detective		
6.7	Workforce planning training delivered and an ongoing offer available.	Preventative		
6.8	Intranet page with information on Workforce Planning set up for managers.	Preventative		
6.9	Wage stream available for Bank staff.	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	Roll out the organisationally agreed workforce planning model by delivering training which supports services to develop their resource plans.	DP&C	Ongoing	Ongoing
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	Workforce performance and assurance reports provided regularly to the Executive Committee, People and Culture Committee and Local Partnership Forum.	L1 – Management		
	Staff Experience Stories reported to regularly to the Board	L2 – Risk Oversight		
	Reasonable Assurance provided by Internal Audit in regard to Staff Retention in November 2024	L3 – Audit and External Assurance		
	Audit Wales's 2024 review of workforce planning arrangements found the Health Board is taking appropriate action to address its significant workforce challenges, with good oversight of its Workforce Futures ambitions	L3 – Audit and External Assurance		

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Summary position

- Controls largely balanced between preventative, detective and corrective
- Gaps in control are recognised
- Control improvement action identified and underway
- Assurance is balanced across the Three Lines, with the majority sat in L2 or 3
- No identified gaps in assurance

SRR 007		There is a risk that the care provided in some areas is compromised due to the health board’s estate being not fit for purpose.						
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L2 x I4 = 8				Risk Category: Quality			
					Boards Risk Appetite: Minimal			
Executive Lead: Executive Director of Finance, Capital, and Support Services					Assuring Committee: Finance and Performance Committee			
BAF Dashboard Assurance Rating								
	Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
	SRR 007: Estate EDoFC&E	16	16	8	Minimal 	Multiple Controls	Some control weaknesses	Assurance largely substantial/ reasonable
Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
	ESTATES					- Review of current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address establishment staff numbers in Works Team and recruitment challenges. Resource review undertaken by IEG in 2023 with proposal limited by financial position, due to financial challenges within the Health Board, this review remains on hold. - significant pressure on space with expanding staff numbers alongside implementation of new agile working approach. Rationalisation of space of health board and other public sector bodies underway.		
7.1	Specialist sub-groups for each compliance discipline				Preventative/Detective			
7.2	Risk-based improvement plans introduced				Preventative			
7.3	Specialist leads identified for key compliance areas				Preventative			
7.4	Estates Compliance Group and Capital Control Group established				Preventative/Detective			
7.5	Medical Gases Governance Group; Fire Safety Group; Water Safety Group; Electrical Safety Group; Asbestos Safety Group; Ventilation Safety Group convened with cross organisation & NWSSP-SES membership.				Preventative/Detective			

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7.6	Capital Programme developed for Compliance and approved capital programme	Preventative	- International Recruitment has introduced significant extra workload, which is affecting output of core activity. Better Together may also have significant impact. - significant cost pressures related to energy and inflation are acting to increase pressure on Estates Revenue and Capital projects outturn costs and material / Supplier availability. Estates related pressure on revenue due to reactive failures of key building fabric and infrastructure. - Significant fire safety infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented but are dependent on capital funding.
7.7	Capital and Estates set as a specific organisational priority in the Health Board's Annual Plan	Preventative	
7.8	Address (on an ongoing basis) maintenance and compliance issues	Corrective	
7.9	Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards	Corrective	
7.10	30+ Specialist Maintenance Contracts in place to ensure appropriate specialist service provision over 3-5 year contract periods	Preventative	
	CAPITAL		
7.11	Capital Procedures for project activity	Preventative	
7.12	Routine oversight / meetings with NWSSP Procurement	Preventative/Detective	
7.13	Specialist advice, support and audit from NWSSP Specialist Estates Services / Authorising Engineers	Preventative/Detective	
7.14	Audit reviews by NWSSP Audit and Assurance	Detective	
7.15	Close liaison with Welsh Government, Capital Function	Preventative/Detective	
7.16	Reporting routinely to Finance & Performance Committee	Preventative/Detective	
7.17	Capital Programme developed and approved	Preventative	
7.18	Detailed Strategic, Outline and Full Business Cases defining risk	Preventative	
7.19	Capital and Estates set as a specific Organisational Priority	Preventative	
7.20	Capital projects developed for consideration for Welsh Government slippage in order to take advantage of any available funding	Preventative	
	<u>ENVIRONMENT</u>		

7.21	ISO 14001 accreditation	Preventative		
7.22	Environment & Sustainability Group	Preventative/Detective		
7.23	NWSSP-Specialist Estates Services (Environment) support and oversight	Preventative/Detective		
7.24	Welsh Government support and advice to identify and fund decarbonisation project initiatives	Preventative		
7.25	Welsh Government Energy Service / Re:fit energy programme of works underway. Investment Grade Proposal (IGP) published to illustrate invest to save projects	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	Continue to seek Welsh Government capital funding to underpin investment to improve the estate / support Transformation.	DFC&SS	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	Comprehensive governance structure established by the Innovative Environments Group (Sub-Group of the Executive Committee)	L1 – Management	Prioritisation plans linked to Strategic Priorities	
	Comprehensive documentation produced and reported to support development of projects and programmes (BJC, SOC, OBC, FBC etc)	L1 – Management		
	Key Performance Indicators in place across services	L1 – Management		
	Regular assurance reporting to the Executive Committee and Finance and Reporting Committee with Board oversight of key documents such as the Capital Programme	L2 – Risk Oversight		
	All 2025-26 (Contract Management, Llandrindod Phase 2) and 2024-25 (Decarbonisation, Capital Systems, Energy Management, Cleaning Standards) Internal Audits provided Reasonable Assurance	L3 – Audit and External Assurance		

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	Close liaison with Welsh Government, Capital Function	L3 – Audit and External Assurance	
	ISO 14001 accreditation	L3 – Audit and External Assurance	
Summary position • Controls largely balanced between preventative, detective and corrective • Gaps in control are recognised • Control improvement action identified and underway • Assurance is balanced across the Three Lines, with the majority sat in L1 or 3 • Recognised gap in assurance			

