

Audit, Risk and Assurance Committee

Tue 12 May 2026, 10:00 - 13:00

Agenda

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

0 min

 Agenda_ARAC_ 12May2026 FINAL.pdf (4 pages)

1.1. Welcome and Apologies

Verbal Chair

1.2. Declarations of Interest: Board Members Register of Interests 2026/2027

Verbal & Attached All

 ARA_1.2_Board Members Declaration of Interest May26.pdf (3 pages)

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

0 min

The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.

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

0 min

3.1. Minutes of the previous meeting held on 10 March 2026

Attached Chair

 ARA_3.1_ARAC_Minutes_10 March 2026.pdf (12 pages)

3.2. Committee Action Log

Attached Chair

 ARA_3.2_Action Log.pdf (2 pages)

3.3. External Audit Annual Plan 2026

Attached External Audit

 ARA_3.3_Powys THB Audit Plan 2026.pdf (22 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. Draft Accountability Report and Financial Accounts

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

 ARA_5.1a_Accountability report cover 25-26 draft.pdf (5 pages)

 ARA_5.1ai_Draft accountability report 2025-26 06052026.pdf (140 pages)

 ARA_5.1bi_Draft Annual Accounts 2025-26 ARAC 12-5-26 cover.pdf (3 pages)

Powell Bethan
12/05/2026 15:11:24

5.2. Draft Head of Internal Audit Opinion 2025/26

Attached *Head of Internal Audit*

- ARA_5.2_Draft HIA Opinion & Annual Report 25-26 Cover.pdf (2 pages)
- ARA_5.2a_Powys THB Draft HIA Opinion and Annual Report 2025-26.pdf (27 pages)

5.3. Board Assurance Policy, Risk Management Policy and Risk Appetite

Attached *Director of Corporate Governance*

- ARA_5.3a_Risk Management Framework and Board Assurance Framework Cover Paper.pdf (3 pages)
- ARA_5.3ai_AppendixA_Risk Management Framework May 2026.pdf (35 pages)
- ARA_5.3aii_AppendixB_CGP 014 Board Assurance Framework May 2026.pdf (27 pages)
- ARA_5.3b_Risk Appetite Statement_April 2026.pdf (2 pages)
- ARA_5.3bi_AppA_Risk Appetite Statement_April2026.pdf (6 pages)

5.4. Counter Fraud Annual Plan and Update

Attached *Counter Fraud*

- ARA_5.4a_Counter Fraud Annual Plan cover paper.pdf (2 pages)
- ARA_5.4ai_PTHB Counter Fraud Work Plan 2026-27.pdf (14 pages)
- ARA_5.4b_Counter Fraud Update Report cover.pdf (2 pages)
- ARA_5.4bi_Counter Fraud Update Report May 2026.pdf (4 pages)
- ARA_5.4bii_Appendix 1 - PTHB Counter Fraud Annual Report 2025-26.pdf (21 pages)

5.5. IG Toolkit (National Audit replaces Caldicott Principles)

Attached *Executive Medical Director*

- ARA_5.5_IG Toolkit Out-Turn Report and Improvement Plan 26-27.pdf (9 pages)

5.6. Finance Grip and Control

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

- ARA_5.6_Powys_Financial_Grip_Control_Board_Assurance_non-workforce areas.pdf (17 pages)

5.7. Hosted Body Annual Report

Attached *Executive Director of People, Culture and Transformation*

- ARA_5.7_HCRW PTHB Audit Committee May 2026 - PUBLIC COPY.pdf (13 pages)

5.8. Internal Audit Progress Report 2025/26

Attached *Head of Internal Audit*

- ARA_5.8_Internal Audit Progress Report May 26 Cover.pdf (2 pages)
- ARA_5.8a_Internal Audit Progress Report May 26.pdf (12 pages)

5.9. Internal Audit Reports:

Attached *Head of Internal Audit*

- ARA_5.9a_North Powys Integrated Wellbeing Hub Final Report.pdf (16 pages)
- ARA_5.9b_Risk Management Final Internal Audit Report.pdf (11 pages)
- ARA_5.9c_Asbestos Management Final Internal Audit Report.pdf (16 pages)
- ARA_5.9d_Mattresses Follow-up Final Internal Audit report.pdf (8 pages)

5.10. External Audit Progress Report

Attached *External Audit*

- ARA_5.10_Audit Wales Audit Committee Update May 2026 PDF.pdf (10 pages)

5.11. External Audit Reports:

Attached External Audit

- ARA_5.11ai_Powys THB Quality Governance Follow-up Review.pdf (28 pages)
- ARA_5.11aii_Management Response Form QG Follow Up FINAL 060526.pdf (12 pages)
- ARA_5.11bi_Audit Wales Digital Transformation May26.pdf (29 pages)
- ARA_5.11bii_Audit Wales Digital Transformation Management Response.pdf (9 pages)
- ARA_5.11c_Management Response Form - Powys THB SA 2025 May 26 FINAL.pdf (6 pages)

5.12. Single Tender Waivers

- ARA_5.12a_ARAC Single Tender Waiver Report May 2026.pdf (3 pages)
- ARA_5.12b_Single Tender Waiver Annual Report May 2026.pdf (4 pages)

5.13. Losses and Special Payments Annual Report

- ARA_5.13_Losses and Special Payments Annual Report May26.pdf (7 pages)

5.14. PTHB Policies and Written Control Documents

Attached Director of Corporate Governance

- ARA_5.14_Policy & Written Control Documents Summary Report 23 April 2026.pdf (11 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. Post Payment Verification Year End

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

- ARA_7.1_PPV END OF YEAR 2025-2026.pdf (3 pages)
- ARA_7.1a_End of year PPV Report 2025-2026.pdf (2 pages)

7.2. Annual Audit Summary 2025

Attached External Audit

- ARA_7.2_External Audit Reports_Powys THB AAS 2025.pdf (16 pages)

7.3. Annual Committee Work Programme 2026/2027

Attached Director of Corporate Governance

- ARA_7.3_Work Programme 2026-2027.pdf (3 pages)

7.4. Committee Annual Report 2025/26

Attached Director of Corporate Governance

- ARA_7.4_ARA Committee Annual Report_2025-26.pdf (9 pages)

7.5. PTHB Glossary

Director of Corporate Governance

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

10:00 - 10:00 8. OTHER MATTERS

0 min

Powell Bethan
12/05/2026 15:11:29

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: 09 June 2026 via Microsoft Teams

8.5. Confidential Item

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Minutes of the In-Committee meeting held on 10 March 2026

8.9. Committee Risk Register - SRR011 Failure of Digital and Electrical Infrastructure

8.10. Digital First Six Monthly Monitoring Report (including cyber security)

Powell Bethan
12/05/2026 15:11:29

AUDIT, RISK AND ASSURANCE COMMITTEE

TUESDAY 12 MAY 2026
10:00-13:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
 Addysgu Powys
 Powys Teaching
 Health Board

AGENDA

Time	Item	Title	Attached / Verbal	Owner
	1	PRELIMINARY MATTERS		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest Board Members Register of Interests 2026/27	Verbal/ Attached	All
	2	CONSENT AGENDA BUSINESS		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	ITEMS FOR APPROVAL / DECISION / RATIFICATION		
	3.1	Minutes of previous meeting held on 10 March 2026	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
10:10 5	3.3	External Audit Annual Plan 2026	Attached	External Audit
	4	ESCALATED ITEMS		
There are no items for inclusion within this section				
	5	ITEMS FOR ASSURANCE		
10:15 20	5.1	Draft Accountability Report and Financial Accounts	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services and Director of Corporate Governance
10:35 5	5.2	Draft Head of Internal Audit Opinion 2025/26	Attached	Head of Internal Audit
10:40 15	5.3	Board Assurance Policy Risk Management Policy Risk Appetite	Attached	Director of Corporate Governance
10:55 15	5.4	Counter Fraud matters: - Annual Plan - Update	Attached	Counter Fraud
11:10 10	5.5	IG Toolkit (National Audit replaces Caldicott Principles)	Attached	Executive Medical Director
11:20	COMFORT BREAK (10mins)			
11:30 10	5.6	Finance Grip and Control	Attached	Deputy Chief Executive/ Executive Director of

				Finance, Capital and Support Services
11:40 10	5.7	Hosted Body Annual Report	Attached	Executive Director of People, Culture and Transformation
11:50 10	5.8	Internal Audit Progress Report 2025/26	Attached	Head of Internal Audit
12:00 30mins	5.9	Internal Audit Reports: • North Powys Integrated Wellbeing Hub • Asbestos Management • Risk Management & Assurance • Mattresses Follow-up.	Attached	Head of Internal Audit
12:30 5	5.10	External Audit Update Report	Attached	External Audit
12:35 20	5.11	External Audit Reports: • Quality Governance Follow-up • Digital Transformation • Structured Assessment Management Response	Attached	External Audit
12:55 5	5.12	Single Tender Waivers	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
13:00 5	5.13	Losses and Special Payments Annual Report	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
13:05 5	5.14	PTHB Policies and Written Control Documents	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	Post payment verification Year End Purpose: For assurance	Attached	Deputy Chief Executive/Executive Director of Finance, Capital and Support Services
	7.2	Annual Audit Summary 2025 Purpose: For assurance	Attached	External Audit
	7.3	Annual Committee Work Programme 2026/27 Purpose: For approval	Attached	Director of Corporate Governance
	7.4	Committee Annual Report 2025/2026	Attached	Director of Corporate Governance

		Purpose: For approval		
	7.5	PTHB Glossary Purpose: For Information	Attached	Director of Corporate Governance
	8	OTHER MATTERS		
	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 09 June 2026 via Microsoft Teams		
8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 <i>"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"</i>				
13:10	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declarations of Interest	Verbal	All
	8.8	Minutes of the In-Committee meeting held on 10 March 2026	Attached	Director of Corporate Governance
13:15	8.9	Committee Risk Register • <i>SRR011 - Failure of Digital & Electrical Infrastructure</i>	Attached	Executive Director of Allied Health Professions, Health Science and Digital
13:20 10	8.10	Digital First 6 monthly monitoring report (including cyber security)	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.

Powell, Bethan
12/05/2026 15:11:29

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2026-27							Updated: May 2026
Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
INDEPENDENT MEMBERS							
PTHB Chair	Carl Cooper	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	Nil
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil
Vice Chair	Rhiannon Beaumont-Wood	Non Financial professional interests	Outside Employment	Jun-23	Ongoing	Director and Owner of RBW Executive and Professional Coaching	Salaried Employment
		Non Financial personal interests	Loyalty Interests	May-23	31/05/2026	Non-Executive Member Dorset ICB (In the process of forming a cluster with Dorset ICB, Somerset ICB, Bath, East Somerset, Swindon and Wiltshire ICB)	Remunerated as per Non-Executive Member, Terms and Conditions
		Non Financial personal interests	Loyalty Interests	Jun-24	31/03/2027	Registrant Council Member - Nursing and Midwifery Council (NMC)	Remunerated as per Registrant Council Member Terms and Conditions
Independent Member (General)	Rhobert Lewis	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL
Independent Member (Trade Union)	Cathie Poynton	NIL	NIL	NIL	NIL	NIL	NIL
Independent Member (finance)	Stephen Elliot	Non Financial professional interests	Loyalty Interests	17/04/2024	Current	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	NIL
		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
Independent Member (General)	Ronnie Alexander	Indirect Interests	Outside Employment	2012	Current	Partner Director of RA and CJ Consulting Limited	Dividend Payment only
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only
Independent Member (University)	Simon Wright	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Variou Healthcare Programmes	Salaried Employment
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment
		Non Financial professional interests	Loyalty Interests	02-Jan-20	Ongoing	Labour Party member	NIL
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	Salaried Employment
Independent Member (Third Sector)	Jennifer Owen Adams	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None
		Non Financial professional interests	Loyalty Interests	01.09.2024	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
		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

Independent Member (Local Authority)	Christopher Walsh	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 •Member of the Community Speed Watch Group	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL
Independent Member (Capital)	Michael Giannasi	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated
Independent Member	Ian Thomas	NIL	NIL	NIL	NIL	NIL	NIL
EXECUTIVE MEMBERS							
Chief Executive Officer	Hayley Thomas	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of Finance, Capital and Support Services	Pete Hopgood	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant
Executive Director of Allied Health Professions, Health Science and Digital	Claire Madsen	Financial Interests	Outside Employment	07-Jan-19	01-Apr-28	Occasional Lecturer for University of West of England.	Hourly rate
		Non Financial professional interests	Loyalty Interests	10-Jun-05	01-Mar-28	Member of the The Chartered Society of Physiotherapy	NIL
Executive Medical Director	Kate Wright	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of People and Culture	Debra Wood Lawson	Indirect Interests	Outside Employment	01-Nov-24	01-Nov-27	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated
			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).
		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
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work
		Indirect Interests	Outside Employment	May-25	Current	Partner - Associate for Practice Solutions	

Director of Strategic Improvement and Transformation	Lucie Cornish	Nil	Nil	Nil	Nil	Nil	Nil
Executive Director of Planning, Performance & Commissioning	Nicola Johnson	Nil	Nil	Nil	Nil	Nil	Nil
Executive Director of Primary, Community Care and Mental Health	Elaine Lorton	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - 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	15-May-26	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil
Executive Director of Nursing, Quality, Women and Family Health	Paul Hooton	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	25/10/2025 Started with PTHB October 2025



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Powys Teaching
Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC)

UNCONFIRMED MINUTES OF THE MEETING HELD ON 10 MARCH 2026 HELD VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ronnie Alexander	RA	Independent Member (General)
Mick Giannassi	MG	Independent Member (General)
Rhobert Lewis	RL	Independent Member (General)
Ian Thomas	IT	Independent Members (General)
IN ATTENDANCE		
Rhiannon Beaumont-Wood	RBW	PTHB Vice Chair (Observing)
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Carl Cooper	CC	PTHB Chair (Observing)
Vicki Cooper	VC	Chief Digital Officer
Stella Gwynne	SG	Deputy Board Secretary
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Bethan Hopkins	BH	Audit Wales
Mike Jones	MJ	Audit Wales
Beth Powell	BP	Corporate Governance & Risk and Assurance Officer
Sarah Pritchard	SP	Assistant Director of Finance
Hayley Thomas	HT	Chief Executive
Ian Virgil	IV	Head of Internal Audit
APOLOGIES FOR ABSENCE:		
Matthew Evans	ME	Counter Fraud
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Louisa Steele	LS	Counter Fraud

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/086)

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

1.2 DECLARATIONS OF INTEREST (ARA/25/087)

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

A query was raised regarding governance arrangements, noting that the register had not been updated since the departure of the PTHB Vice Chair, resulting in two vice chairs listed. It was explained that the register had been updated, but in line with policy, the names of former executive or independent members are retained for a period of time to support any retrospective review.

2. CONSENT AGENDA BUSINESS

The Chair asked Members if they wished to bring forward any items from the Consent agenda to the main agenda. The Committee confirmed that agenda item 7.2 Single Tender Waiver, would be discussed within the main agenda due to the number of waivers included within the report.

3. ITEMS FOR APPROVAL / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (ARA/25/088)

The minutes of the meeting held on the 13 January 2026 were **CONFIRMED** as an accurate record.

3.2 ACTION LOG (ARA/25/089)

- 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 May 2026 was requested to enable the finalisation of the document.
 - ARA/25/081 (Digital First): A query was raised regarding ensuring continued oversight of the NHS Wales App compatibility issue, which had been marked as complete in relation to the Digital First Annual Plan. It was confirmed that, because the matter was formally reported to the Board, it now sits within the Board’s overarching log of escalated or alerted items and would remain there until satisfactory resolution. Ongoing executive work continued, and the issue would be updated and reported at each Board meeting.

3.3 INTERNAL AUDIT ANNUAL PLAN 2026/2027 (ARA/25/090)

IV provided the committee with an overview of the plan which was developed in line with Internal Audit Standards. It was noted that the plan schedule aimed to ensure an even flow of audits throughout the year, avoiding previous issues of workloads clustering at yearend. As audits progress, final scopes and timings would be agreed with executives and reported back to the committee.

The plan contained 25 audits, consistent with the size of the 2025/26 plan, and provided sufficient coverage to support the Head of Internal Audit opinion. The plan would be kept under review throughout the year, and any required amendments would be reported to the committee through routine progress updates.

Independent Members sought assurance by asking the following questions:

Were Executives satisfied that each task within the plan was essential and provided clear value, given the current financial pressures and the need to control expenditure?

It was confirmed that all audits had been reviewed individually and as a whole to ensure the plan was balanced, affordable, and meets statutory requirements. It was confirmed that Executives were confident that the programme was appropriate, noting lessons learned from last year’s reduction. The plan was also reviewed by the Chief Executive and was emphasised that internal audit remained essential for maintaining effective governance and assurance.

Was there sufficient capacity and resilience to deliver next year’s full audit programme, given current organisational pressures?

IV explained that while some audits were deferred due to internal audit resourcing issues, recruitment had strengthened the team to deliver the full 2026–27 plan.

Could assurance be provided that the audit plan places enough emphasis on the highest risk areas?

Assurance was provided across key risk areas, informed by discussions with executives and awareness of work already undertaken by other assurance providers. Areas such as cyber security were considered but placed on a longer list for future years, forming part of a rolling three-year plan to ensure cyclical coverage across all major risks.

It was agreed to produce a simple overview map showing all audit related assurance activity in one place including Grant Thornton work, and other relevant reviews. The summary would help the committee clearly see how assurance sources align and avoid duplication, providing greater collective reassurance.

Action: Director of Corporate Governance

The Committee **APPROVED** the Internal Audit Plan for 2026-27, **APPROVED** the Internal Audit mandate and charter, and **NOTED** the associated Internal Audit resource requirements and key performance indicators.

3.4 LOSSES AND SPECIAL PAYMENTS (ARA/25/091)

PH introduced the report and highlighted that the proposed debt write-off related to historic invoices dating back as far as 2006–07, and not a single financial year. This was part of a good practice exercise to address longstanding, unrecoverable debt and ensure compliance with the six-year statutory limitation period. SP highlighted the following themes for Committee members attention:

- The debt was considered irrecoverable despite all reasonable recovery actions.
- The write off would have no financial impact on the 2025–26 position.
- A review of historic debt would be undertaken more regularly going forward.

Independent Members sought assurance by asking the following questions:

Could assurance be provided that tighter controls would be put in place to prevent recurring issues with unrecovered debts, given public and Welsh Government scrutiny if such write offs happen again?

SP confirmed that processes for managing historic debt had already been strengthened through closer work with Powys County Council, and most of the write off relates to old cases.

Committee members welcomed the clarity provided on the total bad debt write off but expressed difficulty understanding the table, noting that some debts had exceeded the six-year statutory limit while others had not, yet all were presented as a single total. It was confirmed that most debts were beyond the six-year statute, with only a small number of very low value recent invoices included due to disproportionate administrative effort.

Could assurance be provided that the Health Board has a more proactive, ongoing process for writing off irrecoverable debt rather than accumulating it and was the exgratia payment part of an all Wales scheme?

SP confirmed that bad debt write offs would be reported annually going forward and provided assurance that the recognition payment was part of a national, Welsh Government led process being implemented consistently across all Health Boards.

The committee emphasised the need to tighten debt recovery and write off processes by reinforcing the responsibilities of budget holders and line managers, whose actions directly influence salary overpayments and the accuracy of invoices issued to other organisations.

The Committee **APPROVED** the write off from debts totalling £210,474.75 and **NOTED** the submission to Welsh Government for approval for the losses element of the Band 2/3 recognition payment for Health Care Support Workers.

4. ESCALATED ITEMS

There were no items for inclusion in this section.

5. ITEMS FOR ASSURANCE

5.1 APPROACH TO THE ANNUAL ACCOUNTS 2025/2026 (ARA/25/092)

SP introduced the report and highlighted areas where estimates would be required. It was noted that significant capital valuations would take place this year, including formal revaluations of Llandrindod and Brecon Hospitals following substantial works. Significant work had been undertaken to strengthen CHC processes following an Audit Wales ISO 260 recommendation raised in the 2024–25 accounts, with additional work undertaken in 2025–26 to improve robustness of information and controls in this area.

Independent Members sought assurance by asking the following questions:

What was the current position in developing an overall capital asset strategy?

SP explained that Powys’ capital investment had increased significantly in recent years and was managed within a clear, Welsh Government mandated accounting framework, with the Board approving a two-year capital programme. Capital was spread across the estate due to its age, and derecognition is part of a national exercise distinguishing between asset enhancing works and routine maintenance.

Which of the estimates in the accounts were most likely to attract Audit Wales scrutiny, what mitigation was in place and was there confidence to avoid delays as experienced last year?