SRR 008		There is a risk that: The Health Board is unable to shift to a primary prevention focused health care system							
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L5 x I4 = 20 Target: L2 x 3I = 6			Risk Category: Innovation and Strategic Change					
				Boards Risk Appetite: Eager					
Executive Lead: Executive Director of Public Health				Assuring Committee: Planning, Partnerships and Population Health					
BAF Dashboard Assurance Rating									
		Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
		SRR 008: Prevention EDPH	20	16	6	Eager In appetite	Some controls	Controls largely effective	Assurance largely reasonable
Key Risk Controls:						Preventative, Corrective or Detective	Gaps in Control		
8.1	The Health Board Annual Plan 2025/26 contains a number of prevention focused activities under the strategic priority 'Focus on Wellbeing'.					Preventative	- Clinical services need to embed prevention across patient pathways as part of everyday patient interactions - Some The NHS historically has prioritised acute and reactive care and has not invested in prevention by allocating resources to keep people healthy and prevent ill-health - Health Board needs to invest in resources and funding to delivery the Board approved Public Health Strategic Framework - Lack of Corrective key risk controls		
8.2	The Powys Public Services Board Wellbeing Plan has the objective that 'People in Powys live happy, healthy, and safe lives' with the priority objective delivery step of 'Taking a whole systems approach to healthy weight' targeting childhood obesity.					Preventative			
8.3	The Powys Regional Partnership Board Area Plan 2023-28 includes 'Priority 1.3 Population health improvement, including health inequalities'.					Preventative			

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8.4	Population health need priorities in the Annual Plan for PTHB are tackling obesity, tobacco control, Vaccination and health protection. The HB is required to report against vaccination uptake and smoking cessation targets contained in the <i>NHS Wales Performance Framework 2025-26</i> .	Detective		
8.5	Population Health Framework for Powys approved by the Board in September 2025	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	The 2026/27 planning process in the Health Board will be used to take forward actions in the Population Health Framework, including choices on investment in evidence based population health interventions.	DPH	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	NHS Wales Planning Framework reporting procedures.	L1 – Management		
	Regular assurance reporting to the Executive Committee and Planning, Partnership and Population Health Committee	L2 – Risk Oversight		
	Powys Regional Partnership Board internal and external reporting requirements.	L3 – Audit and External Assurance		
	Powys Public Services Board internal and external reporting requirements.	L3 – Audit and External Assurance		
Summary Position				
- Controls largely preventative, singular detective control and no current corrective controls should the risk materialise - Gaps in control are recognised - Control improvement action identified and underway - Assurance is balanced across the Three Lines, with the majority sat in L3 - Recognised gap in assurance				

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SRR 009		There is a risk that: The Health Board is unable to stabilise the growing implications of Continuing Health Care						
Current Risk Score: 16	Risk rating detail: (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I3 = 9				Risk Category: Performance and Sustainability			
					Boards Risk Appetite: Open			
Executive Lead: Executive Director of Primary, Community Care and Mental Health					Assuring Committee: Finance and Performance Committee			
BAF Dashboard Assurance Rating								
Strategic Risk		Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
SRR 009: Continuing Health Care EDPCCMH		16	16	9	Open <i>In appetite</i>	Some controls	Some control weaknesses	Assurance largely reasonable
Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
9.1	HB wide Group established for Variable Pay, identified leads and clear expectation re delivery. Variable pay, CHC and Commissioning regular deep dive areas of focus at F&P Committee to track actions to improve.				Corrective/Detective	- The number of CHC placements has significantly increased in recent years, doubling in numbers and costs in the last 4 years alone, which is having a significant budgetary and workforce impact. - Aging population in Powys forecast to continue until at least 2040		
9.2	A Complex Care and Continuing Health Care (CCCHC) workstream is in place to monitor progression of identified key principles, escalate issues, and guide next steps through regular updates. This structured oversight supports early risk identification, informed decision-making, and contributes to meeting savings targets through improved processes, enhanced reporting, and strengthened assurance.				Preventative			
9.3	Robust governance embedded through a multi-disciplinary panel and approval process, including Continuing Healthcare, to ensure consistent, transparent, and accountable decision-making				Preventative/Detective			
9.4	Monthly Directorate Management Team (DMT) meetings include a standing agenda item whereby the Assistant Director for Complex Care provides an update incorporating Continuing Healthcare (CHC) via the DMT Highlight Report. This ensures regular oversight, facilitates early identification of risks, and supports timely decision-making.				Preventative/Corrective			

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Control Improvement Actions:				
	Action	Owner	Status	Due Date
	External support contract had been awarded to Grant Thornton providing support with partners, clarity consultant associates and UB Healthcare. The key work streams are to improve financial sustainability, commissioning contracting and Continuing Health Care (CHC) including mental health providers.	DoFC&SS	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	A Complex Care and Continuing Health Care (CCCHC) workstream is in place to monitor progression of identified key principles, escalate issues, and guide next steps through regular updates. This structured oversight supports early risk identification, informed decision-making, and contributes to meeting savings targets through improved processes, enhanced reporting, and strengthened assurance.	L1 – Management		
	Variable pay, CHC and Commissioning regular deep dive areas of focus at Executive Committee and Finance and Performance Committee to track actions to improve position.	L2 – Risk Oversight		
	Reasonable Assurance Internal Audit Report on CHC and FNC in May 2024	L3 – Audit and External Assurance		
Summary Position • Controls largely balanced between preventative, detective and corrective • Gaps in control are recognised • Control improvement action identified and underway • Singular source of assurance from each line • No identified gaps in assurance				

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SRR 010		There is a risk that: The Health Board is unable to respond in a timely, efficient, and effective way to a major incident, or critical incident							
Current Risk Score: 12		Risk rating detail: (likelihood x impact) Current: 3 x 4 = 12 Inherent: 4 x 4 = 16 Target: 2 x 3 = 6			Risk Category: Safety				
					Boards Risk Appetite: Averse				
Executive Lead: Executive Director of Public Health					Assuring Committee: Planning, Partnerships and Population Health Committee				
BAF Dashboard Assurance Ratings									
		Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
		SRR 010: Emergency Preparedness/Incident Response EDPH	16	12	12	Averse @ target	Multiple Controls	Controls largely effective	Assurance largely substantial
Key Risk Controls:						Preventative, Corrective or Detective	Gaps in Control		
10.1	Major Incident and Emergency Response Plan and Corporate Business Continuity Plan are in place and updated on an annual basis.					Corrective			
10.2	Business Continuity Policy in place, with supporting 'Business Continuity Toolkit' available for operational services to develop service level business continuity plans.					Preventative			
10.3	PTHB Pandemic Framework is in place to guide the Health Board's response to a new or emerging pandemic. The Health Board is currently awaiting the publication of updated UK Pandemic Guidance, prior to completing a further review of the Framework.					Corrective			
10.4	PTHB Adverse Weather Arrangements is in place and is updated on an annual basis.					Corrective			
10.5	Internal protocols are in place for the management of patients self-presenting with a suspected High Consequence Infectious Diseases (HCID) are in place and are subject to regular review.					Corrective			