SP confirmed that the accounts process was well established, with key estimates such as primary care accruals and clinical negligence provisions supported by robust data and regular in year checks that reduce yearend risk. External inputs like district valuers were used where needed, and their work was scrutinised by auditors. Although some information relies on partners, ongoing dialogue provides confidence that risks are managed and timelines would be met.

The Committee noted that scheme pays was a COVID related, Welsh Government funded measure to protect staff from pension impacts linked to extra pandemic related work. It was not limited to medics and others could apply through the national NHS Pensions process. The protection applies only to COVID related impacts, not to other pension changes such as those arising from temporary senior acting up roles.

The Committee **NOTED** the report and **TOOK ASSURANCE** a plan was in place to deliver the annual accounts and report, **NOTED** the planned approach to accounting areas, including use of estimates where needed as outlined within the paper.

5.2 INTERNAL AUDIT PROGRESS REPORT (ARA/25/093)

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 three 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 and would be presented at the next meeting in May. An overview of the progress with the delivery of the audit plan was provided:

- Five Audits had been completed since the previous meeting and were on the agenda to be discussed, including one under the consent agenda.
- 25 audits were planned for 2026/27 (13 had been finalised)
- Two audits were in draft.
- Seven audits were due to be delivered in year and would be presented at the May meeting
- Two adjustments to the plan were requested:
 - Three deferred audits from the 2025/26 plan were anticipated for: Discretionary Capital, Community Care and Site Coordination. Discussion had been held with relevant leads regarding deferrals. These audits had been included within the 2026/2027 audit plan.
 - A follow-up audit on the previously limited assurance mattresses review had been added to the plan, an omission now corrected to provide assurance on progress over the next couple of months.

Independent Members sought assurance by asking the following questions:

What learning from this year’s delays had been built into next year’s audit plan to prevent falling behind target again?

IV explained that lessons learned had been incorporated into next year’s plan, including more precise scheduling of audits within specific quarters and ensuring work was evenly spread throughout the year. Earlier planning, earlier agreement of scopes, and prompt escalation of any delays, supported by executives and the corporate governance team was emphasised.

When audits were deferred, what risk assessment process was used, and how did the Health Board ensure that risks, such as those related to asbestos management or mortality reviews, were properly mitigated while the work is postponed?

It was noted that historically, there may have been some over-optimism and high compliance, and the focus was being clearer in agreeing and accepting audit recommendations. Whilst planning and discipline was improving; the approach would need to balance reality with flexibility.

What was the rationale for the deferred audits from 2025/2026 plan and could assurance be provided that there was sufficient capacity to deliver essential work on estates and site investment?

IV confirmed that the discretionary capital audit was delayed due to internal audit resource constraints. The site coordination audit was deferred due to processes were being refreshed, meaning an audit at that point would not have added value. IV noted

these were specific, isolated reasons, not indicators of wider resourcing concerns in Capital and Estates.

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 which included the deferral of three audits: Discretionary Capital, Community Care and Site Coordination. These audits had been included within the 2026/2027 audit plan.
- **APPROVED** the follow-up audit on the previous limited assurance mattresses review which had been added to the plan.

5.3 INTERNAL AUDIT REPORTS (ARA/25/094)

IV introduced the item and provided a summary of the following reports:

a) Clinical Supervision (Reasonable Assurance)

What was the rationale for the overall assurance rated 'Reasonable' rather than Limited, if clinical supervision was required at least quarterly, and the audit found it was happening less frequently?

IV confirmed that due to clinical supervision taking place for all staff reviewed, supported by an up to date policy that clearly sets expectations, the issue identified related mainly to inconsistent timing, rather than a failure to provide supervision at all. On balance, because the framework and supervision was happening, the finding warranted a high priority action but did not lower the overall assurance to Limited.

How did the Health Board plan to address the high proportion of staff missing annual supervision and was it appropriate that the audit relied mainly on survey evidence rather than access to supervision notes?

IV confirmed that access to confidential supervision notes was restricted to protect trust and confidentiality but did not compromise the audit. In this case the comprehensive questionnaire responses provided sufficient, reliable evidence to form a sound assurance opinion without needing individual notes.

b) Anti Racism Action Plan (Reasonable Assurance)

Given that several actions in the Anti-racism Action Plan we remarked "on track" from the internal audit, despite slipped deadlines, could assurance be provided on the robustness of the governance and accuracy of the plan, and should reporting be more frequent to reflect the national and moral significance of this work?

HT noted that a discussion was held at the People and Culture Committee last week and an update would be provided to members following further discussions.

Action: Chief Executive Officer/Director of Corporate Governance

c) Policy Management (Reasonable Assurance)

What urgent actions would be taken to prioritise and update the oldest and most critical policies, and how would this be sustained to ensure the backlog was cleared and not recur?

IV explained that the high number of overdue policies as a priority issue, noting that although the Corporate Governance team had made progress, 30% remains high and

therefore a high priority action had been set and management had committed to addressing it.

Given that 30% of policies are out of date, with some dating back to 2012 were any of the policies seen as pivotal?
IV explained this would be reviewed and an update would be provided to committee members.

Action: Head of Internal Audit

Could clarity be provided on where Policy performance and monitoring is reported to?
BP confirmed that the Corporate Governance team had made significant progress over recent months to prioritise and updating internal mechanisms for tracking policy management. A report is due to the Executive Committee in Q1 to gain clearer oversight of the risks linked to overdue policies. The reporting cycle would be confirmed within the 2026/2027 work programme.

d) Follow Up DoLs (Not Rated)

IV confirmed that the DoLs follow up audit received limited assurance in December 2024, which had six findings, and under the updated follow-up approach which focused on confirming completed actions in replacement of issuing a new assurance rating, it was confirmed that all six actions had been fully implemented.

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

5.4 EXTERNAL AUDIT REPORTS (ARA/25/095)

BH introduced the report and outlined the current audit position. Several draft reports remained with the Health Board, specifically the follow-up reviews which were scheduled for the next meeting in May. The committee was also alerted to two upcoming deep dive reports, Digital Systems Investment and Estate Management arrangements, both expected at forthcoming meetings.

Committee members recognised the high number of Internal Audit reports anticipated at the next meeting in May and was suggested that relevant Executive Directors be present to discuss their respective reports. Members were advised that the team were exploring options to present some Internal Audit reports to other Committees, whilst presenting the full reports for information to the Audit, Risk and Assurance Committee.

STRUCTURED ASSESSMENT

The Committee received the final Structured Assessment report for 2025 and noted the Management response was not included due to timing to complete executive sign-off. This would be presented to the Board in March.

Independent Members sought assurance by asking the following questions:

Had consideration been given to including Llais within audit scope, given their regular input and important role in representing patient voices across Wales?
BH confirmed that Llais was taken into account and were contacted as part of the structured assessment to understand what they are hearing locally and how patient feedback was being collected and used. Llais reports were regularly reviewed, and issued raised, were considered in the audit work.

The Committee welcomed the positive findings within the report, particularly recognition of the Board Assurance Framework (BAF), and the acknowledgement of effective engagement with Llais. Members noted that clarity on financial plans should emerge in the coming months, with Grant Thornton involved, and agreed that making savings more visible would be helpful. A query was raised in terms of what “tailored individual support for Independent Member’s” means and noted this could be discussed further at an upcoming Board Development session.

Members also raised that following an introductory meeting with the newly formed JCC in January 2025, to consider a follow up session, focused specifically on performance issues, such as ambulance response, rising costs, and Recommendation 4. This would be explored with the Director of Corporate Governance and relevant Executives.

Action: Director of Corporate Governance

Had thought been given to looking beyond Wales, to see whether their Board processes or governance approaches offer lessons, rather than relying solely on a Wales centred perspective?

BH confirmed that they benchmark structured assessment criteria against governance models both within and outside Wales and update the approach each year. Some measures may be dropped if they no longer add value and produce all Wales themes by moderating findings across Health Boards, highlighting common issues and strengths.

Had the Health Board planned to refresh its strategic risks given they were incorporated into the annual plan?

SG explained that strategic risks were already integrated into the planning process as the plan is developed. Following anticipated Board approval of the annual plan in March, a dedicated Board Development session would be used in April/May each year to review and update the strategic risks to ensure they remain aligned. A major review took place last year, and further refinements are expected over the coming months based on feedback being received.

It was noted that Board members may benefit from more targeted training, in areas like finance to ensure a strong baseline understanding when scrutinising information. Annual committee self-reflections were acknowledged, but the report suggested a greater focus on tailored individual Independent Member training.

The Committee **RECEIVED** and **DISCUSSED** the External Audit Report and Structured Assessment.

5.5 COUNTER FRAUD ANNUAL PLAN AND REPORTS (ARA/25/096)

PH advised the committee that both the Head of Counter Fraud and the Local Counter Fraud Officer were currently absent, and mitigating actions were being worked through with Swansea Bay. This had caused a delay in bringing the Counter Fraud Plan to the committee. A follow up meeting was scheduled for Thursday, after which a position statement would be shared with the committee to provide assurance ahead of the May meeting.

Action: Executive Director of Finance, Capital and Support Services

The Committee **RECEIVED** a verbal update on the current position and would receive assurance outside of the meeting on Counter Fraud reporting.

5.6 WELSH HEALTH CIRCULAR (WHC) AND MINISTERIAL DIRECTIONS (MDS) TRACKER (ARA/25/097)

SG introduced the report and provided an overview of the current position of Welsh Health Circulars and Ministerial Directions. A typo was noted on the cover page and should indicate the correct figure of three WHCs showing no progress, the correct figure was three, reflecting a better position than reported.

The committee was reminded that the Health Board must report annually to Welsh Government on WHC and Ministerial Direction implementation as part of the wider Annual Report, and the position would directly inform that submission.

Independent Members sought assurance by asking the following questions:

The committee raised concerns over WHC 2022 006 - Direct Paramedic referral to same day emergency care as this linked to discussions in other committees. There was an interest as to why the action was partially complete, given the importance of SDEC. An update would be provided to members outside of the committee.

Action: Director of Corporate Governance

Comments were raised about the report as an assurance tool identifying the lack of detail reported against actions marked as Partially Complete could make taking assurance difficult. For those WHCs that were reported as No Progress, some had no explanation or expected timescales of completion. Committee Members identified that some aspects of the report lacked sufficient follow up, audit trail, or analysis to understand the position.

The Committee highlighted the importance of strengthening the report.

RA highlighted queries about WHC 2025 051 - Safety netting discharge leaflets for adults and children as no update had been provided. Emphasis was drawn to the importance of providing patients with appropriate take-home guidance. The committee requested for further assurance to be provided outside of the meeting.

Action: Director of Corporate Governance / Director of Nursing, Quality, Safety and Family Health

The Committee **RECEIVED** the report and **REVIEWED** those WHCs and MDs reported as No Progress. The Committee **NOTED** that the position would be reported to Audit Wales, Internal Audit and Welsh Government for scrutiny and review as part of the Annual Report 2025/26.

5.7 AUDIT FINDINGS TRACKER (ARA/25/098)

SG introduced the Audit Tracking Report and highlighted the current position showed an improvement, with 66 open recommendations, the lowest level in many years. SG reported the overdue items remained, including three internal audit reports approaching the six month deadline.

It was noted that the five overdue actions from the mattresses audit had been highlighted. A specific follow up of this audit had now been included in the internal audit plan, which would allow clearer assurance on the true status of the actions. An update would be provided at the May meeting.

The Committee raised concern around the proportion of audit actions currently off track, noting that although the position had improved, having around a third delayed needed to be understood as to the reasons why. The tracker showed which actions were overdue but did not clearly explain why they were off track or how recovery would be achieved. It was noted a lack of thematic analysis, prioritisation, and clarity on underlying barriers—such as capacity, process issues, or structural challenges. While the report was helpful for understanding the current status, more work could be developed to add sufficient insight into the reasons behind delays or the steps needed to improve the position going forward.

It was acknowledged that significant progress had been made in improving the audit tracking process and it remained an ongoing piece of work. Feedback from members was welcomed, with assurance that further refinements would be explored to ensure the report continues to provide meaningful value and supports members in gaining assurance.

The Committee **CONSIDERED** the position of outstanding Audit Findings and **TOOK ASSURANCE** that the organisation has an appropriate system for tracking and responding to Audit Recommendations, with a particular focus on those findings given high priority ratings

5.8 ORGANISATIONAL REGISTER OF INTERESTS, GIFTS AND HOSPITALITY (ARA/25/099)

SG provided the committee with an overview of the progress made over the past 1–2 years in strengthening standards of behaviour processes. Communications, education, and engagement by the team had increased awareness of standards, gifts and hospitality, and the importance of declaring interests. This had led to a noticeable rise in entries on the gifts and hospitality register. While positive progress had taken place, there remains an ongoing programme of improvement, with further work planned to continue to promote uptake across the organisation.

Independent Members sought assurance by asking the following questions:

Was there any oversight of declared interests beyond individuals submitting their forms, to ensure any concerned interests were identified and followed up?

It was confirmed that oversight of declared interests sits primarily with the individual’s line manager, who was responsible for assessing the impact of any declared interest and determining whether any action was needed. Work was underway with HR to embed the responsibility into induction and PADR processes, ensuring managers understand their obligations. The team also provides advice and support on managing specific cases where needed.

The Committee were also advised that declared interests inform the related party notes in the annual accounts, with a £1,000 materiality threshold. Conflicts are also checked through the National Fraud Initiative, which periodically matches staff bank details with external payments and directorships.

The Committee **RECEIVED** the contents of register of interests for Powys Teaching Health Board members and those staff with budget oversight and the PTHB Gifts and Hospitality Register and **TOOK ASSURANCE** that the organisation had appropriate processes to support the collection management and reporting of declarations of interest.

5.9 BOARD ASSURANCE FRAMEWORK AND STRATEGIC RISK REGISTER (ARA/25/100)

There was agreement that there was not sufficient time to discuss the Board Assurance Framework and Strategic Risk Register and could not be given adequate attention given time constraints.

The Committee recognised that the framework had developed well, and the reassurance mapping was welcomed, but a fuller future discussion would be scheduled.

Action: Director of Corporate Governance

The Committee **RECEIVED** the report agreed to **DEFER** the Board Assurance Framework and Strategic Risk Register.

5.10 REVIEW TERMS OF REFERENCE (ARA/25/101)

SG presented the annual review of committee Terms of Reference, noting that a comprehensive revision had been carried out last year. No material changes were proposed, aside from strengthening references to digital within the committee's purpose. Members were invited to provide comments verbally or via email before the Terms of Reference proceed to the Board for approval in May.

The Committee

- **RECEIVED** the report,
- **ENDORSED** the proposed amendments to the Terms of Reference
- **AGREED** that the Chair of the Committee and Director of Corporate Governance would finalise the revised Terms of Reference for presentation to the Board in May 2026 for approval.

5.11 SINGLE TENDER WAIVER (including extensions to contracts) (ARA/25/102)

SP introduced the report and confirmed that one single tender waiver had been enacted since the previous meeting, relating to Healthcare Research Wales (HCRW), a hosted body of the Health Board responsible for R&D across NHS Wales. The waiver concerned a procurement request for R&D activity originating in NHS England that is now being expanded to the devolved nations, including Wales. HCRW's budget and work plan was agreed with Welsh Government.

Independent Members sought assurance by asking the following questions:

Why was the HCRW procurement flowing through the Health Board's accounts rather than being handled directly at Welsh Government level, and does the Health Board have the authority to make the payment?

SP explained that Healthcare Research Wales had expanded its functions, taking on some responsibilities previously held by Welsh Government. Procurement colleagues had overseen the single tender waiver, so additional documentation may exist that is not captured on the form. The position would be checked directly with HCRW, including confirmation of the funding and approval route via Welsh Government.

What specific benefits would the procurement deliver for NHS Wales?

SP highlighted that given the significant investment involved, HCRW would be asked to provide further information. A response would be shared with members outside the committee once received.

Action: Executive Director of Finance, Capital and Support Services

Members suggested seeking information from Healthcare Research Wales (HCRW) to provide broader clarification on the procurement, its purpose, and the wider implications for NHS Wales. It was noted that procurement specialists had already been involved in the single tender waiver process, but further assurance on the procurement route would be helpful. Broader concerns were also raised about the principle of the investment, including whether Powys might be “doublepaying” for a service already commissioned externally. Further discussion was therefore recommended outside the committee setting.

Action: Executive Director of Finance, Capital and Support Services

The Committee **RECEIVED** the report and **TOOK ASSURANCE** that an effective system of monitoring and reporting single tender waivers was in place.

6 ITEMS FOR DISCUSSION

There were no items for discussion.

7 CONSENT AGENDA

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

- **FOR ASSURANCE:**
- **7.1** Internal Audit Reports (Substantial Assurance)
 - Catering Services
- **7.3** PTHB Glossary
- **7.4** Review Standing Orders and Financial Instructions
- **7.5** Committee Governance Action Plan
- **FOR INFORMATION:**
- **7.6** Committee Work Programme 2025/2026

8 OTHER MATTERS

8.1 ANY OTHER BUSINESS (ARA/25/103)

No other business was raised.

8.2 COMMITTEE REFLECTIONS (ARA/25/104)

The following feedback was noted:

- The pace of the meeting was well-judged, with the Chair keeping discussion focused throughout and a broad range of topics covered;
- The committee did not avoid challenging issues, including financial pressures, audit capacity, and affordability.
- There was strong and appropriate scrutiny of overdue, partial, or no progress actions on the Audit tracker, sending a clear message.
- The structured assessment prompted valuable self-reflection on the nature and purpose of scrutiny, including what good scrutiny looks like and whether the right issues are being scrutinised.
- The meeting was described as well-run and thought-provoking, with thanks offered to members and to the Chair for maintaining focus and preventing discussions from going off track.

8.3 DATE OF NEXT MEETING (ARA/25/105)

12 May 2026 via Microsoft Teams

Meeting closed at 13:03.