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10.6	PTHB Civil Contingencies Training Plan in place and updated on an annual basis.	Preventative		
10.7	Corporate level Business Continuity arrangements subject to internal audit 2023/24.	Detective		
10.8	Operational level Business Continuity arrangements subject to internal audit 2024/2025.	Detective		
10.9	The Health Board is fully engaged in Dyfed Powys Local Resilience Forum's planning and response structures.	Preventative/Corrective		
10.10	The Health Board is fully engaged in the NHS Wales Emergency Preparedness, Resilience and Response planning structures.	Preventative/Corrective		
10.11	The Health Board has participated in a variety of exercises. Examples of these exercises are included below (not inclusive): - Exercise Mighty Oak (National Power Outage) - Exercise Pen Y Darren (Mass Casualty) - Exercise CYD (Communicable Disease) - Exercise Fad Fellin (Mpox/HCID) - Exercise Solaris (Pandemic) - Exercise Redstreak (Water disruption) - Exercise Wales Connect (Regular Pan Wales Response Plan activation test) - Walkthroughs of the operational response to major incidents/Mpox arrangements Exercise Pegasus (Pandemic Response)	Preventative/Detective		
10.12	Testing of internal major incident and business continuity response plans through response to incidents, including: Powys Train Collision (October 2024) Storm Darragh (December 2024)	Preventative/Detective		
10.13	Internal repository in place for all internal Response Plans	Preventative		
10.14	Strengthened cross-border multi-agency working through the establishment of regular meetings to share information on identified areas of risks, preparedness activities and response.	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date

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	Complete cycle of work to ensure that PTHB internal response plans remain up to date.	DPH	Underway	March 2026
	Complete internal operational review of clinical governance arrangements for operational major incident response arrangements	DPH	Underway	December 2025
	Additional training and exercise opportunities to support PTHB’s staff preparedness in response to an incident or emergency to be made available	DPH	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	Training and exercise outcome reports	L1 – Management		
	Plans and Annual Reports overseen by Executive Committee and Board	L2 – Risk Oversight		
	cross-border multi-agency meetings working through the establishment of regular meetings to share information on identified areas of risks, preparedness activities and response.	L3 – Audit and External Assurance		
	Substantial Assurance Reports provided by Internal Audit on Operational Business Continuity Arrangements (May 2025) and Corporate Business Continuity Arrangements (December 2023)	L3 – Audit and External Assurance		
Summary Position				
• A well-controlled and assured risk • Controls largely balanced between preventative, detective and corrective • No gaps in control identified • Multiple control improvement actions identified and underway • Assurance is balanced across the Three Lines, with the majority sat in L3 • No identified gaps in assurance				

SRR 011		There is a risk that: failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.						
Current Risk Score: 15	Risk rating detail: (likelihood x impact) Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 3 x 4 = 12 <i>Risk scored based on health board wide failure.</i>				Risk Category: Safety			
					Boards Risk Appetite: Averse			
Executive Lead: Executive Director of Allied Health Professionals, Health Sciences and Digital					Assuring Committee: Planning, Partnerships and Population Health Committee			
BAF Dashboard Assurance Rating								
	Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
	SRR 011: Digital EDAHPHS&D	20	15	12	Open <i>In appetite</i>	Multiple Controls	Controls largely effective	Assurance largely reasonable
Key Risk Controls:					Preventative, Corrective or Detective	Gaps in Control		
11.1	To mitigate the risk of local network infrastructure failure. Network resiliency is being introduced where possible to ensure a single component failure does not interrupt service.				Preventative	- PTHB is dependant on BT PSBA national network for public sector bodies in Wales. Whilst there is significant redundancy in core parts of the network, there are single points of failure in the local digital infrastructure. Costs of providing resilient circuits to all key health board sites is financially unfeasible. - Digital services are dependent on stable and clean power supply. Several points in both internal and external power infrastructure are not resilient in Powys. - Departmental business continuity plans not implemented by all departments due top operational pressures - Cyber security team consists of one member of staff, unable to invest further due to financial challenges faced by the Health Board		
11.2	Digital protections to mitigate short periods of electrical instability have been implemented at all key sites. Digital Protection is limited to 15-30 Minutes. This has been implemented at the primary digital hub in each location.				Corrective			
11.3	Site wide protections to mitigate extended outages of electricity are managed by the implementation, maintenance and regular testing of Diesel Generators on each key site. <i>This is managed by the Estates department.</i>				Preventative/Corrective			
11.4	Encourage & Support departments to develop digital independent business continuity processes to ensure services can deliver safe and structured care in the event of an extended loss of digital services.				Preventative			

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11.5	Eliminate the use of legacy software with vulnerabilities	Preventative		
11.6	Support external audits of digital infrastructure and cyber security posture.	Detective		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	Cyber response plan in development	DAHPHS&D	Underway	March 26
	Introduction of resilient PSBA connections to Bronllys utilising RISP funding	DAHPHS&D		
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	• Network Refresh Reporting • Regular Testing Schedule • KPIs and data collection/reporting established for both Estates and Digital Services	L1 – Management		
	Regular assurance reporting and risk deep dives by the Executive Committee and Audit, Risk and Assurance Committee (In-Committee)	L2 – Risk Oversight		
	A number of independent audits of cyber security suggest the health boards cyber security posture is positive	L3 – Audit and External Assurance		
	Reasonable Assurance Internal Audits regarding Cyber Security and IT Infrastructure in 2023-24	L3 – Audit and External Assurance		
Summary position • Controls largely balanced between preventative, detective and corrective • Gaps in control are recognised • Multiple control improvement actions identified and underway • Assurance is balanced across the Three Lines, with the majority sat in L3 • No identified gaps in assurance				