Powell Bethan
12/05/2026 15:11:29

Audit and Risk Assurance Committee					 Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board		
RAG Status:							
At risk	Red - action date passed or revised date needed						
On track	Yellow - action on target to be completed by agreed/revised date						
Completed	Green - action complete						
No longer needed	Blue - action to be removed and/or replaced by new action						
Transferred	Grey - Transferred to another group						

Audit and Risk Assurance Committee								
Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW- (12 MAY 2026)								

OPEN ACTIONS - NOT YET DUE (12 MAY 2026) - NONE								
10-Mar-26	ARA/25/090	DCG	Internal Audit Annual Plan 2026/27	Produce a simple overview map showing all audit related assurance activity in one place including Grant Thornton work, and other relevant reviews. The summary would help the committee clearly see how assurance sources align and avoid duplication, providing greater collective reassurance.	12.05.2026 update: Action on track for due date	Jul-26		On track
ACTIONS RECOMMENDED FOR CLOSURE (12 MAY 2026)								
05-Feb-26	PEQS/25/90	Executive Director of Allied Health Professions, Health Science and Digital	Patient Experience in Primary Care	Digital oversight for concerns relating to cross-border access for Welsh patients using the NHS App to be transferred to Audit, Risk and Assurance Committee for oversight and action.	May 2026 Update: This matter was escalated to Board by ARAC on 13.01.2026 and, as is now on the Board escalation log, has been closed as an ARAC action. This will continue to be monitored under the Board escalation log process.	Apr-26		Transferred
10-Mar-26	ARA/25/095	DCG	Structured Assessment Report	To explore a followup session, following an introductory meeting with the newly formed JCC, which would focus specifically on performance issues, such as ambulance response, rising costs, and Recommendation 4. To be explored with the Drector of Corporate Governance and relevant Executives.	12.05.2026 update: JCC colleagues are scheduled to join the Board development session in August 2026. Recommended action to close on this basis.			Completed
10-Mar-26	ARA/25/103	DCG	Single Tender Waiver	Consider further discussion with Healthcare Research Wales (HCRW) to provide broader clarification on the procurement, its purpose, and implications for NHS Wales, and to offer further assurance on the procurement route. Additional discussion on concerns such as potential "double-payment" should also be taken forward.	12.05.2026 update: Item raised at quarterly review and further discussion scheduled for May. Recopmmend closure on this basis.			Completed
10-Mar-26	ARA/25/100	DCG	BAF and SRR	The framework had developed well, and the reassurance mapping was welcomed, but a fuller future discussion would be scheduled.	May 2026 Update: Item added to the May ARAC agenda.			Completed
10-Mar-26	ARA/25/097	DCG	WHC and MD Report	To provide further information on the rationale as to why WHC 2022-006-Direct Paramedic referral to same day emergency care remained Partially Complete and WHC 2025-051- Safety netting discharge leaflets for adults and children, why no update provided. An update would be shared with members.	March 2026 Update: WHC-2022-006: An update was circulated to Members on 17.03.2026. 12.05.2026 update: WHC 2025-051: An update was circulated to ARAC members on 23.04.2026.			Completed
10-Mar-26	ARA/25/094	DoPC&T	Internal Audit: Anti Racism Action Plan	Following the March People and Culture Committee to provide an update to ARAC regarding the robustness of the governance and accuracy of the Action plan and consider more frequent reporting	12.05.2026 update: Update circulated to ARAC Members on 05/05/26.			Completed

10-Mar-26	ARA/25/096	DoFC&SS	Counter Fraud	To share a position statement with members on the assurance of the Counter Fraud mitigating actions with Swansea Bay given the absence of the team ahead of the May meeting.	12.05.2026 update: Information from DoFC&SS circulated to Members via email on 01/05/2026 with further detail to be provided within in the meeting			Completed
10-Mar-26	ARA/25/094a	Head of Internal Audit	Internal Audit: Policy Management	To review the out of date policies dating back to 2012 and confirm whether any were seen as pivotal	May 2026 update: The small number of out of date policies dating back to 2012 have been reviewed and this has confirmed that they are local operational policies and therefore not pivotal to the Health Board as a whole.			Completed
10-Mar-26	ARA/25/102	DoFC&SS	Single Tender Waiver	Procurement colleagues had overseen the single tender waiver, so additional documentation may exist that is not captured on the form. The position would be checked directly with HCRW, including confirmation of the funding and approval route via Welsh Government. A full response would be brought back once verified.	12.05.2026 update: Update circulated to ARAC Members on 05 /05/2026.			Completed
10-Mar-26	ARA/25/102a	DoFC&SS	Single Tender Waiver	HCRW to confirm the specific benefits the procurement would deliver for NHS Wales, and the response will be shared with members outside the committee once received.	12.05.2026 update: Update circulated to ARAC Members on 05 /05/2026.			Completed
17-Jun-25	ARA/25/032	DCG	Structured Assessment Report 2024	To explore a MoU arrangement with RPB to strengthen governance and processes of responding to the health board	01.07.2025 update: the action will be progressed in line with the target date. 13.01.26 update: discussions held to clarify reporting points and purpose between the RPB and Health Board. Document to be produced to confirm arrangements (may not be an MOU but will be a documented agreement). Date change requested to finalise document. 10.03.26 update: status remains as reported in January and not yet progressed due to other priorities. Reporting from the RPB is however incorporated into all relevant Board and Committee work programmes. Date change requested to finalise document. 12.05.2026 update: Document produced in draft outlining RPB and Health Board reporting and governance interactions in place to ensure clarity. Document will be finalised with RPB colleagues. recommend closure on that basis.	Jan-26	May-26	Completed

Powys Teaching Health Board – Audit Plan 2026

Date issued: April 2026



Powell Bethan
12/05/2026 15:11:29

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Powell Bethan
12/05/2026 15:11:29

Introduction



Adrian Crompton

Auditor General for
Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My [Code of Audit Practice](#) provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three

lines of assurance model (page 20) sets out how we will ensure those standards of quality are met. Our latest annual [Audit Quality Report](#) provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other [national audit work](#) that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit, my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Powell Bethan
12/05/2026 15:11:29

Our aims and ambitions

Our purpose



Assure people that public money is being managed well



Explain how that money is being spent



Inspire the public sector to improve

Our vision



Fully exploiting our unique perspective, expertise and depth of insight



Strengthening our position as an authoritative, trusted and independent voice



Increasing our visibility, influence, and relevance



Being a model organisation for the public sector in Wales and beyond

Our areas of focus



A strategic, dynamic, and high-quality audit programme



A targeted and impactful approach to communications and influencing



A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our [Annual Plan 2026-27](#) and Our [Strategy 2022-27](#).

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our [Statement of Responsibilities](#).

I am also required to certify a return to the Welsh Government which provides information about the [Health Board/Trust/SHA] to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

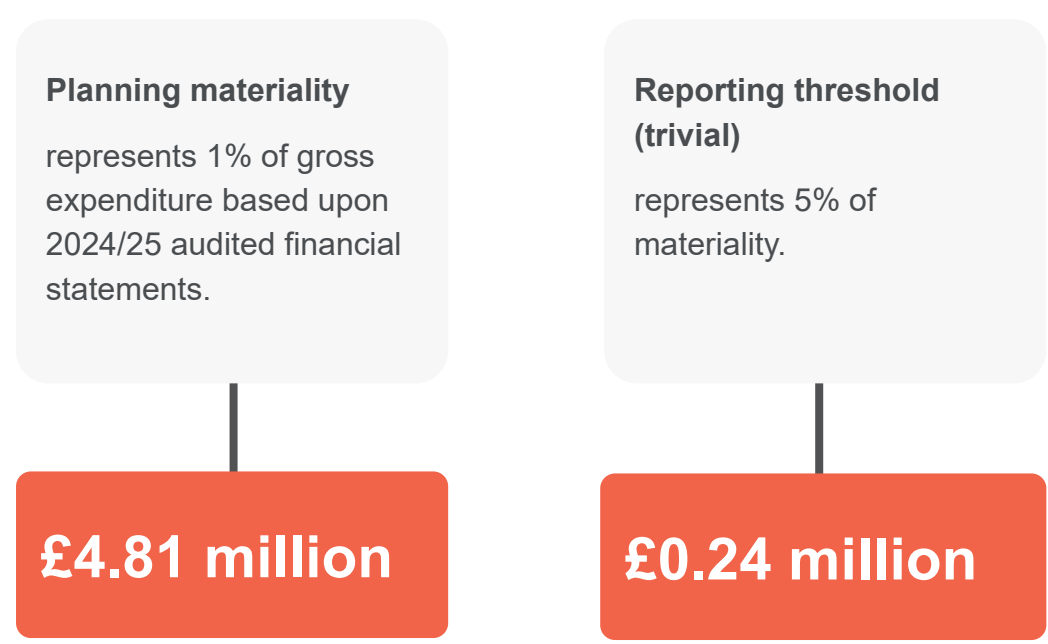
I set planning and performance materiality to:

- determine the level of misstatement that could cause the user of the accounts to be misled;
- assist in the scoping of our audit approach and resultant audit tests;
- determine sample sizes;
- assess the effect of known and likely misstatements in the financial statements; and

Powell
12/05/2022 15:11:29

• report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.



There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report £1,000 or nearest £5,000 banding where relevant	Related party disclosures £5,000

My audit team will assess materiality levels throughout the audit.

Bethan
12/05/2026 15:11:29

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business;

Failure of first financial duty

There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 9 shows a year-to-date deficit of £24.991 million and a forecast year-end deficit of £33.312 million. This, combined with the outturns for 2023-24 and 2024-25, predicts a three-year deficit of £61.048 million.

Where you do not meet this financial duty, we will place a substantive report on the financial statements highlighting the matter and qualify your regularity opinion.

Powell Bethan
12/05/2026 15:11:29

Our planned response

My audit team will:

- continue to monitor the Health Board's financial position for 2025-26 and the cumulative three-year period to 31 March 2026
- perform substantive testing on areas in the financial statements where transactions are at higher risk of being reported in the incorrect period; and
- consider the impact of any relevant uncorrected misstatements over the three-year period to 31 March 2026

Accounting treatment of disputed invoices for 2024-25 and 2025-26

The Health Board is currently disputing a material amount of expenditure invoiced from Wye Valley NHS Trust. Due to the significance and unusual nature of these transactions, there is a material risk that they will be incorrectly accounted for.

My audit team will gather all available evidence to date and form a judgement on whether the accounting treatment applied by the Health Board is reasonable.

Remuneration report disclosures

There have been some changes to senior officer and board member posts during 2025-26 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature. We have also previously identified material issues with these disclosures.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Powell Bethan
12/05/2026 15:11:29

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the LHB and the other body/party.

The LHB has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder. However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;

- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions and Contingent Liabilities

The financial statements include provisions and contingent liabilities for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions and contingent liabilities.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- review management's estimation process for the valuation of provisions;
- consider the competence, capability and objectivity of the management experts who are prepare the estimates.
- perform detailed testing on a sample of claims; and
- ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Continuing Health Care (CHC) Accruals

Our 2024-25 audit identified issues with the valuation and classification of CHC accruals which resulted in an unadjusted misstatement and recommendation raised in the audit report. Due to these issues identified last year, there is an increased risk that this will occur again this year.

My audit team will:

- evaluate the reasonableness of key assumptions and judgements; and
- perform detailed testing on a sample of transactions.

Powell Bethan
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Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning January to March 2026	- Information flows - Planning meeting - Detailed risk assessment procedures - Fraud risk assessment - Accounting estimates planning - Indicative audit fee - Draft Detailed Audit Plan
Interim January to April 2026	- Ongoing risk assessment procedures - IT risk assessment and controls review - Develop testing strategy - Early sample testing
Fieldwork May to June 2026	- Update risk assessment - Audit of financial statements to include narrative report and annual governance statement - Complete audit testing - Evaluate audit findings - Audit closure meeting
Reporting June 2026	- Audit of Accounts Report - Recommendations for improvement - Present findings to those charged with governance - Auditor General certification - Submission of accounts to Welsh Government - Laying of accounts with Senedd Cymru - Post project learning.

Powell Bethan
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Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

 Strategic planning	 Asset management
 Financial planning	 Collaborative working
 Performance and risk management	 Overall governance.
 Workforce planning	

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.

The **Sustainable development principle** is defined as acting in a manner...

...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

To do this, they must take account of the '**five ways of working**'.

Long-term

Prevention

Integration

Collaboration

Involvement

I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Powell Bethan
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Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

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

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.

Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – Review of Workforce Planning Arrangements Follow Up

Scope of the work

I plan to undertake a follow up review of my 2024 Review of Workforce Planning Arrangements. In doing so, my audit team will examine progress made in the implementation of my previous recommendations.

Indicative timescales

Fieldwork to commence September 2026 and reporting by March 2027.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and progress will be communicated regularly through our Audit, Risk and Assurance Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Powell Bethan
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Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Based on those requirements, my estimated total audit fee for 2026 will be £343,708, an increase of 5.2% on my indicative 2025 fee.

Your estimated total audit fee: £343,708

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance and the Director of Corporate Governance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Powell Bethan
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Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£) ¹		Estimated fee for 2025 (£)	
Audit of financial statements ²	Performance audit work ²	Audit of financial statements ³	Performance audit work
£212,269	£131,439	£229,851	£124,775
Total fee: £343,708		Total fee: £ 354,626	

¹ The fees shown in this document are exclusive of VAT.

² Payable November 2025 to October 2026

³ Additional work required to complete the audit increased the audit fee by £28,000 from the original estimate of £201,851

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Tom Haslam	
	<u>Tom.Haslam@audit.wales</u>	
	Financial Audit	Performance Audit
Engagement Lead	Gareth Lucey	Tom Haslam
	<u>Gareth.Lucey@audit.wales</u>	<u>Tom.Haslam@audit.wales</u>
Audit Manager	Mike Jones	Anne Beegan
	<u>Mike.Jones@audit.wales</u>	<u>Anne.Beegan@audit.wales</u>
Audit lead	Erin Terfel	Bethan Hopkins
	<u>Erin.Terfel@audit.wales</u>	<u>Bethan.Hopkins@audit.wales</u>

I can confirm that my team members are all independent of Powys Teaching Health Board and your officers. I am not aware of any potential conflicts of interest that I need to bring to your attention.

Powell Bethan
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Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our [Audit Quality Annual Report](#).



Our People

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality Selection of right team

• Audit platform	• Learning and development
• Ethics	• Leadership
• Guidance	• Technical support
• Culture	



Independent assurance

• EQRs	• Peer review
• Themed reviews	• Audit Quality Committee
• Cold reviews	• External monitoring
• Root cause analysis	

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Further information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our [website](#) to find:

- 

Our [publications](#) which cover our audit work at public bodies.
- 

Information on our upcoming work and forward work programme for [performance audit](#).
- 

[Data tools](#) to help you better understand public spending trends
- 

Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.
- 

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

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Audit Wales

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Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Powell Bethan
12/05/2026 15:11:59





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Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.1a

AUDIT, RISK AND ASSURANCE COMMITTEE		12 MAY 2026
Subject:	Draft Accountability Report Section of the Annual Report 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:	N/A at this stage.	
PURPOSE:		
The purpose of this paper is to present the Draft Annual Accountability Report for 2025/26 to the Audit, Risk and Assurance Committee to provide an opportunity for feedback. This report constitutes one component of the larger document that makes up the statutory Annual Report, comprising the Performance Report, Accountability Report and Financial Statements. (The Draft Performance Report is being considered via a separate process, outlined in more detail below).		
RECOMMENDATION(S):		
The Audit, Risk and Assurance Committee is asked to: • CONSIDER the draft Annual Accountability Report 2025/26 and provide any significant feedback to inform the development of the final draft (noting the draft is subject to CEO review and final proof read will be undertaken for accuracy and consistency).		
Approve/Take Assurance	Discuss	Note
N	Y	Y

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

6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include: Part 1 The Performance Report, Part 2 The Accountability Report (A Corporate Governance Report, A Remuneration and Staff Report, A Parliamentary Accountability and Audit Report), and, Part 3 The Financial Statements.

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

The Draft iteration will be submitted to Welsh Government and Audit Wales on Friday 08 May 2026.

Any feedback provided will be incorporated into the development of the draft, which is due to be considered by the Audit, Risk and Assurance Committee on 22 June 2026. It will be presented to the PTHB Board for formal approval on 23 June 2025; in readiness for the Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by 30 June 2026.

DETAILED BACKGROUND AND ASSESSMENT:

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

Part 1 The Performance Report, which must include:

- An Overview

Part 2 The Accountability Report, which must include:

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

Part 3 The Financial Statements, which must include:

- The Audited Annual Accounts 2025/26

The 2025/26 Chapter 3 Guidance provides the following reporting timescales:

- Draft Accounts to be submitted to HSSG Finance and Audit Wales Friday 01 May 2026;
- Draft Performance Report Overview, Accountability Report (including the Governance Statement), and Draft Remuneration Report to be submitted to HSSG Finance and Audit Wales by noon on Friday 08 May 2026;
- Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by noon Tuesday 30 June 2026, as a single unified PDF document.

The following internal mechanisms have been implemented for the development, approval, and publication of 2025/26 Annual Report and Accounts:

- The Draft Accountability Report presented to the Chief Executive for review and feedback prior to the draft submission. This has been reviewed and cleared by the Director of Corporate Governance;
- The Draft Performance Report will be reviewed by the Executive Director of Planning, Performance and Commissioning and Chief Executive for assurance and any significant feedback to inform the development of the final report;
- The Draft Financial Accounts will be presented to the Audit, Risk and Assurance Committee on 12 May 2026 for comments and feedback;
- All three sections will then be combined into a single document, the 'Annual Report and Accounts 2025/26' which will be reviewed by the Audit, Risk and Assurance Committee on 22 June 2026 and presented to the PTHB Board for formal approval on 23 June 2026;
- Subject to approval by the Board the 'Annual Report and Accounts 2025/26' will then be published and presented at the Health Board's Annual General Meeting, 30 July 2026.

NEXT STEPS:

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

The Annual Report and Accounts 2025/26 will continue to be developed to enable submission in line with reporting timescales provided within the 2025/26 Chapter 3 Guidance.

Powell, Bethan
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IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe					A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial					
Corporate					
Operational					
Reputational					

Powell Bethan
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Annual Report 2025/2026

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



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



To
2027
AND
BEYOND...



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



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



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



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



WORKFORCE FUTURES

INNOVATIVE ENVIRONMENTS

DIGITAL FIRST

TRANSFORMING IN PARTNERSHIP

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Foreword – Statement of Chief Executive and Chair

To be added.



Hayley Thomas
Chief Executive
Powys Teaching Health Board



Dr Carl Cooper
Chair
Powys Teaching Health Board

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CONTENTS

To be added

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PLACEHOLDER – ITEM 1- THE PERFORMANCE REPORT

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SECTION TWO: THE ACCOUNTABILITY REPORT

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Addysgu Powys
Powys Teaching
Health Board

THE ACCOUNTABILITY REPORT 2025/26



SIGNED BY:

DATE: XX.XX.2026

HAYLEY THOMAS
[CHIEF EXECUTIVE]

Powell Bethan
12/05/2026 15:11:29

INTRODUCTION TO THE ACCOUNTABILITY REPORT

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

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

The requirements of the Companies Act 2006 have been adapted for the public sector context and only need to be followed by entities which are not companies, to the extent that they are incorporated into the Treasury's Government Financial Reporting Manual (FReM) and set out in the 2025/2026 Manual for Accounts for NHS Wales, issued by the Welsh Government.

The Accountability Report is required to have three sections:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A Senedd Cymru/Welsh Parliamentary Accountability and Audit Report.

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

The Corporate Governance Report

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2025/2026. It also explains how these governance arrangements supported the achievement of the Health Board's objectives.

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

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

- The Directors' Report;

- A Statement of Accountable Officer Responsibilities;
- The Annual Governance Statement.

Remuneration and Staff Report

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

Senedd Cymru/Welsh Parliamentary Accountability and Audit Report

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

Powell Bethan
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PART A: CORPORATE GOVERNANCE REPORT

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2025/2026. It includes:

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

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1. THE DIRECTOR'S REPORT 2025/2026

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THE COMPOSITION OF THE BOARD AND MEMBERSHIP

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

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

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

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

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

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

VOTING MEMBERS OF THE BOARD DURING 2025-26

During 2025-26, the following individuals were voting members of the Board of Powys Teaching Health Board:

Independent Members (IM)		
Carl Cooper	Chair	Full Year
Ronnie Alexander	IM (General)	Full Year
Rhiannon Beaumont-Wood	Vice-Chair	From 09/02/2026

Steve Elliot	IM (Finance)	Full Year
Mick Giannasi	IM (General)	From 01/10/2025
Rhobert Lewis	IM (General)	Full Year
Jennifer Owen Adams	IM (Third Sector)	Full Year
Cathie Poynton	IM (Trade Union)	Full Year
Ian Thomas	IM (General)	Full Year
Chris Walsh	IM (Local Authority)	Full Year
Kirsty Williams	Vice-Chair	To 30/09/2025
Simon Wright	IM (University)	Full Year
Direct Appointment		
Mick Giannasi	IM (to support vacant Capital & Estates role)	To 30/09/2025
Executive Directors		
Hayley Thomas	Chief Executive	Full Year
Pete Hopgood	Executive Director of Finance, Capital and Support Services Deputy Chief Executive	Full Year
Mererid Bowley	Executive Director of Public Health	Full Year
Paul Hooton ¹	Executive Director of Nursing, Quality, Women and Family Health	From 06/10/2025
Elaine Lorton	Executive Director of Primary, Community Care and Mental Health	Full Year
Nicola Johnson	Executive Director of Planning, Performance and Commissioning	Full Year

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Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	Full Year
Claire Roche ¹	Executive Director of Nursing, Quality, Women and Family Health	To 05/10/2025
Debra Wood-Lawson	Executive Director of People and Culture	To 15/12/2025
Debra Wood-Lawson	Executive Director of People, Culture and Transformation	From 16/12/2025
Kate Wright	Executive Medical Director	Full Year

Footnotes:

1 – there was a period of handover between Claire Roche and Paul Hooton. Paul Hooton started on 29/09/2025 and Claire Roche left on 10/10/2025. Claire Roche handed over Board member responsibility to Paul Hooton as of 06/10/2025.

During 2025/26, vacancies in the Board consisted of:

Independent Members	Executive Director
Vice-Chair from 01/09/2025 to 08/02/2026	None

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

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NON-VOTING MEMBERS OF THE BOARD DURING 2025/2026

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

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

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

AUDIT, RISK AND ASSURANCE COMMITTEE

During 2025/26, the following individuals were members of the Audit, Risk and Assurance Committee:

Independent Members (IM)		
Steve Elliot	Committee Chair – IM Finance	Full Year
Ronnie Alexander	IM (General)	Full Year
Mick Giannasi	IM (General)	From 09/06/2025
Rhobert Lewis	IM (General)	From 09/06/2025
Chris Walsh	IM (Local Authority)	To 08/06/2025
Kirsty Williams	PTHB Vice-Chair	From 09/06/2025 to 30/09/2025
Ian Thomas	IM (General)	From 09/06/2025
Executive Team Officers by Attendance Only		
Hayley Thomas	Chief Executive	Full Year
Pete Hopgood	Executive Director of Finance, Capital and Support Services	Full Year
Helen Bushell	Director of Corporate Governance / Board Secretary	Full Year

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DECLARATION OF INTERESTS

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

PERSONAL DATA RELATED INCIDENTS

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

ENVIRONMENTAL, SOCIAL AND COMMUNITY ISSUES

Environmental, social and community considerations remain central to the planning and day-to-day operations of the Health Board, and throughout 2025-26 the Health Board has continued to reduce environmental impact, strengthen social value and support community wellbeing across Powys. This work contributes to the Welsh public sector ambition for Net Zero by 2030 while ensuring that progress remains fair, inclusive and beneficial to the people we serve.