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SRR 012		There is a risk that: The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.							
Current Risk Score: 15		Risk rating detail: (likelihood x impact) Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 2 x 4 = 8			Risk Category: Reputation and Public Confidence				
					Boards Risk Appetite: Open				
Executive Lead: Director of Corporate Governance / Board Secretary					Assuring Committee: Finance and Performance Committee				
BAF Dashboard Assurance Rating									
		Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls <i>Are there enough controls in place?</i>	Effectiveness of Controls <i>Are those controls working as intended?</i>	Associated Assurance <i>How do we know/evidence?</i>
		SRR 012: Public Confidence <i>DCG</i>	20	15	8	Open <i>In appetite</i>	Multiple Controls	Controls largely effective	Assurance largely reasonable
Key Risk Controls:						Preventative, Corrective or Detective	Gaps in Control		
12.1	Better Together programme in place in order to make lasting decisions about the permanent future shape of safe and sustainable health services, with Stage One engagement completed and Stage Two engagement nearing completion					Preventative	- Significant challenges to public confidence remain possible, particularly given the pressing need for significant change/transformation of health services to ensure that they are fit for the future and sustainable. The scope for managing these challenges is reduced due to the highly complex environment in which the health board operates (very large rural geography, hyperlocal needs and expectations, complex cross-border commissioned pathways with both England and Wales). Trust has been further challenged by decisions the health board has needed to make in the context of in-year financial challenges (e.g. waiting list measures) and to address risks to safety and sustainability (e.g. temporary service changes). - Capacity to communicate back to the public on their influence from feedback		
12.2	Communication and engagement team in place (substantive team = 4.0wte, additional temporary posts) with active management of priorities aligned with organisational priorities and risks					Preventative			
12.3	Weekly informal communications report to Board including reputation risk portfolio to support internal review and scrutiny					Preventative			
12.4	Twice Yearly Engagement and Communication Report supports ongoing review of capacity against opportunities and risks					Preventative/Corrective			
12.5	Temporary strengthening of communications and engagement function including non-pay resources to support Better Together programme					Corrective			
12.6	Procurement of additional engagement delivery and analysis support to Stage Two Better Together engagement					Corrective			

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12.7	Procurement of additional consultation delivery and analysis support to Stage Three Better Together	Corrective	Lack of structured feedback from key partners	
12.8	Stakeholder Map in place	Preventative/Detective		
12.9	Priority stakeholder engagement mechanisms in place (e.g. regular MS/MP briefings, Board to Cabinet meetings with PCC, Joint Leadership Team meetings with PCC, RPB and sub-structures, PSB and sub-structures)	Preventative		
12.10	OD programme in place linked to Better Together transformational change programme	Preventative		
12.11	Channel strategy in place and kept under review (web, govDelivery, Facebook, NextDoor etc.)	Preventative		
12.12	Out of hours media protocol in place via Gold On Call but currently insufficient team capacity for on call comms	Preventative		
12.13	Powys Engagement and Insight Network in place to support pan-organisational co-ordination of engagement and insight (joint sub-group of RPB and PSB)	Preventative		
Control Improvement Actions:				
	Action	Owner	Status	Due Date
	Establish annual Insight Report from community engagement activities for Board review and to inform annual planning	DCG	Underway	March 2026
Key sources of assurance		Associated Line (Three Lines Model)	Gaps in assurance	
	Comprehensive reporting programme linked to the Better Together programme	L1 – Management	- No third line assurance - Citizen experience reporting	
	Quarterly Communication and Engagement Team reporting	L1 – Management		
	Regular reporting to the Executive Committee, Planning, Partnerships and Population Health Committee, People and Culture Committee and Local Partnership Forum.	L2 – Risk Oversight		

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Summary position

- Controls largely balanced between preventative and corrective, with one recognised detective control
- Gaps in control are recognised
- Control improvement action identified and underway
- No current assurance derived from L3
- Recognised gaps in assurance



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.10

Audit, Risk and Assurance Committee		Date: 10 March 2026
Subject:	Audit, Risk and Assurance Committee Terms of Reference	
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary	
Prepared by:	Deputy Board Secretary	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
The purpose of this paper is for the Committee to consider the Terms of Reference of the Audit, Risk and Assurance Committee in order to ensure that they remain fit for purpose.		
RECOMMENDATION(S):		
The Committee is asked to:		
• ENDORSE the proposed amendments to the Terms of Reference • IDENTIFY any further potential amendments • AGREE that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2026 for approval.		
Approve/Take Assurance	Discuss	Note
Y	Y	

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

EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis.

The existing Terms of Reference (May 2024), have been reviewed and proposed amendments have been made utilising tracked changes. The proposed draft Terms of Reference for the Audit, Risk and Assurance Committee is attached as Appendix A.

Any suggested changes will need to be recommended to the Board for approval.

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations and/or final amendments to the Board in May 2026 to take effect into 2026/27.

It is suggested that the Committee considers the following proposals:

Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Strengthened to reflect the oversight of digital and information management and technology (IM&T) systems within section 3.1
Tidying up	The document has undergone general tidying up to ensure correct formatting, job titles etc.

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations to the Board in May 2026 to take effect into 2026/27.

APPENDICES

- a. **Audit, Risk and Assurance** Committee Terms of Reference (Draft May 2026)

Audit, Risk and Assurance Committee

Terms of Reference & Operating Arrangements

Draft May 202~~6~~⁵

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1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to in this document as 'PTHB' or the 'health board') Standing Orders provides that:

"The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

- 1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings. The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

- 2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Working with the other committees of the Board to provide assurance that governance and risk managements arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services;
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations and
- the performance management of digital and information management and technology (IM&T) systems

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- A report regarding the system of risk and assurance in operation within the Health Board, this may include:
 - any significant changes to the organisations framework for managing risk
 - any significant changes to the organisations framework for managing board assurance

- progress updates in relation to the ongoing development and integration of risk and assurance systems and processes
- a progress report from the Head of Internal Audit summarising:
 - work performed (and a comparison with work planned);
 - key issues emerging from the work of internal audit;
 - management response to audit recommendations;
 - changes to the agreed internal audit plan; and
 - any resourcing issues affecting the delivery of the objectives of internal audit
- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings)
- management assurance reports
- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
 - use of single tender waivers
 - extensions of contracts:
 - writing off of losses; or
 - the making of special payments
- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter
- the internal audit strategy
- the Head of Internal Audit's Annual Opinion and Report
- quality assurance reports on the internal audit function
- the draft accounts of the organisation
- the draft Annual Accountability Report which includes the Annual Governance Statement

- a report on any changes to accounting policies
- external Audit's management letter
- a report on any proposals to tender for audit functions
- a report on co-operation between internal and external audit
- the organisation's Risk Management strategy and Board Assurance Framework
- regular reporting on Information Governance arrangements to ensure compliance with statutory obligations in relation to data protection legislation, national frameworks and good practice,
- periodic reporting on Post Payment Verification Audits
- periodic reporting on financial controls
- periodic reporting on declarations of interest and gifts and hospitality;
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval; and
- assurance reporting regarding arrangements for the performance management of digital and information management and technology (IM&T) systems including:
 - the monitoring of digital related objectives and priorities as set out in the Board's Integrated Plan; and
 - the monitoring of the annual business plan for IM&T.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Patient Experience, Quality & Safety Committee;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and
- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the Health Boards's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or

Audit Risk and Assurance Committee:
(TOR)

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documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4 MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2

Additional Independent Members of the Board may be appointed if

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required.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Executive Director of Finance, Capital and Support Services
- Director of Corporate Governance / Board Secretary

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors not listed above;
- other Senior Managers
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter and
- representatives from Llais on an observer basis.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

- 4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.
- 4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

- 4.8 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

- 5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.
- 5.1 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

- 5.2 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than four times a year, and in line with the Health Board's annual plan of Board Business.
- 5.3 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

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(TOR)

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5.2 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance / Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the

confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

Other meeting arrangements

5.6 Committee meetings will be held via virtual means unless otherwise specified.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated by the Corporate Governance Team.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business (holding joint meetings where appropriate);
- sharing of appropriate information; and
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours

Framework and Standards of Behaviour Policy, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of written assurance reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.2 The Director of Corporate Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.3 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

- Issue of Committee papers (some papers are confidential)

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance / Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance / Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

- 10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Catering Services – Food Safety Standards

Final Internal Audit Report 2025/26

Powys Teaching Health Board



Substantial Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTH-2526-09

December 2025 - January 2026

February 2026

10th March 2026

Pete Hopgood, Executive Director of
Finance, Capital & Support Services

Ian Virgil, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal
Audit



Executive Summary

Purpose

The purpose of this audit was to review the Health Board’s food safety standards and to provide assurance that all food provided within the Health Board’s hospitals meets the highest standards of safety and hygiene, thereby safeguarding the health and well-being of patients, staff, and visitors.

The management of hospital catering services within the catering regulatory landscape is complex and demands a thorough understanding of statutory requirements, national guidance, and best practice principles. There are inherent risks associated with catering in healthcare settings, particularly for vulnerable patient groups, reinforcing the critical need for rigorous oversight.

Effective food safety management relies on appropriate staffing levels, effective training of staff, the upkeep of kitchen infrastructure, and strict adherence to standard operating procedures. Routine checks and internal controls remain vital in ensuring consistent compliance, protecting food integrity, and preventing avoidable harm.

Overview

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

- A high number of management and supervisory self-assessment audits were not completed. Whilst of itself this may not result in significant risk, there is no guidance provided in the Food Safety Procedures defining the process, role or target completion level for these assessments.

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:

- Full and up to date staff lists were not included in all training files as would be considered best practice, substantiating completeness of training records.
- Minor inconsistencies in the format of control forms were noted, specifically regarding visitor health declarations. Management should seek examples of best practice displayed across the estate and implement consistently across all services.
- Signed and dated (current) Food Policy Statements were not displayed at all sites. Whilst not a regulatory requirement, display of this document publicly demonstrates transparency and commitment to food safety, potentially enhancing public trust and reputation.
- Some minor degradation to pest screens was noted at two sites. Management should assess the risk posed by this and replace as necessary.

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	Comprehensive and up to date Food Safety Policies and Procedures are in place and appropriate training is provided to relevant staff		-	Substantial
2	Mechanisms and controls are in place and operating effectively to ensure compliance with relevant food safety standards		1	Substantial
3	Risks and incidents relating to compliance with food safety standards are effectively managed with monitoring of actions through to completion		-	Substantial
4	Governance structures are appropriate and effective with mechanisms for regular reporting and escalation of key food safety compliance matters to Committee and Board level where required		-	Substantial

Management Actions



Medium Priority

Themes



■ Performance Monitoring

Risk Types

Legal & Regulatory Non-Compliance

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Findings & Agreed Action Plan

Objective 1: Comprehensive and up to date Food Safety Policies and Procedures are in place and appropriate training is provided to relevant staff	Substantial

There is a robust and up-to-date Food Safety Policy and supporting procedures in place, all of which have been reviewed, approved and are accessible across sites in Powys. All documentation reviewed was within approval date and was available to operational teams on the PTHB SharePoint site as well as in hard copy format at each of the three services visited as part of our sample testing (Brecon War memorial Hospital, Ystradgynlais Community Hospital, Bro Ddyfi Hospital Machynlleth).

The Food Safety Procedures document clearly defined roles and responsibilities for food hygiene, and the Food Safety Management System (FSMS) included a comprehensive set of documents including a Hazard Analysis and Critical Control Points analysis (HACCP), allergen procedures and blank monitoring forms designed to standardise best practice controls across the estate.

The Policy and procedures are operationally owned by the Head of Facilities who demonstrates active monitoring of legislative updates and regulatory changes, supported by Environmental Health and internal governance groups to ensure standards remain current.

Staff in the three sites visited as part of this review were trained commensurately for their roles. All sites retained hard copy training certificates demonstrating staff competence in both food hygiene and allergen awareness and individual catering team members were able to detail when training required renewal.