Environmental progress across the estate has included full transition to LED lighting under the Re:Fit programme and continued expansion of solar generation at sites such as Bronllys, Newtown and Ystradgynlais. These improvements reduce carbon emissions and long-term costs while strengthening resilience for rural communities that rely heavily on local healthcare facilities. Climate adaptation work has commenced, including securing critical infrastructure and major drainage improvements.

Social value continues to be strengthened through improved access to services, most notably the opening of the new Mental Health Community Hub (Richardson Centre) in Llandrindod Wells brings a range of support services together in a single, modern facility, reducing long travel distances and improving the quality of therapeutic spaces available to individuals with mental health needs.

Community wellbeing has been strengthened through nature-based and place-based programmes designed to address isolation, poor mental health and limited access to outdoor activity. The Awyr Iach outdoor health service in Machynlleth (developed with local partners) now offers free activities such as walking, woodland skills and mindfulness, helping people build social connection and confidence. At Bronllys Hospital, partnership work with Flora Cultura continues to provide a therapeutic horticulture pathway

that supports recovery, skill development and social interaction for people experiencing mental health challenges.

Support for equitable access has also extended to travel infrastructure, with new public electric vehicle charging points installed at Bronllys and Ystradgynlais and further sites coming online, helping ensure that rural communities are not disadvantaged in the transition to low-carbon mobility.

The Health Board remains committed to promoting a sustainable, fair and healthy Powys, continuing to embed environmental responsibility, social value and community wellbeing into future planning and decision-making so that environmental improvements proceed hand-in-hand with work to tackle social challenges and support resilient communities.

STATEMENT OF PUBLIC SECTOR INFORMATION HOLDERS

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

SIGNED BY:

DATE: **XX XXXX** 2025

HAYLEY THOMAS
[CHIEF EXECUTIVE]

Powell Bethan
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2. STATEMENT OF ACCOUNTABLE OFFICER RESPONSIBILITIES: 2025/2026

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

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

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

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

I also confirm that:

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

SIGNED BY:

DATE: **XX.XX.2026**

**HAYLEY THOMAS
[CHIEF EXECUTIVE]**

Powell Bethan
12/05/2026 15:11:29

3. STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2025/2026

Powell Bethan
12/05/2026 15:11:29

STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2025/2026

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

In preparing those accounts the Executive Directors are required to:

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

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

- that we have complied with the above requirements in preparing the 2025/2026 accounts: and
- that we are clear of our responsibilities in relation to keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the authority, and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction by the Welsh Ministers.

By order of the Board

SIGNED BY:

DATE:

CARL COOPER [CHAIR]

SIGNED BY:

DATE:

HAYLEY THOMAS [CHIEF EXECUTIVE]

SIGNED BY

DATE:

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

4. ANNUAL GOVERNANCE STATEMENT 2025/26

Powell Bethan
12/05/2026 15:11:29

SCOPE OF RESPONSIBILITY

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

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

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

During 2025/2026, the Health Board and the NHS in Wales continued to face increasing economic and financial challenges. Financial challenges were particularly difficult both locally and across the wider public sector in Wales and the UK. The Executive Committee oversaw internal 'local' escalation arrangements for children's neurodiversity services (ongoing since October 2024).

Outside formal meetings, Board Members remained fully informed receiving briefings at Board Development and Board briefing sessions. Further detail on maintaining good governance during 2025/26 is provided within this Annual Governance Statement.

ESCALATION STATUS

In common with all Health Boards across Wales, the Health Board has faced extreme financial challenges. Although the Health Board had a Board supported Plan, it has not been possible to comply with requirements to balance the budget and therefore the plan has not been approved by Welsh

Government. The Health Board has worked closely with Welsh Government to identify an appropriate way forward matching fiscal prudence against meeting Ministerial priorities. Welsh Government moved the Health Board from Enhanced Monitoring (Level 3) in which it had been placed in September 2023 to Level 4 (previously known as Targeted Intervention) for finance, strategy and planning in November 2024, where it remains. The NHS Wales Escalation and Intervention Arrangements can be seen in more detail here [NHS Wales escalation and intervention arrangements | GOV.WALES](https://gov.wales/nhs-wales-escalation-and-intervention-arrangements)

The Health Board remains at Level 1 (previously known as routine monitoring) for all other domains of the NHS Wales Escalation and Intervention Framework.

FUNCTIONS HOSTED BY POWYS TEACHING HEALTH BOARD

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

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

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

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

OUR GOVERNANCE AND ASSURANCE FRAMEWORKS

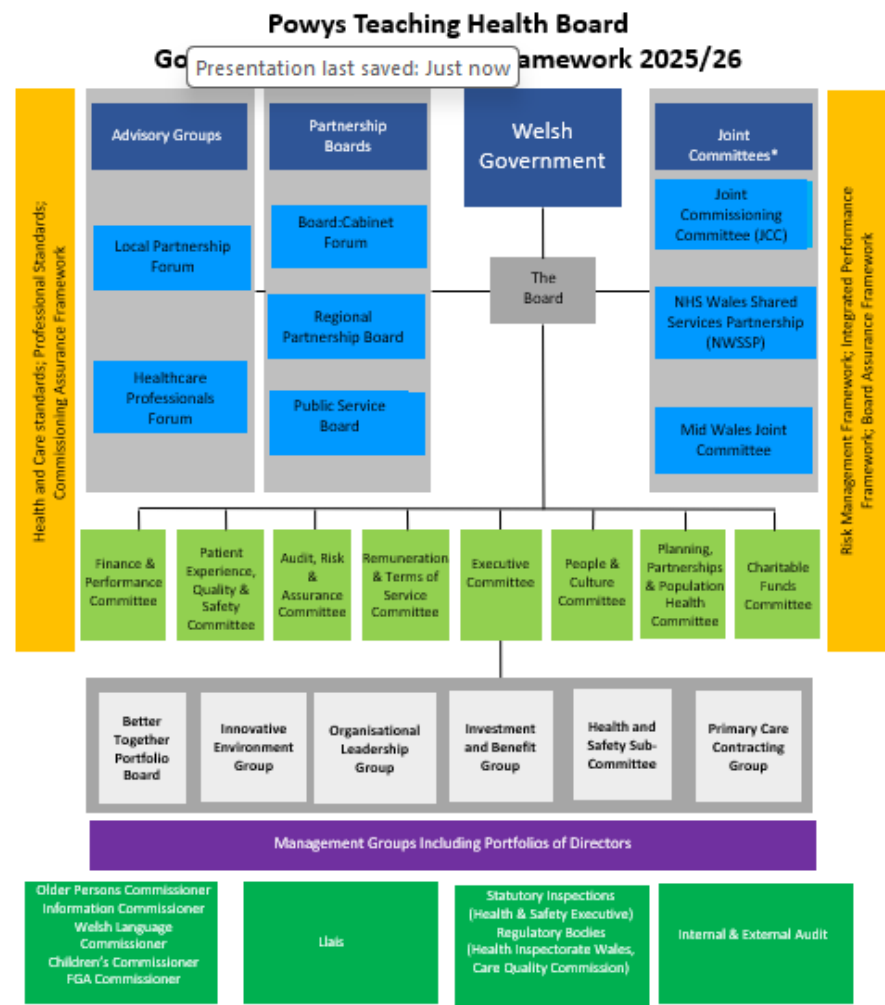
Powys Teaching Health Board has a clear purpose from which its strategic aims and objectives have been developed. Our vision is to enable a 'Healthy

Caring Powys'. The Board is accountable for setting the organisation's strategic direction, ensuring that effective governance and risk management arrangements are in place and holding Executive Directors to account for the effective delivery of its Annual Plan and Annual Delivery Plan. The Annual Plan was approved by Board on 26 March 2025. A copy of our Integrated Plan for 2024 – 2029 and Annual Plan 2025 - 2026 can be found on the Health Board [website](#).

The Board keeps its governance and assurance frameworks under review. Current arrangements in place since July 2021 were reviewed in May 2025 with the following changes:

- Delivery and Performance Committee was renamed Finance and Performance Committee
- Workforce and Culture Committee was renamed People and Culture Committee.

FIG 1 Governance and assurance framework



*The Health Board also sits on the following Joint Committees as an Associate Member:

- South East Wales Regional Joint Commissioning Committee
- South West Regional Joint Committee

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THE BOARD

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

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation, and I, as the Chief Executive and Accountable Officer, am responsible for maintaining appropriate governance structures and procedures. In summary, the Board:

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

STANDARDS OF BEHAVIOUR

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

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

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

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

STANDING ORDERS AND SCHEME OF RESERVATION AND DELEGATION

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

The Board has approved Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice.

Together with the adoption of a scheme of matters reserved for the Board, a detailed scheme of delegation to officers and Standing Financial Instructions, these documents provide the framework for the conduct of the Health Board's business and define its ways of working.

The Standing Orders in place during 2025/26 were adopted by the Board on 22 May 2024. Further minor amendments were made during the year. The Standing Orders are available on the Health Board's [website](#).

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

COMMITTEES OF THE BOARD

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

In line with these requirements the Board has established a standing Committee structure, which it has determined best meets the needs of the Health Board, while taking account of any regulatory or Welsh Government requirements. Each Committee is chaired by an Independent Member of the Board, with the exception of the Executive Committee which is chaired by the Chief Executive as Accountable Officer and is constituted to comply with Welsh Government's Good Practice Guide – Effective Board Committees. All Committees regularly review their Terms of Reference and Work Plans to support the Board's business. Committees also work together on behalf of the Board to ensure that work is planned cohesively and focusses on matters of greatest risk that would prevent the Health Board from meeting its vision, aims and objectives.

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

The following Committee structure is in place:

- Audit, Risk and Assurance Committee;
- Charitable Funds Committee;
- Finance and Performance Committee (previously Delivery and Performance Committee, renamed at Board in May 2025);
- Executive Committee;
- Patient Experience, Quality and Safety Committee;
- People and Culture Committee (previously Workforce and Culture Committee, renamed at Board in May 2025).
- Planning, Partnerships and Population Health Committee; and
- Remuneration and Terms of Service Committee.

Agendas for each of the Committees (except Executive Committee and the Remuneration and Terms of Service Committee) can be found on the Health

Board's [website](#). The agenda and papers for those items to be considered in open session are included in the agenda packs.

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

The Board has appropriate and proportionate arrangements in place to evaluate the effectiveness of the Board and its Committees on an annual basis, providing assurance that governance and assurance arrangements remain fit for purpose. Committee effectiveness reviews operate on a two-year cycle, with a detailed qualitative review undertaken in 2024/25 and a facilitated review completed in March 2026, focusing on composition, functioning, assurance, leadership and culture. The outcomes and any agreed development actions will be reported in Q2 2026/27. The Board also undertakes an annual questionnaire-based effectiveness review; the 2025/26 assessment was issued in April 2026 and the findings, including any resultant development actions, will be reported in Q2 2026/27.

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

ACCESS TO BOARD AND COMMITTEE MEETINGS

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

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

Members of the public are also invited to submit any questions to the Board

to each of the scheduled in-public Board meetings, for which there are generally six in the year.

The following notice is included in each Board agenda:

Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe. At present Board meetings are held virtually and livestreamed. Members of the public are able to view the livestream or view the uploaded copy of the meeting on demand.

The following notice is included in each Committee agenda:

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

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

All Board meetings are livestreamed, and the recording is also available to view after the event.

The opportunity for public questions in advance to be asked at Board was exercised as appropriate in 2025/26. No public questions were received for meetings of the Board's committees.

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

Figures 2 below provide an overview of the role and responsibilities of the

Board's Committees, as set out within respective Terms of Reference.

Figure 3 below provides an overview of Board and Committee meetings held during 2025/26.

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

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FIGURE 2: ROLES AND RESPONSIBILITIES OF COMMITTEES OF THE BOARD FROM APRIL 2025 – MARCH 2026

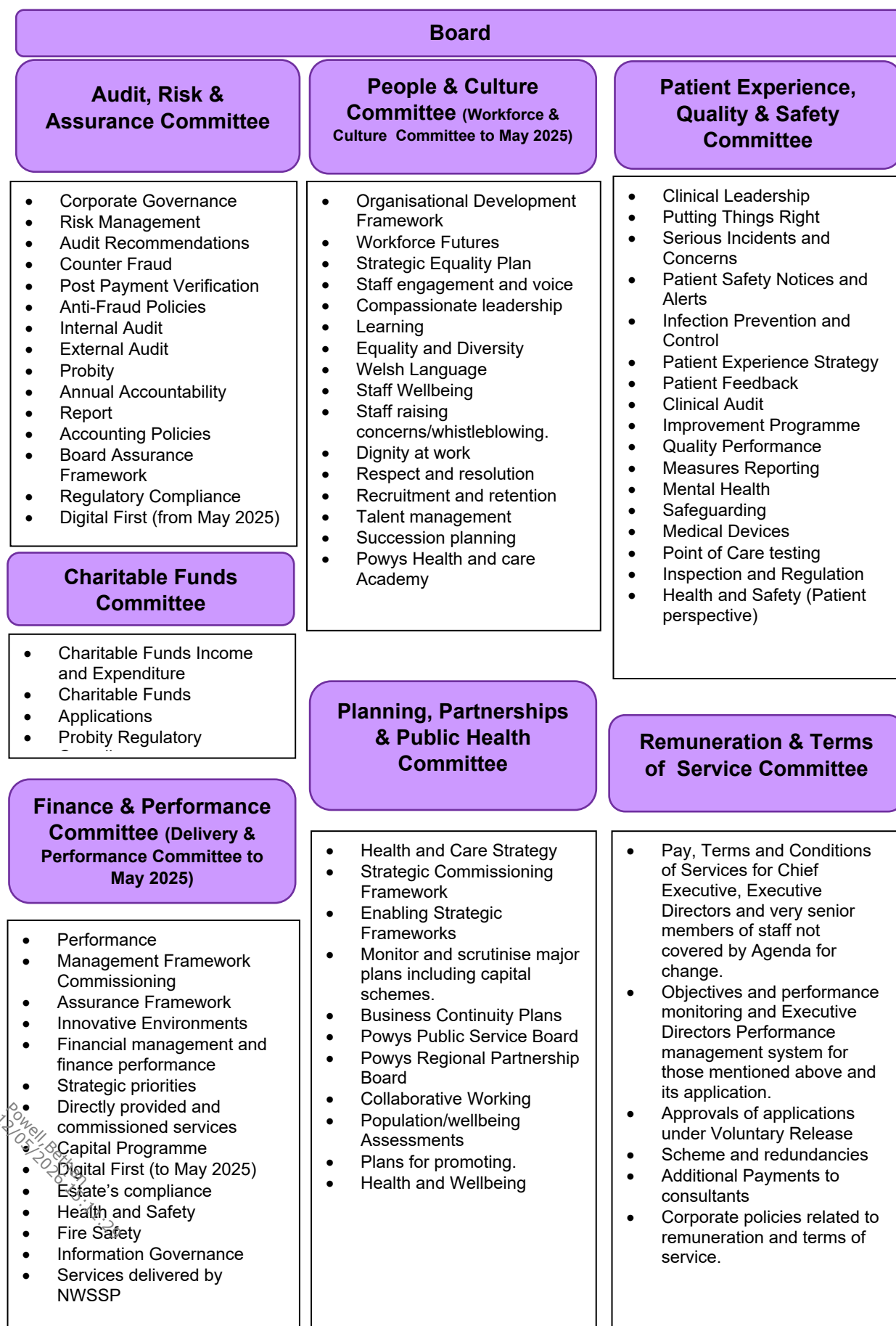


FIGURE 3: BOARD AND COMMITTEE MEETINGS HELD DURING 2025/2026

Board/ Committee	Dates												Quorate?
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Board		21		30		24		26	16	28		25	Yes
Board In-Committee		21	25	30		24		26	16	28		25	Yes
Audit, Risk and Assurance (ARAC)		13	17	08			07			13 ¹		10	Yes
Charitable Funds (CFC)			16			15			01	15		16	Yes
Finance and Performance (F&P) (Previously Delivery and Performance to May 2025)		01 ¹	26 ¹			02	21		04		26 ¹		Yes
Patient Experience Quality and Safety (PEQS)	30 ¹			31 ¹			23				05 ¹		Yes
Planning, Partnerships and Population Health (PPPH)		19			14			20			03		Yes
Remuneration and Terms of Service (RaTS)		08		17					16			12	Yes
People and Culture (P&C) (Previously Workforce and Culture to May 2025)			03			29			09			05	Yes
Joint In-Committee meeting of F&P and PPPH												16	Yes
Executive Committee	04, 16, 23 & 30	07, 14 & 28	10, 11 & 24	09, 16 & 23	06, 15 & 20	09, 17 & 26	01, 15, 22 & 29	11, 12 & 19	03, 10 & 17	07, 14, 21 & 29	04, 11 & 18	04 & 18	Yes

Key ¹ an In-Committee meeting was also held on this date

ITEMS CONSIDERED BY THE BOARD IN 2025/2026

During 2025/2026 the Board formally held:

- seven public meetings, all of which were livestreamed and which had recording uploaded after the meeting;
- eight In-Committee (private) meetings (seven following a public Board meeting, one standalone meeting);
- an Annual General Meeting;
- seven Chair's Actions;
- ten Board Briefings; and
- fourteen Board development sessions.

All meetings of the Board held in 2025/2026 were appropriately constituted with the required quorum.

Board Activity:

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

- General Dental Services Procurement at:
 - Crickhowell,
 - Knighton, and
 - Llandrindod Wells
- A request for Strategic Cash Support
- Silvercloud call off contract extension
- Digital Healthcare Record System Procurement
- Better Together – timetable revision

The Chair's Actions were taken in the interest of timely decision making and were reported into the next scheduled in-public Board meeting.

Powell Bethan
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The Board Approved the following items for:

Approval	Assurance	As Standing Items
• Minutes and action logs of all Board meetings • Annual Delivery Plan 2025/26 • Board Assurance Framework • Strategic Risk Register and Risk Appetite Statement • Integrated Quality and Performance Framework • Health and Safety Annual Report • Welsh Language Standards Annual Monitoring Report • Annual Report and Accounts 2024/25 • Temporary Service Changes • Equality Annual Monitoring Report 2024/25 • Strategic Commissioning Framework • Population Health Strategic Framework 2025-2035 • Planning Maturity Matrix self-assessment • Joint Commissioning Committee Individual Patient Funding Request Policy • North Powys Wellbeing Programme • Charitable Funds Annual Accounts and Report 2024/25 • Annual Plan 2026/27 • Capital Programme 2026/27 • Director of Corporate Governance / Board Secretary Reports ◦ Application of the Common Seal ◦ Consent Agenda Protocol ◦ In-Committee meeting protocol • Board and Committee Annual Work	• Integrated Quality and Performance reports • Annual Plan delivery Performance reports • Financial reports • Risk management reports • Board Assurance Framework reports • Assurance Reports from Board Committees, Joint Committees, Partnerships and Advisory Groups • Escalation and intervention status • Confirmation Committee Effectiveness reviews had been undertaken • Better Together programme • Temporary Service Changes • Speaking up safely and raising concerns report • Regional Partnership Board Annual Report 2024/25 • Annual Duty of Quality Report 2024/25 • Nurse Staffing Levels (Wales) Act 2024/25 • Vaccination Programmes • Winter Planning/Resilience • Digital First Annual Plan • Committee Annual Reports • Partnership Governance Framework	• Experience Stories (patient and staff) • Report of Chair • Report of Vice Chair • Report of CEO • Report of the Director of Corporate Governance • Report of the Regional Director of Llais

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Programmes ○ Committee and Advisory Group Terms of Reference ○ Management of Policies and other Written Control Documents ○ Changes to Standing Orders and Standing Financial Instructions ○ Chair's Actions ○ Committee Membership 2025/26	• Extension to Regional Partnership Board Health and Care Strategy to March 2029 • Primary Care Assurance and Governance report	

The Board within In-Committee meetings approved the following items	The Board within In-Committee meetings considered the following items
• Covid-19 Public Inquiry update • Matters relating to the Annual Plan 2025/26 • Primary Care Out of Hours Contract procurement • Major Incident and Emergency Response Plan • Corporate Business Continuity Plan • Crickhowell General Dental Service procurement outcome • North Powys Wellbeing Programme	• Emergency Planning, Resilience and Response Annual Report 2024/25 • Remuneration and Terms of Services Annual Report 2024/25 • Chief Executive Briefing on: ○ Emergency Medical Retrieval and Transfer Service ○ Annual Plan 2025/26 ○ General Practice Sustainability

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ITEMS CONSIDERED BY COMMITTEES OF THE BOARD

During 2025/26, Board Committees considered and scrutinised a range of reports and issues relevant to the matters delegated to them by the Board. Reports considered by the Committees included a range of internal audit reports, external audit reports and reports from other review and regulatory bodies, such as Healthcare Inspectorate Wales and the Health and Safety Executive.