During our sample visits we did note some minor operational inconsistencies that would not impact an Environmental Health assessment but that are highlighted for completeness:

- One of three sites (Bro Ddyfi) did not retain a full and up-to date list of all staff in their training file. Whilst this could be established through review of staff rotas, it would be considered best practice to have this list available, particularly for EHO inspections; and
- One of three sites (Bro Ddyfi) did not have a signed Food Safety Policy Statement on display. Whilst not a legal requirement, display of a signed copy is encouraged by best practice standard as it publicly demonstrates commitment to food safety and transparency, enhancing public trust and reputation.

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The full Food Safety Management System (FSMS) was available and in use across all sites visited as part of our sample. Working copies of control documents were maintained within kitchen admin areas and these documents showed that all checks had been completed consistently, accurately and fully across all sites with no missing records and exceptions recorded as intended.

Control sheets were completed in alignment with calendar months with prior month’s records maintained fully and neatly in storage areas accessible to staff should ever they be required – for example, during Environmental Health inspections.

Some minor variations in standards were noted during our visits which are highlighted for completeness:

- Visitor health declaration forms differed between sites however, all variations conformed to a minimum regulatory standard;
- At two sites (Ystradgynlais and Brecon) some minor degradation was noted to pest screens obscuring external windows; and
- At two sites (Ystradgynlais and Brecon) there were unmarked low doorways to walk-in chillers potentially presenting risk of head injuries.

Standards across all sites are ensured through a well embedded process of self-assessment audits conducted by site supervisors, coordinators and management. Whilst departmental records show that these audits are conducted regularly, completion rates varied between sites, and we noted several weekly and monthly audits had not been completed. Whilst these checks do add value, they are not formally mandated within the Food Safety Procedures, and no required frequency is formally defined.

Key Findings		Risk & Impact	Agreed Management Action
1	Self-Assessment Audits 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.	If management checks are not completed, there is risk of unknown non-compliance with standards	Agreed Action 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.
			Expected Evidence of Implementation: Copy of updated Food Safety Procedures.
			Medium Priority
Theme: Performance Monitoring		Control Design	

Objective 3: Risks and incidents relating to compliance with food safety standards are effectively managed with monitoring of actions through to completion

Substantial

Compliance with food safety legislation is obtained by adherence to the Food Safety Procedures. Compliance and risks are monitored by management through the self-assessment audits described under Objective 2.

The incident reporting process is clear and well-structured with Datix serving as the central system for reporting all food safety-related incidents with oversight provided by the Professional Lead for Catering Services and escalation of serious or RIDDOR-related incidents to the Head of Facilities.

We reviewed Datix incident data for the period April to November 2025 and noted that there were no food safety related incidents. However, all actions arising from self-assessment audits, EHO inspections and any incident logged in Datix are recorded on a document that is presented at monthly Senior Management Team meetings to ensure visibility, learning and action tracking.

Objective 4: Governance structures are appropriate and effective with mechanisms for regular reporting and escalation of key food safety compliance matters to Committee and Board level where required

Substantial

The governance structure is strong and multi-layered with appropriate reporting mechanisms in place at operational, managerial and sub-committee level. Local self-assessment audits are undertaken regularly with completed copies retained on site for reference by local supervisors. The outputs from these audits are collated and discussed monthly by management as a standing agenda item in the Senior Management Team meetings. Senior management supplement these checks through "360-degree audits" which incorporate compliance assessment with service user feedback, the results of which are escalated to both the Senior Management Team and the Nutrition, Hydration and Catering Group.

The Senior Management Team meets monthly, supported by published agendas and recorded minutes allowing for a structured review of performance, trends and action log updates. Additional oversight and governance are provided quarterly by the Nutrition, Hydration and Catering Group, designed to provide Nursing management with oversight and opportunity to input to catering operations ensuring the best quality of service for patients.

Extraordinary updates are presented at committee level (Finance and Performance) by exception. The most recent example of this came after a 1-star EHO assessment at Bronllys Hospital in October 2023 where updates were presented at the subsequent three committee meetings (June 2024 – October 2025). These updates and the special reporting measures implemented as part of remedial follow-up action demonstrate responsiveness and transparency in addressing regulatory concern. It is worth noting that at the time of our audit, the most recent EHO inspections for the three sites we visited had all been assessed with 5-star ratings.

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Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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Disclaimer

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

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.





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Agenda item: 7.2

Audit Risk and Assurance Committee		Date: 10 March 2026
Subject:	SINGLE TENDER WAIVERS	
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services	
Prepared by:	Assistant Director of Finance (Accounts and Services)	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
To inform the Audit Risk and Assurance Committee that there has been one Single Tender Waiver requests made between 1 January 2026 to 28 February 2026		
RECOMMENDATION(S):		
The Committee is asked to:		
- NOTE there has been one Single Tender Waiver request made between 1 January 2026 to 28 February 2026 - Take ASSURANCE an effective system of monitoring and reporting single tender waivers is in place.		
Approve/Take Assurance	Discuss	Note
N	N	Y

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

EXECUTIVE SUMMARY:

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 January 2026 meeting which covered the period from 1 October 2025 and 31 December 2025.

A summary of the use of Single Tender Action from 1 January 2026 to 28 February 2026 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
2526-082-STA-POW	TENDER	Department for Health and Social Care (DHSC), England	National Institute for Health and Care Research (NIHR) Incubators	Follow on work from NHS England to devolved nations	13/01/2026	£225,000	6 years	Prospective	A1

NWSSP Procurement use a central register now for the majority of Health Boards that use a physical waiver document process and the reference and number is auto generated based on its position on the list. Although the fomal reference on the table states it is 082 STW document issued it is confirmed this is the sixth STW undertaken within Powys for the 25/26 financial year.

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

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Powys Teaching Health Board Glossary (Last updated Januarymars 26)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
APB	Area Planning Board
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice

CNO	Chief Nursing Officer
CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner

GNCC	General Nursing Complex Care Team
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
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
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
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
RIIC	Research, Innovation & Improvement Coordination

RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
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 Trust
YTD	Year to Date

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Agenda item: 7.4

AUDIT, RISK AND ASSURANCE COMMITTEE		Date: 10 March 2026	
Subject:	Annual summary of in year changes to Standing Orders 2025/26		
Approved and presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary		
Prepared by:	Head of Corporate Governance		
Other Committees and meetings considered at:			
PURPOSE:			
To provide the Committee with details of all changes made to the Standing Orders and Standing Financial Instructions for the period April 2025 to date,			
RECOMMENDATION(S):			
The Audit, Risk And Assurance Committee is asked to:			
• NOTE that no further changes to Standing Orders are recommended for the period 2025/26, • NOTE that a light touch review of Committee Terms of Reference is being undertaken in Quarter 4 of 2025/26. Any changes resulting from this review will be taken to Board in May 2026 • TAKE ASSURANCE that all necessary changes have been made to Standing Orders and Financial Instructions.			
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	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

Welsh Government require Health Boards in Wales to keep Standing Orders up to date to ensure continued compliance with Welsh Government regulations and model framework which are periodically amended to reflect changes in legislation, governance structures and nationally mandated ways of working. The changes approved at Board from April 2026 to date are summarised below.

SCHEDULE OF CHANGES MADE TO STANDING ORDERS:

30 July 2025

In response to Welsh Health Circular 2025/012 the Board approved amended Model Standing Financial Instructions in relation to Chapter 11 Procurement and Contracting.

24 September 2025

The Board approved revised Healthcare Professionals Forum Advisory Group Terms of Reference.

26 November 2025

The Board approved amended authorisation levels for the Chief Executive, Deputy Chief Executive and Executive Directors. Administrative updates were also applied such as job title changes, Committee name changes, external agency name changes as appropriate.

28 January 2026

The Board approved the following changes to the Standing Orders:

- Schedule 1 (Scheme of Delegation) – Executive Scheme of Delegation
- Schedule 4 (Board Committee arrangements) - Power of Discharge Group terms of reference
- Schedule 5 (Advisory Groups) - Local Partnership Forum terms of reference
- Section 6.1 (Joint Commissioning Committee) - Revisions to the Standing Orders for the NHS Wales Joint Commissioning Committee (issued via Welsh Health Circular)

No further changes are proposed to Board in March 2026.

NEXT STEPS:

A light touch review of Committee Terms of Reference has been undertaken during Quarter 4 of 2025/26 with this Committee considering its Terms of Reference at item 5.9 on the agenda. Any changes proposed as a result of these reviews will be taken to Board in May 2026.

IMPACT ASSESSMENT

Not required

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Agenda item: 7.5

Audit, Risk and Assurance Committee		Date: 10 March 2026	
Subject:	Committee Effectiveness: Continuous Development Plan 2025-26		
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 – ARAC Continuous Development Plan 2025-26		
PURPOSE:			
This report provides the Committee with the plan for continuous development based upon the matters identified for actions within the 2024-25 annual review of Committee effectiveness. The plan comprises of actions arising from and relevant to all Committees (Cross Committee Action Plan) and those actions which are specific to the Audit, Risk and Assurance Committee.			
RECOMMENDATION(S):			
The Committee is asked to: a. RECEIVE the ARAC Continuous Development Plan 2025-26 and TAKE ASSURANCE that the implementation of continuous improvement actions have been monitored 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.

The approach for 2024/25 comprised of a questionnaire followed by discussion at the Committee. The Committee effectiveness questionnaire focused on the critical themes of:

- (i) composition and establishment
- (ii) effective functioning
- (iii) assurance and
- (iv) leadership and culture

The findings of the Audit, Risk and Assurance Committee review were received and discussed by the Committee on 13 May 2025, and subsequently the findings of all Committees were combined and reported to the Chair's Forum and the Board.

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 Corporate Governance team has undertaken a thematic review of all Committee Effectiveness review findings both holistically for all Committees and for each Committee individually and has pulled out the key actions to enable continuous improvement for implementation throughout 2025-26.

Actions have been identified as either Cross-Committee actions (improvement opportunities/actions arising identified by and/or relevant to all Committees of the Board) or Committee specific actions, identified by and/or relevant to a single Committee.

Implementation of the Continuous Improvement Plan 2025-26 (Appendix A) has been monitored by the Corporate Governance team throughout the year, the Corporate Governance Team will continue to monitor actions still under implementation as of February 2026 and will consider how these are fed into the continuous development processes for 2026/27.

NEXT STEPS:

The Corporate Governance Team will continue to monitor actions still under implementation as of February 2026 and will consider how these are fed into the continuous development processes for 2026/27.

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Appendix A – ARAC Continuous Development Plan 2025-26

Committee Effectiveness: Continuous Development Plan 2025–2026

Audit, Risk and Assurance Committee

Cross-Committee Action Plan (actions relevant to all Committees)

Theme	Action	Owner	Timeline	Status	Comments
Membership	Review and confirm committee membership	DCG / PTHB Chair	Q1	Complete	New Committee Membership confirmed as of May 2025
Assurance to Board (Quality Assurance: QMS)	Develop a standardised reporting template for clear upwards assurance	Governance Team	Q2	Complete	Alert, Advice, Assurance, Inform (AAAI) Reports have been introduced for all Committees for reporting to the Board from March 2025 (having been piloted during 2024/25). This template will be reviewed and matured in readiness for September Board.
Organisational Learning (Quality Learning: QMS)	Schedule opportunity to actively consider evidence of learning and improvement in each Committee	Governance Team	Q3	Underway	Integrated into review of Committee Work programme for 2026-27 as in development as of Q4.
Committee Agenda Focus	Apply risk-based approach to planning	DCG/Committee Chairs	Q1	Complete	Prioritisation is undertaken as part of the agenda setting process, this is

(Quality Planning: QMS)	agendas, prioritising high-risk/high-impact items				aligned to SRR, CRR, ORR and BAF process.
Training & Induction	Develop induction information and training needs analysis for each Committee	Governance Team	Q4	Complete	ARAC induction pilot held in September 2025, further schedule to be considered for 2026/27.
Integration of Risk	Incorporate risk lens in committee discussions and papers	Governance Team	Ongoing	Underway	Committee risk register a core agenda item at every committee. Review of Committee Paper template underway with consideration of how to best integrate risk appetite levels into cover reports.