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

The Committees also considered and advised on areas of local and national strategic developments and new policy areas. Board Members are also involved in a range of other activities on behalf of the Board, such as Board Development sessions, attending partnership meetings, shadowing, and a range of other internal and external meetings.

Figure 4: Key Areas of Focus of Committees of the Board 2025-26

Note Committees also consider some confidential matters in private ‘In-Committee’ meetings.

Audit, Risk and Assurance Committee	▪ ratified approval of Single Tender Waivers and the associated Annual Report; ▪ received the Internal Audit Annual Report and Opinion; ▪ reviewed Standing Orders, Financial Instructions and Board Assurance Framework; ▪ approved the Annual Internal Audit Plan; ▪ received Internal and External Progress reports; ○ Primary Care GMS Unified Contract ○ Pharmacy Stores ○ Business Continuity Planning ○ Risk Management ○ Information Governance ○ Llandrindod Phase 2 ○ Partnership Governance ▪ received Internal and External Audit Reports and tracked implementation of audit recommendations; ○ Structured Assessment ○ Quality and Safety Governance ○ Contract Management ○ Mattress Final Report

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	○ Cancer Services Final Report ▪ received Counter Fraud updates and reports; ▪ tracked implementation of Welsh Health Circulars; ▪ kept under review the Health Board's arrangements for risk management and assurance; ▪ received and sought assurance on the accuracy of the Annual accounts and Annual accountability statement; ▪ received and sought assurance on the accuracy of organisations annual accounts reports (2024/25); ▪ sought assurance on the Standards of Behaviour policy and its mechanisms including; ○ received Annual Register of Interests; ○ Gifts and Hospitality ▪ sought assurance Post Payment verification; ▪ sought assurance on Records Management Improvement plans; ▪ approved the Audit Handbook; ▪ received and recommended the Risk Management Framework for Board approval;(08.07.25) ▪ received and sought assurance on the Annual Governance Programme; ▪ received and sought assurance on losses and special payments; ▪ received and sought assurance on the Clinical Audit Plan; ▪ received and sought assurance on the Digital first Quarterly Monitoring report; ▪ received the Standing Financial Instructions Executive Financial Delegations; and ▪ received and sought assurance on the Digital Strategic Framework Annual Report year two (2025/26).
Executive Committee	▪ provided advice to the Board in relation to the development of the Integrated Plan for 2025-2026 and Maturity Matrix; ▪ received and provided advice to the Board in relation to the identification and management of corporate risks; ▪ sought assurance on the Regional Partnership Board 2025-26 – Annual Delivery Plan including commitments of the plan in 2026-27 including the focus on exit planning. ▪ received and approved Vacancy Freeze management application; ▪ received and sought assurance in relation to limited and no assurance internal and external audit reports;

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Powell, Bethan 12/05/2026 15:11:29	▪ received various service-based business cases, service, and improvement plans, making decisions relevant to operational delivery of the Boards strategy and in-year plan; ▪ took forward actions arising from the Integrated Performance Report and performance managing the delivery of those action plans; ▪ Received the National Reportable Incident (NRI) update ▪ received and sought assurance on the Cross Border Closure and Evaluation Report; ▪ kept the operational effectiveness of policies and procedures under review; ▪ received a summary of the Ministerial Advisory Group performance and productivity recommendations – PTHB response; ▪ scrutinised key reports and strategies prior to their submission to other Committees of the Board and/or the Board to ensure their accuracy and quality; ▪ Supported the PTHB Commissioned Third Sector Services Review Framework; ▪ provided a strategic view of issues of concern ensuring co-ordination between Executive Directorates; ▪ provided advice to the Committees of the Board and/or the Board on matters related to quality, safety, planning, commissioning, service level agreements and change management initiatives; ▪ ensured staff are kept up to date on Health Board wide issues; ▪ received and sought assurance on the Better Together Portfolio; and ▪ received and sought assurance on the Financial Performance Reports ▪ sought assurance on the Update on Climate Response – Decarbonisation and Adaption ▪ received and sought assurance on the Discretionary Capital Pipeline Programme 2025-26 ▪ sought assurance on the Out of Hours (OOH) General Medical Services Mid-Year Performance 2025-26 ▪ sought assurance on the Community Pharmacy Annual Report 2025-26 ▪ Received and sought assurance on the Internal Audit Report – Digital systems uptake ▪ sought assurance on the Strategic Risk Register, Board Assurance Framework Dashboard (SRR, BAF)

Powell, Bethan 12/05/2026 15:11:29	▪ Recommended and approved the North Powys Wellbeing Programme and primary care proposal. ▪ sought assurance and noted the update on the Workforce Performance Report ▪ received the Public Sector Prompt Payment Performance ▪ received the Director of People and Culture Report ▪ received Theme one: Staff Health and Wellbeing ▪ Received Theme three: Workforce sustainability and Transformation ▪ acted as the forum in which Executive Directors and senior managers can formally raise concerns and issues for discussion, making decisions on these issues. ▪ sought assurance on Quarter 2 Information Governance Performance Report ▪ sought assurance on Powys Teaching Health Board (PTHB) Audit Risk and Assurance (ARAC) Committee updates ▪ received the Organisational Risk Register (ORR) ▪ Approved the Role based Essential Training on ESR. ▪ received the Adferiad (Recovery) funding progress report and guidance ▪ received the Single Tender Waiver ▪ received the Winter Escalation/Mandatory Mask Wearing plan ▪ received A Healthier Wales Primary Care Model for Wales National Primary Care Board Closedown Report ▪ received and sought approval on the Finance Capacity Business Case ▪ received the recommendation for Planned Care Insourcing ▪ received the Progress Against Enabling Actions 2025-26 ▪ received the PTHB Corporate Parenting Promises ▪ received the Integrated Quality and Performance Framework (IQPF) Directorate Performance Review proposal. ▪ approved the Mental Health Pharmacy Workforce investment ▪ received the Electronic Prescribing and Medicines Administration (EPMA) Business resource ▪ approved the Mental Health Dialectical Behaviour Therapy Business Case (DBT) ▪ received the Business Continuity Management Policy

Powell, Bethan 12/05/2026 15:11:29	▪ sought assurance on the Complex Care: Private provider uplift for Mental Health ▪ sought assurance on the Staff Survey Results – Action Plan ▪ sought assurance on the Digital Report WCCIS ▪ sought assurance on the Process for revalidation and fitness to practice referrals. ▪ sought assurance on the NHSE Elective Commissioning Implementation update. ▪ received the report on Organisational Escalation Status ▪ sought assurance on the Community Hospital Delays and flow update ▪ received the Review of the (Workforce) Agency Assurance Authorisation Process ▪ received the Temporary Service Changes Evaluation and Assurance Report ▪ sought assurance on the Digital First Assurance and Annual Report ▪ received the Duty of Quality Annual Report 2024-25 ▪ sought assurance on the Monitor Implementation of Management actions for Deprivation of Liberty Safeguards (DoLS) Internal Audit Report. ▪ received the Complex Care: Private provider position and Response for Mental Health ▪ Recommended the Welsh Language Standards Annual Monitoring Report to Board ▪ received and approved the Executive Committee Sub-Structure ▪ received the Respiratory Syncytial Virus (RSV) update ▪ received the draft framework for NHS Wales Job descriptions for Band 2-3 implementation Framework ▪ Approved an extension on the Planned Care In-Sourcing Procurement ▪ received the PTHB Hepatitis B and C Elimination plan update ▪ received the overview of On-Call process ▪ received the NHS Emergency Planning, Resilience and Response Annual Report 2024-25 ▪ received the Major Incident and Emergency Response Plan and Corporate Business Continuity plan ▪ received the Neurodevelopment Service Escalation Oversight update. ▪ received the National Power Outage (NPO) Planning and Pandemic Preparedness.

	▪ received the Infection Prevention and Control improvement plan 2023-24 ▪ received and sought assurance on the Health and Safety Annual Report ▪ received the Strategic Change and Engagement Report ▪ Sought assurance on the Whole System approach: Healthy Weight in Powys ▪ sought assurance on Speaking up Safely Framework actions closure report ▪ sought assurance on the Primary Care Cluster Reporting against Delivery 2024-25 ▪ received the UK COVID-19 Public enquiry Progress Report Q4 2024-25 and look forward. ▪ Approved the Delivery Model Continuing Health Care (CHC) Children and funded Care (Interim)inflationary uplifts 2025-26 ▪ received and approved the Flow Hub and Transfer Co-Ordinator's presentation. ▪ received the Radiological Information Systems Procurement (RISP) Update. ▪ received and recorded the formal approval for the Case for Change. ▪ received the Primary Care Optometry Eye Health Needs Assessment. ▪ Received an update on overseas nurse's programme. ▪ sought assurance on Transformation of PTHB Resuscitation Services. ▪ sought assurance on Theme 2: Great place to work ▪ Sought assurance on the Violence and Aggression Deep Dive ▪ sought assurance on the Cyber Security and Assurance Report. ▪ received the Phase one Options Appraisal Timeline Assessment ▪ received and sought assurance on the Learning from Annual External Audit of Accounts and Annual Report 2024-25. ▪ received and sought assurance on the Peoples Experience Framework. ▪ received and sought assurance on the Medicines Management Annual Report 2024-25 ▪ received the Medical Devices and Point of Care Testing Annual Report 2024-25

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	▪ sought assurance on the Food and Safety Compliance Report. ▪ sought assurance on the Maternity Assurance Report. ▪ received and sought assurance in the Quality and Safety in General Dental Services. ▪ received and sought assurance on the Clinical Audit Progress Report and Annual Report 2024-25. ▪ sought assurance in the Child Immunisations Annual Report 2024-25. ▪ received the Cardiology Heart Rhythm Test Reporting. ▪ received the Planning, Strategy Maturity Matrix – Self Assessment. ▪ sought assurance on the Tobacco Control Action Plan and Vaping Deep Dive. ▪ received the Hate Crime Charter ▪ received the Social Partnership Annual Report 2024-25. ▪ received the MSK First Contact Practitioner Service-South Cluster ▪ received the Options Appraisal: GMS Additional Funding request. ▪ sought assurance on the Implementation of Open Eyes and E-Referrals (Digitilisation of the eye care programme). ▪ received the System Winter Resilience Plan 2025-26. ▪ Received the Tender for the provision of General Dental Services in Crickhowell, ▪ sought assurance regarding the actions in place to manage service and demand and improve performance and control spending on CHC/Complex Care: Brokerage Section 33 with PCC. ▪ received the Workforce Race Equality Standard: Analysis of the Local PTHB Workforce data. ▪ received the Women's Health Options appraisal. ▪ sought assurance on the Safeguarding Annual Report 2024-25. ▪ received the Suicide and Suspected Suicide Review Report ▪ sought assurance on the North Powys Transformation Programme. ▪ received and sought assurance on the Capital and Estates Strategy Monitoring. ▪ sought assurance on the NHS England Elective Commissioning Intentions 2025-26 implementation.

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Powell, Bethan 12/05/2026 15:11:29	▪ sought assurance on the Additional Learning Needs (ALN). ▪ received the COVID and Influenza Vaccination Programme 2025-26. ▪ received the Information Governance Toolkit Outturn Report improvement. ▪ sought assurance on the High-Level Partnership Governance and Assurance Report. ▪ received the Organisational Escalation Status Update ▪ sought assurance on the Six-monthly report on CHC costs. ▪ sought assurance on the Unified Contract Assurance Framework, Primary care, General Medical Services. ▪ received and sought assurance on the Primary Care Out of Hours Service. ▪ sought assurance on the Deep Dive: Mental Health Private Providers. ▪ received and sought assurance on the Nurse Staffing Levels Act. ▪ sought assurance on the Safeguarding Review-Felindre Ward. ▪ received the PACS Fees and RISP implementation ▪ approved the Planned Care Insourcing ▪ Approved the Contract Negotiations – Data Source and provision of Shropdoc changes. ▪ approved the Director of Public Health Annual Report: Population Strategic Framework 2025-2035 ▪ approved the PTHB Commissioned Third Sector Services Review Framework. ▪ received and sought assurance on the Performance MIU Deep Dive. ▪ sought assurance on Endoscopy Services (including JAG accreditation); ▪ Sought assurance on the Organisational Register of Interests, Gifts and Hospitality. ▪ Sought assurance on the Audit Findings. ▪ received the Welsh Health Circular Tracker (WHC). ▪ approved the British Pregnancy Advisory Service SLA 2026-27. ▪ received the LIMS 2.0 National Programme Implementation Delays 2026-27 and Financial Risk. ▪ approved the Arts in Health Pledge. ▪ approved the Infection Prevention and Control (FIT) testing recommendations.

Charitable Funds Committee	▪ scrutinised applications for charitable funds; ▪ kept an overview of charitable funds income and expenditure; ▪ updated Charity Terms of Reference and documents; ▪ received project evaluations; and ▪ reviewed and recommended to the Board the Charity's Annual report and Annual accounts 2025.
Finance and Performance Committee (previously Delivery and Performance Committee)	▪ sought assurance on performance on the Integrated Quality Performance Report and Annual Delivery Plan; ▪ received the Performance section of the Annual Report; ▪ scrutinised the Organisational Status (NHS Wales Escalation Framework) Enhanced Monitoring; ▪ sought assurance on financial performance, closely scrutinising areas of cost pressure and savings plans; ▪ sought assurance on the Emergency Ambulance services; ▪ sought assurance on Tackling the Planned Care challenges; ▪ sought assurance on In-Reach Fragility; ▪ scrutinised primary care performance (General Medical Services, General Dental Services, Community Pharmacy and Out of Hours); ▪ reviewed Digital First Updates including Cyber Security; ▪ sought assurance on Food Safety compliance; ▪ scrutinised the Getting it Right First Time (GIRFT) Report; ▪ reviewed the Capital and Estates Programme delivery overview including Decarbonisation action plan and progress report; ▪ sought assurance on the Public Sector Prompt Payment Performance (PSPP); ▪ reviewed Innovative Environments updates, including seeking assurance on Health and Safety matters; ▪ sought assurance on the Information Governance and Records Management Improvement plans; ▪ reviewed the Powys Public Service Board Climate Working Group update; ▪ sought assurance on Endoscopy Services (including JAG accreditation); ▪ sought assurance on the Mid Wales Joint Committee (MWJC) Highlight Report; ▪ reviewed Internal Audit Reports; ▪ sought assurance on the Committee based Strategic Risk Register;

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	▪ reviewed and sought assurance on the Continuing Health Care (CHC) Performance and System Challenges update; ▪ sought assurance on the Community Hospital Delays and flow update; ▪ sought assurance on the deep dive on Variable Pay; and ▪ sought assurance on Private providers.
Patient Experience, Quality and Safety Committee	▪ Received and sought assurance the Integrated Quality Report including: ○ implementation of the Quality and Engagement Act ○ monitor Incidents and Concerns ○ Once for Wales Content – Management system ○ Putting Things Right – Concerns ○ Duty of Candour ○ Claims, Redress and Clinical Negligence Position ○ Incident Management ○ Early Warning Notifications ○ Nationally reportable Incidents ○ Mental Health Review of Suicides ○ Welsh Risk Pool Assurance Report ○ Peoples Experience – CIVICA ○ Llais Activity ○ Infection Prevention and Control ○ Health Inspectorate Wales Inspections ○ PAVO reports ○ Bereavement Framework ○ Venous Thromboembolism Scoping Review ○ Strengthening Safeguarding in Health Review ○ QAUILS reports from Service Groups ○ PSOW Annual Letter ▪ received and sought assurance on Maternity Services ▪ received and sought assurance on the Childrens Neurodevelopment Services; ▪ received and sought assurance on Staff Experience of Mental Health and Learning Disability services in escalation ▪ received the Annual assessment of Committee Effectiveness 2024-25 ▪ received and sought assurance on the Annual Report of the Accountable Officer Controlled Drugs 2024-25; ▪ received patient stories; ▪ sought assurance on the Clinical Audit Programme Annual report and plan 2024-25, 2025-26

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	▪ sought assurance on the Joint Inspection of Child Protection arrangements and Child Practice review; ▪ sought assurance on the Infection Prevention and Control Plan; ▪ sought assurance on the EPMA system update ▪ scrutinised and received the Duty of Quality Annual Report 2023/2024; ▪ received and sought assurance on the Transition of Care Annual Report 2023/2024 and 2024-25 and progress reports; ▪ received and sought assurance on the Annual Safeguarding Report 2024/25; ▪ received and sought assurance on the Medicines Management Annual report 2024-25; ▪ received and sought assurance on the Medical Devices and Point of Care Testing report; ▪ received Internal Audit Reports on: ○ Patient Flow and Discharge Management Final Report ○ Additional Learning Needs Legislation ○ Deprivation of Liberty Safeguards (DoLS) - Monitoring of matters arising. ○ Pharmacy Stores ○ Quality, Safety and Governance ○ Business Continuity Planning ○ Risk Management ○ Mattresses Final Report ○ Duty of Candour ○ Decontamination ○ Continuing Health Care ○ MH and LD Triage and Assessment Process ▪ received Audit Wales report; ○ Cancer Services ○ Joint Commissioning Committee – Quality Safety and Outcomes Sub-Committee Highlight Report ▪ sought assurance on the Committee based Corporate Risk Register. ▪ received the Duty of Quality Annual Report 2024-25 ▪ Received the Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements ▪ received the JAG accreditation update. ▪ received and sought assurance on the six-monthly report on antimicrobial resistance.

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	received and sought assurance on the GMS Access and Patient experience
Planning, Partnerships and Population Health Committee	- sought assurance on the Strategic Change programmes/activities; - sought assurance the Integrated Plan 2025/26 development and the 2026-27 draft plan - Received the draft Welsh Government Planning Maturity Matrix; - sought assurance on Childhood Immunisations; - sought assurance on the Additional Learning Needs (ALN) - Sought assurance on the Public Service Board Report (PSB) and Annual Report 2024-25. - sought assurance on a Whole System Approach of prevention of obesity (including weight management pathways, Healthy Child Wales Programme; - received and approved the Adult Weight Management Pathway Update; - Received and sought assurance on the Healthy Child Wales Programme (CR) Health visiting programme - sought assurance on Better Together transformation and change programme; - sought assurance on the Winter/System Resilience Planning 2025-26; - sought assurance on the Approach to the Annual Report of Director of Public Health 2025-26 - received the Regional Partnership Board approach to the Delivery Plan 2025/26; - sought assurance on the Partnership Governance and Assurance Framework report - sought assurance on the Regional Partnership Board – Annual Delivery Plan 2026-27 exit planning - received the Primary Care Cluster reporting 2024-25; - sought assurance on the Health Protection Summary Report; - sought assurance on the population Eye Health Needs assessment; - sought assurance on the Population Screening Programme uptake and Health protection; - sought assurance on North Powys Transformation; - sought assurance on Tobacco Control and Smoking cessation, Substance misuse, and vaping; - sought assurance on the Committee based Corporate Risk Register;

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	▪ received the Internal Audit/Audit Wales Audit reports; ○ NWSSP Performance Report 2025-26 ○ NWSSP Performance Report 2024-25 ○ JCC Planning, Performance and Finance Sub-Committee; ○ Primary Care Clusters Final Report 2025-26 ○ Additional Learning Needs Final Report 2024-25 ▪ received and sought assurance on the Partnership Governance Framework; and
People and Culture Committee	▪ received and sought assurance on the Workforce Performance Reports; ▪ received and sought assurance on the Director of People and Culture reports, including priorities within the Workforce section of the Integrated Plan for 2024-25; ▪ Received and sought assurance on the Workforce Race, Equality Standard: Analysis of Local PTHB Workforce data. ▪ received and sought assurance on the Workforce Futures: ○ Transformation and Sustainability ○ Staff Health and Wellbeing ○ Great Place to Work ○ Including Nurses Retention Implementation Plan/Six monthly report/outcome of deep dive into why people leave the HB in the first two years of joining ○ NHS Wales Staff Survey for Health Board ▪ sought assurance on the Professional Revalidation Internal Process; ▪ sought assurance on the Primary and Community Care Academy; ▪ sought assurance on the Welsh Language Annual Report 2024-25 ▪ received and sought assurance on the Violence and Aggression Incidents; ▪ received the Internal Audit/Audit Wales Audit reports; ○ Staff Development Programme Final Internal Audit 2025-26 ▪ received the Workforce measures to support financial recovery; ▪ received the staff story Clinical Learning in Practice (CLIP)

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	▪ Received and sought assurance on the Committee Governance Action plan 2025-26; ▪ received the Terms of Reference; ▪ received the Committee Annual Report 2025-26 ▪ received the Committees Effectiveness results; ▪ sought assurance on the Committee based Strategic Risk Register.