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Committee-Specific Action Plans

Audit and Risk Assurance Committee (ARAC)

Theme	Action	Owner	Timeline	Status	Comment
Benchmarking and monitoring effectiveness	Use external benchmarks to help assess ARAC effectiveness annually	Governance Team	Q3	Complete	Benchmarking and good practice standards have been identified and will be factored into the next survey cycle due to be deployed in 2026/27.
Level of focus on lower assurance audits and overdue recommendations	Develop agenda and papers to ensure proportionate focus on areas of most risk	Governance Team / Chair of Committee	Q2	Complete	Consent agenda utilised for substantial assurance audit reports in year and streamlining and refocusing of Audit Tracking and WHC reports complete
Training and Induction	Develop a specific training/induction process for ARAC Members	Governance Team supported by Chair of Committee	Q3	Complete	ARAC induction pilot held in September 2025

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Audit, Risk and Assurance Committees 2025-26

Theme	Item Title	Duration (mins)	Role of Committee	Onward Journey to Board (Y/N)	Exec Lead	May 13/05/2025	June 17/06/2025 (Annual Accounts)	July 08/07/2025	Oct 7/10/24	Jan 13/01/2026	March 10/03/2026
Governance	Minutes of previous meeting	15	Approval	N	DCG	✓		✓	✓	✓	✓
Governance	Declaration of Interests		Compliance	N	DCG	✓		✓	✓	✓	✓
Governance	Action Log		Approval	N	DCG	✓		✓	✓	✓	✓
Governance	Annual Work Programme	15	Recommendation to	Y	DCG	✓		✓			
Governance	Work Programme (updated through year)	5	Review	N	DCG			✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	10	Review	Y	DCG	✓					✓
Governance	Committee Governance Action Plan			N	DCG			✓	✓		✓
Governance	Committee Annual Report	10	Recommendation to	Y	DCG	✓					
Governance	Audit Findings Tracker	15	Assurance	N	DCG				✓		✓
Governance	WHC/MD Tracker	10	Assurance	N	DCG	✓			✓		✓
Governance	Organisational Register of Interests	10	Assurance	Y	DCG				✓		✓
Governance	Organisational Register of Gifts and Hospitality	5	Assurance	N	DCG				✓		✓
Governance	Board Assurance Framework				DCG				✓		✓
Governance	Review of Terms of Reference	10	Recommendation to	Y	DCG	✓					✓
Governance	Review of Standing Orders and Standing Financial Instructions	10	Recommendation to	Y	DCG						✓
Governance	Confirmation Clinical Audit Programme in place		Assurance		EMD			✓			
Annual Accounts	Approach to the Annual Accounts	5	Assurance	Y	ED FC&SS/DCG						✓
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	30	Recommendation to	Y	ED FC&SS	✓					
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	5	Recommendation to	Y	ED FC&SS		✓				
Internal Audit	Head of Internal Audit Opinion Draft	10	Assurance	N	DCG	✓					
Internal Audit	Head of Internal Audit Opinion Final	5	Recommendation to	Y	DCG		✓				
Internal Audit	Internal Audit Annual Plan	15	Approval	N	DCG						✓
Internal Audit	Internal Audit Progress Report 25/26	10	Assurance	N	DCG	✓		✓	✓	✓	
Internal Audit	Internal Audit Reports (as required)	20	Assurance	N	DCG	✓		✓	✓	✓	✓
Internal Audit	Internal Audit Trend Report		Assurance	N	DCG					✓	
External Audit	Enquiries of Management and Those Charged with Governance		Assurance	N	ED FC&SS/DCG		✓				
External Audit	External Audit Annual Plan	5	Approval	N	ED FC&SS/DCG						✓
External Audit	External Audit Progress Report		Assurance	N	DCG	✓		✓	✓	✓	
External Audit	External Audit Reports (as required)	20	Assurance	N	Lead	✓		✓		✓	✓
External Audit	Structured Assessment		Recommendation to	Y	DCG	✓				✓	
Counter Fraud	Counter Fraud Annual Plan	10	Approval	N	ED FC&SS						✓
Counter Fraud	Counter Fraud Update		Assurance	N	ED FC&SS	✓		✓	✓	✓	
Counter Fraud	Counter Fraud Reports (as required)		Assurance	N	ED FC&SS	✓		✓		✓	✓
Finance and Procurement	Single Tender Waivers Annual Report		Assurance	N	ED FC&SS	✓					
Finance and Procurement	Single Tender Waivers (including extensions to contracts)		Assurance	N	ED FC&SS	✓		✓	✓	✓	✓
Finance and Procurement	Losses and Special Payments Annual Report		Assurance	N	ED FC&SS	✓					
Finance and Procurement	Losses and Special Payments		Assurance	N	ED FC&SS	✓			✓		✓
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Jan		Assurance	N	ED FC&SS	✓				✓	
Finance and Procurement	Financial Controls		Assurance	N	ED FC&SS				✓		
Risk	Review of Risk Management Framework		Assurance	Y	DCG				✓		
Risk	Assurance of Risk Management arrangements inc. revised Risk Management Toolkit		Assurance/Approval	N	DCG	✓		✓	✓	✓	
Hosted Bodies	Hosted Body annual report (HCRW)		Assurance	N	DWOD		✓				
Information Governance	IG Annual Report	10	Assurance	N	DCG	✓					
Information Governance	IG Performance Report	10	Assurance	N	DCG				✓	Q2✓	
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)	10	Assurance	N	EMD			✓	✓		
Information Governance	Information Governance & Records Management report	15	Assurance	N	DCG	✓				✓	
Digital First	Strategic Risk deep dive •Failure of 'Digital and Electrical Infrastructure (In-Committee)	15	Assurance	N	DoAHP,HS&D					✓	
Digital First	Digital First Annual Plan	20	Assurance	Y	DoAHP,HS&D				x	✓	
Digital First	Digital First Quarterly Monitoring (including cyber security)	15	Assurance	N	DoAHP,HS&D			✓	✓	✓	
	WCCIS assurance update (In-Committee)	10	Assurance		DoAHP,HS&D					✓	✓
	SFI executive financial delegation limits	10	Assurance	Y	DCG				✓		
Key	Key:										
Date to be confirmed	Date to be confirmed										
Item to be confirmed	Item to be confirmed										
Item deferred	Item deferred										
Item brought forward	Item brought forward										
Going to Board	Going to Board										
Find Exec Cttee date	Find Exec Cttee date										
Added to draft agenda	Added to draft agenda										

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