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BOARD DEVELOPMENT

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

Developing the (Board) team	Developing the Organisation	Engaging with and learning from the organisation	Engaging with and learning from external partners
• Cyber Security • Board Member perspectives • Team time • Board and Committee Effectiveness	• Prevention and population health framework • Strategic Risk Register and Review of Risk Appetite • Level 4 escalation and intervention • Level 4 escalation support – Grant Thornton • Better Together Transformation Programme • Political Landscape in Wales – Overview and 2026 Election Outlook • Strategy and Planning including ○ Annual Plan 2025/26 ○ Annual Plan delivery confidence and update ○ Integrated Plan 2026 – 2029 ○ Finance updates	• Information Governance and Records Management • Medical Directorate • Staff Wellbeing practitioners • NHS Staff Survey	• Audit Wales – overview of Structured Assessment • Powys County Council – Review of Adult Social Care • Llais • Welsh Risk Pool

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	○ Annual Plan 2026/27 • Strategic Commissioning Framework • Strategic Commissioning Intentions • Transformation and Change including ○ Developing the route map to sustainability		

Specific Briefing sessions have been held on the following topics:

- Capital and Estates
- Maternity, Children's and Family Health
- Out of Hours
- Professional Nursing
- Community Nursing
- Information Governance
- Community Dental Services
- Digital, Data and Technology
- Community Services
- Optometry

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ADVISORY GROUPS

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

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

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

The Local Partnership Forum (LPF) is well established. Work has continued during 2025/2026 to strengthen the Forum's operating arrangements and maximise its role in providing advice to the Board. The Forum has considered the Integrated Plan, reviewed the Terms of Reference, received regular updates on the financial position, workforce analysis and a regular summary report from the Director of People and Culture. Other areas considered include NHS Staff survey results, approved Annual Plan 2026/27, Collective agreement on Registrant CPD Hours, Social Partnership Duty Annual Report 2024/2025, temporary service change, Bands 2 and 3 Nursing workforce and Speaking up Safely. All reports have a staff side focus.

The Healthcare Professionals Forum (HPF) held its inaugural meeting in March 2026 where members received a presentation on the work of the forum. Further meetings are planned for 2026/27.

The Health Board does not operate a Stakeholder Reference Group although engages with stakeholders through established partnership arrangements, including the Powys Public Service Board and the Regional Partnership Board, rather than a separate Stakeholder Reference Group. These arrangements support coordinated, citizen focused engagement and are complemented by targeted local engagement on specific service changes reflecting Powys' geography and cross border care pathways.-focused engagement and are complemented by targeted local engagement on specific service changes reflecting Powys' geography and cross-border care pathways.

JOINT COMMITTEES

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

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JOINT COMMISSIONING COMMITTEE (JCC)

The JCC was constituted as of 01 April 2024. Update and assurance reports from the JCC are reported to Board, from the JCC's Quality and Patient Safety Committee to the Patient Experience, Quality and Safety Committee and from the Planning, Performance and Finance Sub-Committee to the Finance and Performance Committee and Planning, Partnerships and Population Health Committee. Further detail about the NHS Joint Commissioning Committee can be found here - [Home - NHS Wales Joint Commissioning Committee](#)

REGIONAL JOINT COMMITTEES

During 2025/26 Welsh Government directed Health Boards to work in strategic collaboration. Two Regional Joint Committees have been established under Ministerial Direction; the South East Wales Regional Joint Committee and the South West Wales Regional Joint Commissioning Committee. The Health Board is an Associate Member of both Regional Joint Committees. Further detail regarding the South East Wales Regional Joint Committee can be found here: [South-East Wales Regional Joint Committee - Aneurin Bevan University Health Board](#). Further detail regarding the South West Wales Regional Joint Commissioning Committee can be found here: [Regional Joint Committee \(RJC\) - Swansea Bay University Health Board](#)

PARTNERSHIP AND COLLECTIVE WORKING

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

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE (NWSSPC)

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

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

POWYS COUNTY COUNCIL

Powys Teaching Health Board and Powys County Council have a series of overarching Section 33 agreements through which the organisations manage

joint arrangements for the Community Equipment Service, Glan Irfon and Substance Misuse. **HB TO FINALISE WORDING**

In addition to Section 33 agreements, a Memorandum of Understanding is in place regarding services for Carers and there are a number of key areas where there is integrated working. These include Mental Health services, services for people with learning disabilities, older people, and children. Oversight arrangements of Section 33 agreements are provided by the Joint Leadership Team between the Health Board and County Council.

BOARD TO CABINET FORUM AND JOINT LEADERSHIP TEAM

Powys was made a region in its own right under Part 9 of the Social Services Wellbeing (Wales) Act 2014. In light of this and combined with the requirements of the Well-being of Future Generations Act (Wales) 2015 and the Social Services Wellbeing (Wales) Act 2014, together with the collective drive towards increased integration between the two organisations, in February 2016, PTHB and Powys County Council established a Joint Partnership Board (JPB). In January 2024 this was superseded by a Joint Leadership Team (JLT) and Board to Cabinet Forum (BCF)

The JLT meets bi-monthly to consider matters of common operational concern and engender closer working arrangements between the Health Board and the County Council.

The senior membership of the Board to Cabinet Forum met in March 2026 and considered future working arrangements noting it had been difficult to convene meetings of the Board to Cabinet Forum due to the large numbers involved. A proposal to move to more regular meetings of the senior membership of the organisation is under examination.

POWYS PUBLIC SERVICE BOARD

The Public Service Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Powys to meet the needs of Powys citizens present and future. The aim of the group is to improve the economic, social, environmental, and cultural well-being of Powys. Working in accordance with the five ways of working, the Board has published its Well-being Assessment (revised in 2022) and Well-being Plan (2023-2026).

The Well-being Plan which has been developed through extensive engagement sets out three well-being objectives to meet the PSB vision of a Fair, Sustainable and Healthy Powys with three priorities identified to help achieve the well-being objectives.

The Health Board contributes to achieving these objectives through the delivery of 'A Healthy Caring Powys' and the Annual Plan.

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

POWYS REGIONAL PARTNERSHIP BOARD

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

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

The RPB identifies key areas of improvement for care and support services in Powys. The RPB has also been legally tasked with identifying integration opportunities between social care and health. This has been achieved through building on years of joint working and through the development of 'A Healthy Caring Powys' which has identified key priorities. The key opportunities for integrated working identified, and the actions to be taken in support of them are outlined in the Area Plan and focuses on 'Delivering the Vision'.

Priorities have been identified as a Focus on Well-being, Tackling the Big 4 (Cancer, Cardio-vascular diseases, respiratory diseases, and mental health), Early Help and Support and Joined up Care. The RPB is currently overseeing a major integrated project in North Powys providing a new model of care jointly for health and social care and extending to include supported accommodation and primary education.

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

Some of the RPB's responsibilities include making sure resources are available, that people remain independent for as long as possible, and that health and care services are fully joined up.

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

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

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MID WALES JOINT COMMITTEE FOR HEALTH AND CARE

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

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

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

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

THE CORPORATE GOVERNANCE CODE

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

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

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

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

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

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

The system of internal control is based on an ongoing process designed to

identify and prioritise the risks to the achievement of policies, aims and objectives of the Health Board, to evaluate the likelihood of those risks being realised and to manage them efficiently, effectively, and economically. I can confirm the system of internal control has been in place at the Health Board for the year ending 31 March 2026 and up to the date of approval of the annual report and accounts.

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

CAPACITY TO HANDLE RISK AND KEY ASPECTS OF THE CONTROL FRAMEWORK

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

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

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

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

Emergency plans and business continuity arrangements have been in place for the duration of 2025/2026, in accordance with the Health Board's statutory duties under the Civil Contingencies Act 2004 and Emergency Planning Guidance as issued by Welsh Government. The organisation continues to work closely with a wide range of partners, including the Welsh Government as it

continues with its response to system pressures including our enhanced status of monitoring and escalation. It has been necessary to ensure that this is underpinned by robust risk management arrangements and the ability to identify, assess, and mitigate risks which may impact on the ability of the organisation to achieve its strategic objectives.

THE RISK MANAGEMENT FRAMEWORK

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

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

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

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

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

In year the Health Board has further strengthened its oversight and assurance of its risk management arrangements. In March 2025 Board approved a

revised Risk Management Framework, the main update was to the structure deployed by the Health Board to manage risk, which included the closure of the previous Corporate Risk Register from May 2025. The Board received the first iteration of a newly developed Strategic Risk Register in July 2025 and a summary of the Organisational Risk Register, focused on significant and cross-organisation operational risk, in November 2025. The Organisational Risk Register is owned by the Executive Committee and reported to the Board for awareness. This creation of the Organisational Risk Register additional risk register focused on significant operational risk is intended to allow greater focus on the risks to Health Board's strategic objectives at Board level, as well as more dynamic escalation, oversight and management of significant, cross-organisational operational risks by the Executive Team. Work will continue in 2026/2027 to embed and mature the organisation's risk management infrastructure and reporting arrangements for both strategic and operational risks.

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

The Risk Management Framework undergoes annual review and is due to be considered by the Board in May 2026. The focus of the 2025/2026 review will be to ensure robust alignment between the Risk Management Framework and Board Assurance Framework. In 2026/2027 work will also continue to be undertaken by the Corporate Governance Team to develop comprehensive risk management training materials in support of the Risk Management Framework with a focus on the introduction of a digital risk registers platform. Engagement will also continue with Executive Directors and other senior leaders to identify directorates or services who would benefit from tailored risk management training and support in order to develop a risk management training plan.

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

MANAGEMENT OF RISKS DURING 2025/2026

Strategic Risks

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

Strategic risks are recorded on the Board's Strategic Risk Register (SRR), which provides an organisational-wide summary of significant risks to the delivery of one or more of the Board's strategic priorities.

A fundamental review of the SRR was developed in Q1 of 2025/2026 following the closure of the previous Corporate Risk Register and in alignment with the 2025/2026 Integrated Plan, in order to ensure that the consistent reflection of the risks to delivering the Health Board's strategic priorities. The Strategic Risk Register was reviewed on a continuous basis throughout 2025/2026 with updates reported to the Board via the Executive Committee in July, November and March. Key themes of the Strategic Risk Register are as follows:

- financial sustainability and the duty to achieve financial breakeven
- the delivery and realisation of benefits of transformation
- the ability to respond to the demand for both provided and commissioned services
- the ability of primary care services to respond to demand
- ongoing challenges in recruiting and retaining staff
- the potential for care to be compromised due to the Health Board's estate not being fit for purpose
- the ability to stabilise the growing implications of Continuing Health Care
- the ever-present risk of to the Health Board's digital and electrical infrastructure
- the risk presented by the need to respond to a major incident or emergency and;
- risk regarding maintaining public confidence in relation service delivery and transformation.

Operational Risks

Operational risks are those risks that represent a threat to the day-to-day activities of the Health Board. The most significant operational risks within the organisation are recorded within the Organisational Risk Register, which is supported by a hierarchy of Directorate and Service Level Risk Registers.

The Organisational Risk Register was newly developed in Q3 of 2025/2026 and regularly reviewed by the Executive Committee. Key themes identified in 2025/2026 included:

- delivery of the financial forecast and savings target for 2025/2026
- the implementation of the NHS App
- urgent care flows
- the sustainability of service models
- limited service and staffing capacity within specific service areas and;
- potential deterioration in partnership working

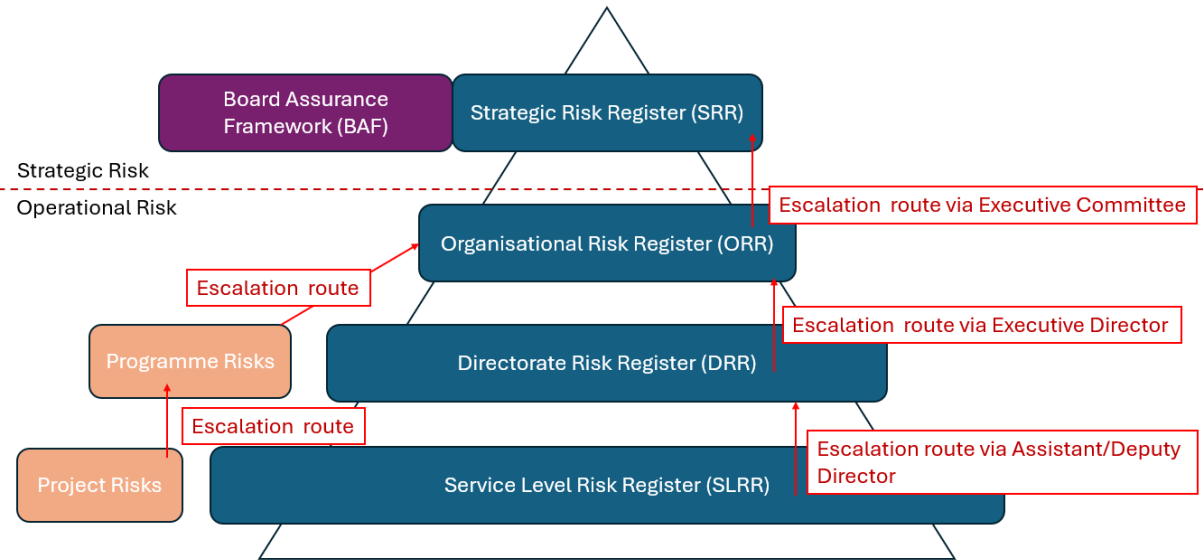
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EMBEDDING EFFECTIVE RISK MANAGEMENT

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

Since March 2021 Internal Audit has provided reasonable assurance each year in relation to the Health Board’s arrangements for Risk Management and the Board Assurance Framework. At the time of writing, the draft report for 2025/2026 was yet to be received.

The Risk Management Framework outlines the roles and responsibilities for risk management, the organisation’s risk architecture, Strategic and Directorate monitoring and reporting lines, the Board’s approach to risk appetite and risk management processes including the escalation, consolidation, and aggregation of risks. The Framework (alongside the Risk Appetite Statement) is reviewed on an annual basis by the Board. In Q4 of 2024/2025 the Board approved a range of updates to the Risk Management Framework, including the closure of the Corporate Risk Register, to be replaced with a Strategic Risk Register, owned by the Board and an Organisational Risk Register, focused on significant and cross-organisation operational risk, owned by the Executive Committee, as outlined in the figure included below. These updated were fully operationalised and embedded in 2025/2026, with further work planned for 2026/2027 to continuously develop and mature the established risk management arrangements.



The annual review of the Risk Management Framework for 2025/2026 was undertaken in Quarter 4 and the revised Framework is due to be presented to the Board in May 2025 for approval. The 2025/2026 review was focused on

ensuring consistency and integration with the Health Board's Board Assurance Framework (BAF).

The Health Board's Board Assurance Framework was approved by the Board in May 2024, and in 2025/2026 significant work was undertaken to operationalise the key elements of the BAF in relation to risk management. This included:

- The establishment of a Board Assurance Framework (BAF) Dashboard which reports to the Board alongside each Strategic Risk Register update to provide 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 action where gaps or weaknesses are identified;
- The development of the Board Assurance Framework Analysis Principles document which demonstrates the mechanism and standards by which the information within the BAF Dashboard is analysed to produce the ratings and findings presented, to support Board members utilisation of the tool; and
- The development of an Annual Review of Strategic Risk Assurance report to the Audit, Risk and Assurance Committee which provided a detailed analysis of each Strategic Risk to consider whether controls and assurance are effective, adequate and well balanced as well as the opportunity to assess any gaps in control or assurance and assess the appropriateness of control improvement actions.

The Board Assurance Framework was reviewed in Q4 of 2025/2026 and will be reported to the Board in May 2026, alongside the Risk Management Framework, for approval.

A revised Risk Toolkit remains in development and will look to provide staff with an easy read, step by step guide for the practical implementation of the key elements of the Risk Management Framework.

In May 2025 the Executive Committee approved a revised sub-group structure, which including the dissolution of the Risk and Assurance Group – the Group previously tasked with the oversight and escalation of operational risk and the integration of the Risk Management Framework. The former Groups responsibilities in regard to the oversight and escalation of operational risk were transferred to the Operational Leadership Group (OLG) a newly developed sub-group constituted of Assistant and Deputy Directors and responsible for overseeing key cross-organisational issues on behalf of the Executive Committee. The inclusion of risk management in the purpose of the Group is intended ensure the full integration of risk management in key organisational developments. The OLG met 8 times in 2025/2026 and regularly considered issues pertaining to risk management, the OLG was also tasked with the development of the Operational Risk Register (ORR) on behalf of the Executive Committee.

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

RISK APPETITE

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

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

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

In 2024/2025 the Board undertook a fundamental review of its Risk Appetite Statement in response to the increasingly complex and significant challenges and opportunities facing the Health Board. In recognising the risks inherent in healthcare services, the risk appetite statement starts at the basis of a low appetite. In 2024/2025 it was agreed that appetite would be increased in regard to reputation and public confidence, and financial sustainability risks, which may be necessary to support achievement of the Board's ten-year strategy 'A Healthy, Caring Powys'. The Board recognised the need to balance all categories of risk appetite, in reality complex decisions contain components that fall across the range of risk categories, for example financial sustainability, performance and service sustainability and workforce could all be contained within any one decision.

The whole Board were involved in preparing the statement and the complexities in relation to the establishment of the Board's appetite in respect of quality in the context of current and future system pressures and financial outlook was recognised. Ongoing monitoring of the external environment

within which the Health Board operates, and the internal risk environment will continue to be monitored, and the Risk Appetite Statement adjusted as required to provide clarity and granularity to aid effective decision making and the treatment of risk.

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

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry very limited or virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

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

Risk Category	Description
APPETITE FOR RISK: Averse	
Safety	We consider the safety of patients and staff to be paramount and core to our ability to operate and

Risk Category	Description
	carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of, incidents of avoidable harm to our patients or staff. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.
Financial Governance	We will not accept risks, nor any incidents or circumstances which may compromise to the integrity of financial reporting and associated processes; and risks relating to financial impropriety our fraud. We will maintain robust controls to ensure compliance with our Standing Financial Instructions financial propriety, to prevent fraud or error; and we will ensure remedial actions are enacted diligently should any concerns be identified.
APPETITE FOR RISK: Minimal	
Quality	The provision of high-quality services is of the utmost importance for the health board. The Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a low appetite for risks which my compromise the Duty of Quality and/or the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact on quality could adversely affect outcomes and experiences of our patients, service users and communities.
APPETITE FOR RISK: Cautious	

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Risk Category	Description
Regulation & Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.
Workforce	The Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximise the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. Our work will continue to be undertaken in partnership with our Trade Union colleagues.
Financial Sustainability	We recognise we have been entrusted with public funds and must remain financially viable. Our financial deficit means that robust controls are required to manage our exposure to risks which might increase our expenditure. We will make the best use of our resources for patients and staff ensuring maximum value is achieved. Though we recognise that some risk is inherent to achieving our priorities.
APPETITE FOR RISK: Open	
Performance and Service Sustainability	We have a low-moderate risk appetite for risks which may affect our performance and service sustainability. We are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19, workforce availability and limited resources) which may result in lower performance levels and unsustainable service delivery for a short period of time. We will also consider impacts on both short and

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Risk Category	Description
	long term performance and service sustainability in our decision making.
Financial Investment	Risks associated with investment or increased expenditure will only be considered when linked to delivery of core patient services supporting innovation and strategic change and/or legal or regulatory compliance. Though we are open to evidence-based innovations and investments which will significantly impact the drivers behind our financial deficit position, provided that these are aligned to our financial governance arrangements.
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, championing our Values and Behaviours Framework, and will not accept risks or circumstances that could unduly damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. Our communication and engagement will remain open and transparent. In light of the challenging environment related to public sector funding, we have a more open appetite for risks that may impact on the reputation of the Health Board when these arise as a result of the Health Board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory and financial environment.
Partnerships	The Health Board is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties at a local, regional and national level. We therefore have a high risk appetite for partnerships which may support and benefit the patients in our care. For example, the Health Board has a high appetite for risks associated with innovation and partnership with the third sector, industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and

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Risk Category	Description
	improvements in clinical practice. However, the Health Board will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.
APPETITE FOR RISK: Eager	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

THE HEALTH BOARD'S RISK PROFILE

As can be seen from the Heat Map at Figure 7, at the end of March 2026 a number of key risks to the delivery of the Health Board’s strategic priorities had been identified. Full details of the controls in place and actions taken to address these risks can be found in the Strategic Risk Register on the Health Board’s website [here](#).

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Figure 7: Strategic 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

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

Figure 8: Key Risks and Controls

SRR 001 – Risk Score 20 - The Health Board is unable to achieve its duty to achieve financial breakeven (and therefore sustainability).

CONTROLS IN PLACE & ACTION TAKEN	IMPROVEMENT ACTIONS
- Financial Plan approved by Board. Subsequent AO letters set out savings target of £23.1m. - Additional control - Introduced joint CEO and ED Finance only focussed meetings with each Exec Director individually. - Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks. - Group established for Variable Pay, identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. Variable Pay, CHC and Commissioning regular deep dive areas of focus at F&P Committee to track actions to improve. - Investment Benefits Group - focus on benefits realisation of previous investments, including consideration of dis-investment. - 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.	- Executive Directors are focussed on delivery of £23.1m savings targeted for 2025/26. - Executive Team workshops focussed on actions to reduce expenditure in 2025/26. - 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.

SRR 011 – Risk Score 15 - Failure of Digital & Electrical Infrastructure in Powys (Internal & External) poses a risk to the delivery of care.

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

SRR 012 – Risk Score 15 – The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.

CONTROLS IN PLACE & ACTION TAKEN	IMPROVEMENT ACTIONS
▪ 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 ▪ Communication and engagement team in place (substantive team = 4.0wte, additional temporary posts) with active management of priorities aligned with organisational priorities and risks ▪ Weekly informal communications report to Board including reputation risk portfolio to support internal review and scrutiny ▪ Twice Yearly Engagement and Communication Report supports ongoing review of capacity against opportunities and risks ▪ Temporary strengthening of communications and engagement function including non-pay resources to support Better Together programme ▪ Procurement of additional engagement delivery and analysis support to Stage Two Better Together engagement ▪ Procurement of additional consultation delivery and analysis support to Stage Three Better Together ▪ Stakeholder Map in place ▪ 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 ▪ OD programme in place linked to Better Together transformational change programme ▪ Channel strategy in place and kept under review (web, GovDelivery, Facebook, NextDoor etc.)	▪ Stakeholder engagement assurance included within TI support framework ▪ Identification of named Locality leads for each of the 13 Powys localities ▪ Establish annual Insight Report from community engagement activities for Board review and to inform annual planning

▪ Out of hours media protocol in place via Gold On Call but currently insufficient team capacity for on call comms ▪ Powys Engagement and Insight Network in place to support pan-organisational co-ordination of engagement and insight (joint sub-group of RPB and PSB) ▪ Programme of continuous engagement in place as of October 2025 following strengthening of the engagement team.	

A full copy of the Strategic Risk register is linked here - [Strategic Risk Register - March 2026](#). The Board received and reviewed the Strategic Risk Register at three meetings of the Board during 2025/2026. As a result of the reviews undertaken by the Executive Committee and the Board, the risk scores for a number of risks changed during the year in the context of the external environment, and other developments such as improvements made to the control process.

As undertaken in 2025/2026, following Board approval of the Integrated Plan for 2026/2027 a full review of Strategic Risk will take place to ensure priorities are identified, assessed and mitigating actions established, as well as assurance levels assessed.

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EMERGENCY PREPAREDNESS

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

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

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

To demonstrate compliance with the Civil Contingencies Act, the Health Board is required to submit an assessment (Annual Report) on the Health Board's emergency preparedness activities to NHS Wales Performance & Improvement on an annual basis. The Annual Report was considered at the July 2025 In-Committee Board meeting, prior to its submission to NHS Wales Performance & Improvement.

KEY ASPECTS OF THE CONTROL FRAMEWORK

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

Quality Governance Arrangements

As an NHS Wales organisation, the Health Board has a statutory Duty of Quality and operates an integrated system of quality governance, providing assurance to the Board that services are safe, effective, person-centred and continuously improving.

Quality governance arrangements are informed by:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- NHS Wales Quality and Safety Framework

- *A Healthier Wales*
- Health and Care Quality Standards (2023)

Quality is embedded as a golden thread throughout organisational planning, performance management and assurance arrangements, supported through the Integrated Quality and Performance Framework. This enables quality intelligence to inform decision-making, risk management and improvement priorities across the organisation.

Governance and Assurance

The Board gains assurance through the Patient Experience, Quality and Safety Committee, which provides independent scrutiny and oversight of:

- patient safety and experience
- quality performance indicators
- clinical risk management
- Duty of Candour compliance
- learning from incidents, complaints and mortality reviews.

During 2025-26, the Health Board commenced planning and implementation of the NHS Wales People's Experience Framework, strengthening how people's feedback and experience intelligence are systematically captured, analysed and used alongside safety, performance and outcome data to inform improvement and provide assurance to the Board. This work supports a more consistent national approach to understanding what matters to people who use services and how this drives quality improvement.

In preparation for the introduction of the Listening to People framework in April 2026, preparatory work has also been undertaken to further strengthen compassionate engagement, early resolution and organisational learning arrangements, ensuring governance systems are aligned with forthcoming national changes to concerns handling and feedback processes.

Escalated risks are incorporated within the Board Assurance Framework and Corporate Risk Register, ensuring alignment between operational risks and strategic objectives and enabling Board oversight of significant quality and safety risks.

Clinical Risk Management

Clinical risks are identified through incident reporting, audit findings, concerns, experience feedback, external reviews and regulatory activity. Risks are assessed using the organisational risk management framework and monitored through committee structures to ensure mitigation actions are implemented and effectiveness evaluated.

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Significant clinical risks are monitored through the Board Assurance Framework, enabling the Board to assess the effectiveness of controls and the impact of improvement actions on patient outcomes.

Clinical Audit

The Clinical Audit Programme provides independent assurance regarding compliance with standards and effectiveness of care. Audit priorities are risk-based and aligned to national requirements, local quality priorities and areas of identified variation.

Audit outcomes inform improvement plans and are monitored through governance committees, supporting organisational learning and service improvement.

Information Governance

Information governance arrangements provide assurance regarding data quality, confidentiality and security, supporting safe decision-making and effective oversight. Processes are in place to ensure that any data security incidents are appropriately managed, reported and learned from in line with statutory and organisational requirements.

Sources of Quality Assurance

Key assurance mechanisms include:

- Putting Things Right (concerns, incidents and redress)
- People's experience feedback and engagement intelligence
- Clinical audit and national benchmarking (e.g. GIRFT, CHKS)
- External reviews and regulatory inspections
- Professional regulation and supervision
- Workforce and staff survey feedback
- Integrated Quality Reporting.

Collectively, these arrangements provide the Board with assurance that quality risks are appropriately identified and managed, learning is embedded across the organisation, and actions taken are contributing to improved patient outcomes.

The Board considers quality governance arrangements to be integral to the organisation's overall system of internal control and risk management, forming a key component of the assurance framework described within the Governance Statement.

Health and Care Standards and the Duty of Quality

The Health Board discharges its statutory Duty of Quality in accordance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Health and Care Quality Standards (2023) provide the framework through

which quality is planned, assured and improved across all services, and form a core component of the Integrated Quality and Performance Framework underpinning Board decision-making, risk assessment and improvement priorities across the organisation.

Care delivery is assessed against the STEEP principles:

- Safe,
- Timely,
- Effective,
- Efficient,
- Equitable, and
- Person-centred

supported by organisational enablers including leadership, workforce, culture, information, learning and whole-system collaboration.

The Board and its Committees use the Quality Standards to:

- assess service performance and outcomes
- inform risk escalation and assurance discussions
- guide quality improvement priorities
- evaluate equity and population outcomes.

During 2025-26, the Health Board further strengthened its approach to quality assurance through the development of a triangulated system of reporting, bringing together intelligence from incidents, audits, claims, concerns and complaints. This enables a more comprehensive assessment of organisational performance and supports the identification of emerging risks and improvement hotspots.

The STEEP principles have also informed organisational planning and improvement activity, including the Annual Plan, the Better Together programme and wider programmes of work within the Integrated Medium-Term Plan (IMTP), ensuring that quality considerations are embedded within service transformation and delivery planning.

Compliance with the Duty of Quality is monitored through integrated reporting arrangements, enabling triangulation of performance, patient experience and safety intelligence to support Board oversight and informed decision-making.

The Duty of Quality and Duty of Candour Annual Report will be published after this Annual Report and made available via the Health Board website, with findings informing ongoing governance and improvement activity.

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Clinical Audit

For 2025/26 a comprehensive Clinical Audit Plan was developed by the directorates and/or service groups and approved by the Patient Experience, Quality and Safety Committee in April 2025.

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

A closure report on the 2024/2025 Clinical Audit Programme and a verbal progress reports on the delivery of the Clinical Audit plan for 2025/26 were presented to the Patient Experience Quality and Safety Committee at the August 2025 meeting.

A written update report on the 2025/26 programme was presented to the Patient Experience Quality and Safety Committee in October 2025.

The Surgery and Endoscopy Service noted that they were undertaking work on the Association for Perioperative Practices (AfPP) audits for theatres to adapt them for use in a community hospital day surgery environment.

After undergoing a full review, items duplicating information in other audits were removed or amalgamated to provide a more logical approach to audit in this space.

In January 2026 the Deputy Medical Director submitted a report to Welsh Government on the Health Board's achievements on audits from the NHS Wales National Clinical Audit Plan in response to the Welsh Health Circular WHC/2025/042.

Complaints and Concerns Framework

The Health Board operates its concerns arrangements in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, ensuring concerns are managed openly, proportionately and in a manner that supports learning and service improvement.

Performance against statutory response times has continued to improve during 2025-26, supported by an increased focus on early resolution where appropriate, and engagement with people raising concerns.

Implementation of the Duty of Candour continues to support a culture of openness, transparency and learning across the organisation. After launch, an increase in recorded duty of candour incidents reflected growing staff awareness of the duty. However, further training and staff confidence in recognising where harm thresholds are met has seen a slight reduction, to stable reporting levels, with assurance that we are responding appropriately.

Learning arising from concerns is considered alongside wider sources of quality intelligence, including incidents, claims, audit findings and patient feedback. This triangulated approach supports identification of themes; highlights areas requiring improvement and informs organisational learning.

Preparatory work has also commenced in readiness for the introduction of the national Listening to People framework, supporting continued development of compassionate engagement, early resolution and strengthened learning from feedback and concerns.

The Patient Experience, Quality and Safety Committee receives regular assurance reports covering concerns performance and emerging trends, compliance with regulatory timescales, thematic learning identified through concerns and improvement actions arising from feedback and investigations.

Through these arrangements, concerns intelligence contributes to the Board Assurance Framework and supports organisational risk management and quality governance oversight.

Further information regarding Putting Things Right arrangements is available on the Health Board [website](#).

Medical Examiner Service

Since 2024 the Medical Examiner (ME) service has reviewed all deaths of Powys residents. This was a significant increase in workload for all of the ME related services. As a result, in some cases delivery of the Medical Certificate of Cause of Death (MCCD) was delayed. Following a period of review and collaborative working between Health Boards and the ME service, performance has improved.

The June 2025 data for Powys Teaching Health Board indicated that overall MCCD completion times remained in line with the Wales average, however there were areas where comparison to other Health Boards suggested areas for improvement. A key metric is the time taken for notes to be sent to the ME service and for the ME service to review the case. A task and finish group was set up to review processes and both metrics have improved. A dashboard has been published by the ME service so that performance can be easily monitored.

Collaborative working with the ME service continues and at a stakeholder panel held in December 2025, generally positive feedback was shared with the Health Board. It was highlighted that proformas completed by GPs were exemplary and improved performance in communicating with the ME service was noted. It was noted that some MCCDs are being returned for rewording. The learning from this is being shared with General Practice teams.

Whilst there have been no serious issues for concern raised, there is helpful feedback and learning which is fed back to teams and other provider services to inform our continuous improvement.

Comparative data for 2024/2025 demonstrates that the number of deaths fell slightly in 2025. Fewer people are dying in hospital, and more people are dying at home.

Deaths of Powys Residents Summary

2024	2025
Total deaths: 1,641	Total deaths: 1,593
Hospital: 848 (192 in Powys hospitals; 656 in hospitals outside Powys)	Hospital: 763 (189 in Powys hospitals; 574 in hospitals outside Powys)
Home: 414	Home: 454
Care home: 304	Care home: 301
Hospice: 39	Hospice: 38
Other: 36	Other: 37

LEARNING FROM EXPERIENCE GROUP

The learning from experience group continues to evolve and will be reviewed over coming months as the Quality Management System is further developed.

During 2025/26 key areas considered were the roll out of the NEWS 2 early warning score, learning from internal audits and key learning from a review of maternity and neonatal services in another Welsh Health Board.

Mechanisms for improving ‘floor to board’ communication were considered as were sharing learning by including key themes and areas of concern in the corporate induction programme.

EXECUTIVE PORTFOLIOS

In May 2024, the Board approved an updated Scheme of Delegation and Reservation of Powers. This document sets out the delegation of responsibility to Executive Directors. The allocation of responsibilities is based on ensuring an appropriate alignment of accountabilities and authority within each Executive Directorate and Executive Director portfolio, and to also ensure that Executive Directorates focus on their core responsibility. A review was undertaken during 2025/26 which resulted in minor changes and was approved at Board in January 2026.

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

Figure 9: Executive Portfolios

Executive Medical Director – Full Year
• Professional lead for Medicines Management including Patient Group Directions - written instructions to help supply or administer medicines to patients, usually in planned circumstances. • Research and Development - Including clinical trials. • Professional Medical and Dental Workforce: Standards, Education, Regulation and Responsible Officer – Appraisal and Revalidation • Caldicott Guardian • Medical Legislation and National Policy • Medical Leadership and Engagement • Admission to the performers list • Blood Safety and Quality • Human Tissue issues • Executive lead for Organ Donation • Clinical Audit • Resuscitation • Mortality Reviews • Development of and Engagement with Clinical Networks • Individual Patient Commissioning • Implementation and compliance with Medical Royal College Standards • Implementation and compliance with National Institute for Clinical Excellence (NICE) guidelines. • Strategic responsibility to Board for Clinical Informatics
Revisions in January 2026 • Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies. • Cancer • Antimicrobial Stewardship • Medical Students
Executive Director of Nursing, Quality, Women and Family Health
• Professional leadership of Nursing and Midwifery • Lead Executive for implementation of the Duty of Quality and the Duty of Candour, quality of Health and Care Services, Patient Experience and Satisfaction, including raising Concerns – patients and public (Putting Things Right, NHS Redress), review and addressing of patient safety incidents and the associated Board level reporting • Infection Prevention and Control • Decontamination • Implementation and compliance with Patient Safety Alerts • Executive lead for children and young people services • Safeguarding Adults and Children • (CYSUR & CWMPAS – the Regional Safeguarding Boards) • Safeguarding, protecting and promoting the health and well-being of children, young people, vulnerable adults and victims of domestic abuse. PTHB actively contribute locally, regionally and nationally on a number of Safeguarding agendas including:

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- Child Protection
- Adult Protection
- Looked After Children
- VAWDASV and Gender Based Violence
- Community Safety Partnership
- Youth Offending Board
- Deprivation of Liberty Safeguards
- MAPPA
- Female Genital Mutilation
- Modern Day Slavery and Trafficking
- Child Sexual Exploitation.
- Deprivation of Liberty Safeguards
- Nutrition and Hydration
- Dementia
- Professional Nursing and Midwifery Workforce: Standards; Education; Regulation; Supervision of Midwives; and NMC Revalidation
- Women and Children's Services including ALN.
- Integration Agenda with Powys County Council in relation to operational delivery: Children
- Nurse Staffing Act Compliance
- Nationally Reportable Incidents and Early Warning Notifications to WG.
- Review and Monitoring of regulation 28 with HM Coroner
- Responsible for PSOW actions and liaison with PSOW office.
- Lead Executive for relationship with HIW

Revisions in January 2026

- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies.
- Safeguarding Adults and Children including Prevent

Executive Director of Finance, Capital and Support Services and Deputy CEO

- NHS Wales Statutory Financial Duties and requirements
- Professional leadership of Finance staff
- Financial Planning (Revenue and Capital)
- Financial Management, Monitoring and Reporting
- Financial Systems and Controls
- Provision of Financial Services to Directorates
- Procurement including tenders and post tender negotiations. Liaison with Shared Services to enable delivery of robust procurement services.
- Counter Fraud including PPV.
- Liaison with External Financial Auditors
- Charitable Funds Accounting
- Health and Care Research Wales financial arrangements including accounts.
- Asset Accounting
- Preparation of Annual Accounts
- Continuing Healthcare and Funded Nursing Care – financial authorisation
- Strategic oversight Capital and Estates
- Facilities and Support Services
- Logistics

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- Fire Safety
- Agile working

Revisions in January 2026

- The Health Service Procurement (Wales) Act 2024 and The Health Services (Provider Selection Regime) (Wales) Regulations 2025
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies including NHS Wales Performance and Improvement.
- Deputy Chief Executive – deputising as appropriate for the CEO as agreed
- Health and Safety (estate and support service related)
- Foundational Economy
- Continuing Healthcare and Funded Nursing Care – financial authorisation up to £250k

Executive Director of Allied Health Professions Health Sciences and Digital

- Medical Devices including implementation and compliance with Medical Device safety Alerts.
- Professional Allied Health professionals and Healthcare Sciences and Social Workers: Leadership; Standards; Education; Point of Care Testing; and Regulation and Revalidation
- Data quality and clinical coding
- Delivery of Information management and Technology Strategy and Services
- Provision of Clinical Information Systems - hosting and enabling connectivity. This does not include system administration or management.
- Provision of ICT management systems
- Business Intelligence systems
- Provision of ICT infrastructure and telephony

Revisions in January 2026

- Senior Information Risk Owner (SIRO)
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies including Digital Health and Care Wales.

Executive Director Public Health

- Health Improvement Strategy (as part of overarching health and care strategy)
- Health Needs Assessment
- Public Health Planning
- Public Health Initiatives linked to the NHS Wales Delivery Framework.
- Stop Smoking
- Vaccination and Immunisation
- Flu
- Obesity
- Screening

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- Professional Public Health Workforce: Standards; Education; and Regulation
- Outbreak Control
- Public Health Monitoring and Surveillance
- Provision of Public Health Advice
- Production of Director of Public Health Annual Report
- Executive lead for Armed Forces and Veterans
- Civil Contingency, Emergency Planning, Business Continuity
- Executive lead for Prudent Health and Care
- Executive lead for the Well-being of Future Generations Act
- Strategic lead for co-ordination of RPB/PSB
- Carers

Revisions in January 2026

- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies including Public Health Wales.
- Health Impact Assessment (Wales) Regulations 2025.
- Executive lead for the Well-being of Future Generations Act (ED Planning, Performance and Commissioning is the lead relating to the planning cycle)

Executive Director of People, Culture and Transformation

- Professional Workforce and Organisational Development Workforce: Standards; Education; and Regulation
- Employment and staff relations
- Workforce Planning
- Workforce Policies and Practices
- Employee Health and Well-being including the provision of Occupational Health Services
- Employee Engagement
- Trade Union partnership arrangements
- Employee Record Management
- Workforce Information Management Systems
- Values and Standards of Behaviour Framework
- Raising Concerns
- Barring and Disclosure Arrangements
- Equality and Diversity & Human Rights
- Welsh Language provision
- Executive Lead for Violence & Aggression
- Volunteering
- Hosting arrangements – Health and Care Research Wales
- Wellbeing Guardian
- Speaking Up Safely Exec Lead
- Library Services

Revisions in January 2026

- Working Carers
- Co-ordination of medical student placements
- Health and Safety (workforce related areas)
- Organisational transformation including Better Together programme and executive leadership of the Transformation and Improvement department

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- North Powys Wellbeing Programme
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies including NHS Employers and HEIW.
- Hosting arrangements – Health and Care Research Wales (with support from Director of Corporate Governance)

Executive Director of Primary Care, Community and Mental Health

- Planned care and specialties.
- Learning Disability Services
- Mental Health Services (including CAMHS)
- Palliative Care Services
- Rehabilitation Services
- Intermediate Care Services
- Diabetes Services
- Respiratory Conditions Services
- Older Peoples Services
- Unscheduled Care
- Diagnostic Services
- Continuing Healthcare and Funded Nursing Care – Strategic and operational application
- Meeting of Access Targets / Referral to Treatment Times – Powys provider services
- Oversight of the performance of Ambulance Services
- Pathways of Care Delays
- Medicines Management [in conjunction with the Medical Director – professional]
- Site Coordination
- Primary Care
- Primary Care Out of Hours arrangements, including 111
- Primary care development including Clusters (with support from Executive Medical Director)
- Primary Care contractor performance management, including accreditation of enhanced services (with support from Executive Medical Director)
- Removal of violent patients from GMS Services
- Pain Management Services / Powys Living Well service.
- Stroke and Neurological Services
- Responsible Officer - Cottage View

Revisions in January 2026

- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies.
- Responsible Officer - Cottage View (discharged through Assistant Director – Community Services Group)

Executive Director of Commissioning, Performance & Planning

- Commissioning development, monitoring and performance monitoring across the organisation
- Performance management across the organisation, including the development and implementation of the Integrated Quality and Performance Framework and integrated reporting.

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- Meeting of Access Targets/ Referral to Treatment Times – commissioned services
- Executive lead for commissioning relationship with WHSCC and EASC
- Executive lead for liaison and engagement with third sector
- Executive lead for Planning (strategic and operational), including strategic planning with key partners, and partnership working.
- Executive lead for the organisation's longer-term strategy, including its transition into a clinical service plan.
- Continuous engagement and consultation and liaison with Llais on those matters relating to service change (supported by the Deputy Director of Engagement, Communication and Corporate Governance).
- Board level lead for service change and public consultation (supported by the Deputy Director of Engagement and Communication).
- Compliance with national guidance on service delivery change - engagement and consultation
- Continuous engagement and consultation and liaison with Llais on those matters relating to service change.

Revisions in January 2026

- Executive Lead for the development and monitoring of the organisation's Integrated Medium-Term Plan/Integrated Plan
- Organisational oversight of Regional Committees (lead for Southeast) and support to the PTHB Chair for the Southwest Committee
- (ED planning, Performance and Commissioning is the lead relating to the planning cycle) Executive lead for the Strategy Well-being of Future Generations Act
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies.

Director of Corporate Governance/ Board Secretary

- Professional advice to the Chair, CEO and Board on all matters relating to corporate governance
- Risk Management Framework
- Board Assurance Framework
- Board and Committee Arrangements and Annual Work Programme
- Board Development Programme
- Production of the Annual Governance Statement and Coordination of the Annual General Meeting
- Compliance with Standing Orders including delivery of the Board governance structure
- Legislation and Legal Services / provision of legal advice
- Use of the Common Seal
- Register of Interests and Gifts and Hospitality
- Policies Management
- Internal and External Audit Liaison
- Public inquiries, including COVID-19
- Board level lead for the Health Board's Charity
- Information Governance
- Records Management Framework
- Intellectual Property Rights and Commercialisation
- Corporate Communications

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- Corporate Business support to the executive team, Chair, Vice Chair and Independent Members

Revisions in January 2026

- Oversight and resourcing of corporate engagement (Board level lead for Strategic Engagement sits with Executive Director of Planning)
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies.
- Information Governance and GDPR
- Corporate Policies Framework and Management

Executive Director of Finance, Capital and Support Services and Deputy CEO

- NHS Wales Statutory Financial Duties and requirements
- Professional leadership of Finance staff
- Financial Planning (Revenue and Capital)
- Financial Management, Monitoring and Reporting
- Financial Systems and Controls
- Provision of Financial Services to Directorates
- Procurement including tenders and post tender negotiations. Liaison with Shared Services to enable delivery of robust procurement services.
- Counter Fraud including PPV.
- Liaison with External Financial Auditors
- Charitable Funds Accounting
- Health and Care Research Wales financial arrangements including accounts.
- Asset Accounting
- Preparation of Annual Accounts
- Continuing Healthcare and Funded Nursing Care – financial authorisation
- Strategic oversight Capital and Estates
- Facilities and Support Services
- Logistics
- Fire Safety
- Agile working

Revisions in January 2026

- The Health Service Procurement (Wales) Act 2024 and The Health Services (Provider Selection Regime) (Wales) Regulations 2025
- Strategic partnership and stakeholder management in relation to portfolio including all professional groups, Powys County Council, Welsh Government and other NHS bodies including NHS Wales Performance and Improvement.
- Deputy Chief Executive – deputising as appropriate for the CEO as agreed
- Health and Safety (estate and support service related)
- Foundational Economy
- Continuing Healthcare and Funded Nursing Care – financial authorisation up to £250k

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Staff and Staff Engagement

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

A summary of activity includes:

- Executive Director of People and Culture reports and workforce performance reports including:
 - A Great Place to Work
 - Employee Health and Wellbeing
 - Welsh Language, Equalities
 - All Wales Job Descriptions
 - All Wales Anti-Sexual Harassment Policy
 - All Wales Flexible Working Policy
 - Employment Rights Bill
 - National Position on Pay Ballots
 - Aspiring Nurse Programme
 - Internationally Educated Nurses
 - Health Care Support Workers
 - Student Placements
 - Leadership and Management Competence Framework for NHS Wales
 - Cardiff University (Nursing Degree Course)
 - The NHS Business Services Authority (NHSBSA)
 - NHS Wales Shared Service Partnership: International Recruitment
 - Workforce Futures – Partnership
 - Workforce HR business partners and workforce resourcing
 - Transformation and Sustainability of our Workforce
 - National Work Programmes in place
 - Review of Statutory and Mandatory Training
 - Audit Wales report: Addressing workforce challenges in NHS Wales
 - Clinical Leadership Immersive Programme
 - The Strategic Nursing Workforce Plan 2025-2030
 - Speaking up safely
 - Library Services Update
 - Reverse Mentoring
- NHS Staff Survey results for the Health Board
- Better Together Portfolio Update including Temporary Service changes
 - Staff Engagement
 - Programme updates
 - Potential implications for the future workforce
- Finance Reports including financial recovery
- Admin Review update

- Integrated Plan – Focus on Workforce Elements
- Social Partnership Annual Report
- Final Annual Plan 2025/26
- 2026/27 Integrated Annual Plan
- Collective Agreement on Registrant CPD Hours
- Achievements over the past year (Capital Group)
- Achievements over the past year (Estates)
- Approved Annual Plan 2025/26
- Discussion on various topics including Band 2 and Band 3 Nursing Workforce and Speaking Up Safely

INFORMATION GOVERNANCE & RECORDS MANAGEMENT

Information Governance (IG) sets out how the Health Board ensures that personal and sensitive information relating to patients, service users, staff and corporate activity is managed lawfully, securely and effectively.

Robust IG arrangements are supported through clear leadership, accountability and professional oversight, including:

- A dedicated Information Governance Team providing leadership, coordination and assurance.
- A Caldicott Guardian safeguarding patient information.
- A Senior Information Risk Owner (SIRO) overseeing information risk.
- A Data Protection Officer providing independent assurance and advice on compliance.
- A Chief Clinical Information Officer ensuring alignment between clinical requirements and digital systems.
- Digital leadership teams working in partnership with IG to ensure compliance with UK GDPR, NIS Regulations and wider standards.
- Information Asset Owners (IAOs) across all services, accountable for the information assets they manage.
- IG and Records Management and Digital Governance groups providing oversight, professional advice and assurance across digital and information initiatives.
- Active participation in NHS Wales IG and Records Management networks to support consistency and shared learning.

DELIVERY AND ASSURANCE

The Information Governance Team provides assurance, oversight and operational delivery across records management, freedom of information and data protection compliance. This includes ensuring the lawful and appropriate use, sharing, retention and protection of information; managing information rights and requests; overseeing information risk and incidents; and

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embedding data protection principles across the organisation through policies, training, contracts and professional advice.

Assurance is provided through:

- Formal reporting to the Audit, Risk and Assurance Committee and annual completion of the NHS Wales Information Governance Toolkit.
- A comprehensive IG framework, including an annual workplan, policy suite, Information Asset Register (incorporating Records of Processing Activities), and maintained IG and Records Management webpages.
- Oversight of mandatory Information Governance, Records Management and Cyber Security training, including monitoring compliance, targeted follow-up, role-specific training and staff alerts.
- Investigation, management and reporting of IG incidents, including escalation to the ICO where required, and the promotion of learning and continuous improvement.
- Routine monitoring of access to clinical systems through the National Intelligent Integrated Audit Solution (NIIAS).
- Assurance of new and existing digital systems to embed data protection by design and default.
- Delivery of Data Protection Impact Assessments (DPIAs) and support for lawful and secure data sharing arrangements.
- Ongoing engagement with services, governance forums and external partners across NHS Wales.

As of 31 March 2026, mandatory training compliance was 81%, below the NHS Wales benchmark of 85%. Improvement actions remain in progress, alongside continued alignment with the NHS Wales national IG and Records Management support framework.

PERSONAL DATA INCIDENTS

Personal data incidents are reviewed daily in line with UK GDPR requirements. Significant incidents are reported to the ICO within statutory timescales. During 2025/26, five incidents were reported to the ICO, with no further action required.

A total of 230 IG-related incidents were recorded, representing an increase on the previous year. The majority were low-level issues, such as misdirected emails or records management errors, with no major incidents identified. Enhanced data quality checks introduced during the year improved incident detection and categorisation and may have contributed to this increase.

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FREEDOM OF INFORMATION

During 2025/26, the Health Board received 514 Freedom of Information requests, with 475 completed within statutory timescales. Six internal reviews and five Environmental Information Regulation requests were also received and responded to appropriately. This reflects a 7.5% increase compared with the previous year. Information continues to be proactively published through the Health Board's website and Publication Scheme.

REQUESTS FOR PERSONAL INFORMATION

During 2025/26, the Health Board processed 852 requests for personal information, the majority being Subject Access Requests, alongside a small number of other UK GDPR rights-based requests. All requests were handled in line with statutory requirements, clinical obligations and records management legislation. This represents a 4.6% increase compared with the previous year.

WELSH IG TOOLKIT

The Health Board met the submission deadline for the 2025/26 NHS Wales Information Governance Toolkit. The outcome demonstrated a good level of assurance, supported by an agreed improvement plan that will continue into 2026/27.

DATA PROTECTION OFFICER

The Data Protection Officer provides independent advice and oversight on data protection and confidentiality compliance, with key areas including information sharing and privacy risk management. IG performance and emerging risks are overseen through the Executive Committee and the Audit, Risk and Assurance Committee.

PLANNING ARRANGEMENTS

The organisation's planning arrangements in 2025/2026 form a key part of the Performance Report section of the Annual Report. Further detail can be found throughout the Performance Report.

DISCLOSURE STATEMENTS

Equality, Diversity, and Inclusion

The organisation's approach to Equality, Diversity, and Inclusion in 2025/2026 forms a key part of the organisations work. The Equalities, Diversity and Inclusion Annual Report 2025/2026 will be considered for approval at Board in July 2026 and then published to the Health Board's website where the

2024/2025 Report can be found - [Equality - Powys Teaching Health Board \(nhs.wales\)](https://nhs.uk/equality)

Pensions Scheme

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

Carbon Reduction Delivery Plans

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

The organisation has undertaken risk assessments and is planning to ensure that the organisation's obligations under the Climate Change Act and Adaptation Reporting requirements are complied with. During 2025/26, the organisation was compliant with its requirements.

Data Security

A summary in relation to personal data incidents which required formal reporting to the Information Commissioner's Office (ICO) is provided on page XXX of this report. Five personal data incidents were reported.

Quality of Data used by the Board

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

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MINISTERIAL DIRECTIONS AND WELSH HEALTH CIRCULARS

Welsh Government has issued a number of Ministerial Directions in 2025/26. A record of the Ministerial Directions given is available via the following link: [Health and social care | Topic | GOV.WALES](#). A record of the Welsh Health Circulars given is available via the following link: [Health circulars: 2024 to 2027 | GOV.WALES](#)

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

Appendices 3a/3b (page XXX) provide an overview of Ministerial Directions and Welsh Health Circulars received during 2025/26 and their implementation status as of March 2026.

Post Payment Verification

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

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

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

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

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

INTERNAL AUDIT

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

The Head of Internal Audit Annual Opinion provides assurance on governance, risk management and the system of internal control and is based on the risk-based audit programme. The opinion contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement. A summary of the Head of Internal Opinion 2025/2026 is provided below.

Head of Internal Audit Opinion for 2025/2026

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

Limited Assurance Reviews

Two Limited assurance rated reviews had been received during 2025/2026. The reports were in respect of:

- Mattresses
- Digital Systems Update
- NOTE - DOUBLE CHECK THIS WHEN IN FINAL REVIEW

The full reports were reported to the Audit, Risk and Assurance Committee

on 08 July 2025 and 13 January 2026 and can be found at:

[Agenda and papers-Audit, Risk and Assurance Committee-08-July-2025](#) and [Agenda and papers - Audit, Risk and Assurance Committee-13 January-2026](#)

All Limited Assurance Rated Reviews are reported to Welsh Government on a quarterly basis in addition to our own internal reporting and monitoring arrangements.

The Audit and Risk Assurance Committee receive regular reports on progress being made against audit recommendations for all internal audits, with specific focus on those with limited assurance

Counter Fraud

In line with the Government Functional Standard 013 Counter Fraud NHS Requirements the Local Counter Fraud Specialist (LCFS) and Executive Director of Finance agreed a work plan for 2025/26 at the beginning of the financial year. This was approved by the Audit, Risk and Assurance Committee.

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2025/26 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high-risk work to be undertaken urgently and dynamically.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. NHS Wales have adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. At the conclusion of 2025/26 the Health Board Standards are assessed as 7 Green rated, 4 Amber rated and 2 Red rated. This year's overall rating is classed as Amber.

Work Plan actions are included in the 2026/27 workplan to address the Amber and Red area's and aimed to uplift back to Green rating.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 1.2 FTE of accredited counter fraud specialist resource supplemented by 0.2 FTE admin support which translate to 308 days deliverable for counter fraud activity. This SLA arrangement remains in place for 2026/27.

Audit Wales Structured Assessment

The Auditor General for Wales is the Health Board's statutory external auditor, and the Wales Audit Office undertakes audits on his behalf. The Structured Assessment enables the Auditor General to be satisfied proper arrangements have been made to secure economy, efficiency, and effectiveness in the use of resources.

The 2025 Structured Assessment took place at a time when NHS bodies were continuing to respond to a broader set 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.

Some relevant extracts from the report are included below:

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.

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.

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.

Audit Wales made seven recommendations based on the 2025 work in relation to clarifying referrals in committee action logs, further refining the strategic and organisational risk registers, updating the format of the Integrated Quality Report, 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. All these actions have either been completed or are well progressed.

The Structured Assessment was reported to the Audit, Risk and Assurance Committee on 10 March 2026 and to the Board on the 25 March 2026 and can be found on the Health Board's website: [25 March 2026 - Powys Teaching Health Board agenda-pack-part-2/](#) on pages 146 to 179.

MODERN SLAVERY ACT 2015: TRANSPARENCY IN SUPPLY CHAINS

The Welsh Government's Code of Practice: Ethical Employment in Supply Chains was published in May 2017 to highlight the need, at every stage of the supply chain, to ensure good employment practices exist for all employees, both in the UK and overseas. It is expected that all NHS Wales organisations will sign up for the Code.

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

Modern Slavery and Human rights abuses;

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

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

- We follow the All-Wales procedure for staff to raise concerns (Whistleblowing), which provides the workforce with a fair and transparent process, to empower and enable them to raise suspicions of any form of malpractice by either our staff or suppliers/contractors working on University Health Board premises;
- We have a target in place to pay our suppliers within 30 days of receipt of a valid invoice;
- We comply with the six NHS pre-employment check requirements to verify that applicants meet the preconditions of the role they are applying for. This includes a right to work check;
- We do not engage or employ staff on zero hours' contracts;
- We have an Equality, Diversity and Human Rights Policy in place which ensures that no potential applicant, employee, or worker engaged is in any way unduly disadvantaged in terms of pay, employment rights, employment, or career opportunities;
- We also seek assurances from suppliers, via the tender process, that

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they do not make use of blacklists/prohibited lists. We also require confirmation and assurances that they do not make use of blacklist/prohibited list information;

- In accordance with Transfer of Undertaking (Protection of Employment) Regulations any Health Board staff member who may be required to transfer to a third party will retain their NHS Terms and Conditions of Service;
- We use the Modern Slavery Act (2015) compliance tracker by way of contracts procured by NHS Wales Shared Services Partnership (NWSSP) on behalf of the Health Board. NWSSP is equally committed to ensuring that procurement activity conducted on behalf of NHS Wales is undertaken in an ethical way. On our behalf, they ensure that workers within the supply chains through which they source our goods and services are treated fairly, in line with Welsh Government's Code of Practice for Ethical Employment in Supply Chains. Further detail on this area of work is available at:

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

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

CONCLUSION

As Accountable Officer for Powys Teaching Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board, including its Executive Directors, are alert to their accountabilities in respect of internal control and the Board has had in place, during the year, a system of providing assurance aligned to corporate objectives to assist with identification and management of risk. As a result of a number of complex pressures including demand for our services, system pressures, cost of living and inflation as well as national and international economic and other pressures, Powys Teaching Health Board's status increased from Level 3, Enhanced Monitoring to Level 4, Targeted intervention for Finance, Strategy and Planning on the 5 November 2024. Having been in Level 3 since July 2023.

During 2025/2026, we proactively identified areas requiring improvement and commissioned an external review to undertake detailed assessments in order to manage and mitigate associated risks. Further work will be undertaken in 2026/2027 to ensure implementation of recommendations arising from both internal audit and external reviews. Work will continue in 2026/2027 to

continue to embed risk management and the assurance framework across the organisation. Implementation of the Board's Annual Governance Programme will see a further maturing of the Board's effectiveness and the system of internal control in 2026/2027.

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

SIGNED BY:

DATE:

**HAYLEY THOMAS
CHIEF EXECUTIVE**

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Appendix 1: Board and Board Committee Membership - and Attendance at Board (2025-26)

Name	Position and Area of Expertise	Board and Board Committee Membership	Attendance 2025-26	Board Champion Role
Carl Cooper	Chair	Chair of the Board Chair of Board In-Committee	7/7 8/8	Speaking Up Safely
		Chair of the Charitable Funds Committee	5/5	
		Chair of the Remuneration and Terms of Service Committee	4/4	
		Finance and Performance Committee (attended to ensure a quorum)	1/1	
Ronnie Alexander	Independent Member [General]	Member of the Board Member of Board In-Committee	4/7 5/8	
		Member of the Audit, Risk and Assurance Committee	5/6	
		Chair of the Delivery and Performance Committee then Finance and Performance Committee	6/6	
		Member of Planning, Partnerships and Population Health Committee	4/4	
Rhiannon Beaumont-Wood	Vice-Chair (from 09.02.2026)	Vice Chair of the Board Vice-Chair of the Board In-Committee	1/1 1/1	
		Vice Chair of the Remuneration and Terms of Service Committee	0/1	
Steve Elliot	Independent Member [Finance]	Member of the Board Member of Board In-Committee	7/7 7/8	
		Chair of the Audit, Risk and Assurance Committee	6/6	
		Delivery and Performance Committee then Finance and Performance Committee	5/6	
		Member of the Planning, Partnerships and Population Health Committee (from May 2025)	3/3	
		Member of the Remuneration and Terms of Service Committee	4/4	
		Member of Pharmaceutical Applications Committee	1/1	
Mick Giannasi	Independent Member (Directly Appointed to 30.09.2025. Independent	Member of the Board Member of Board In-Committee	6/7 7/8	
		Member of the Delivery and Performance Committee (to May 2025)	0/1	
		Member of the Audit, Risk and Assurance Committee	2/5	

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	Member from 01.10.2025)	(from June 2025)		
		Member of the Patient Experience, Quality and Safety Committee (from June 2025)	3/3	
Rhobert Lewis	Independent Member [General]	Member of the Board Member of Board In-Committee	6/7 7/8	Innovation
		Chair of the Planning, Partnerships and Population Health Committee	3/4	Research and Development
		Member of the Delivery and Performance Committee then Finance and Performance Committee	5/6	
		Member of the Audit, Risk and Assurance Committee (from June 2025)	4/5	
		Remuneration and Terms of Service Committee (attended to ensure a quorum)	1/1	
Jennifer Owen-Adams	Independent Member [Third Sector]	Member of the Board Member of Board In-Committee	5/7 4/8	
		Member of the Patient Experience, Quality and Safety Committee	4/4	
		Chair of the People and Culture Committee	3/4	
		Member of the Planning, Partnerships and Population Health Committee	4/4	
		Member of the Remuneration and Terms of Service	2/4	
Cathie Poynton	Independent Member [Trade Union]	Member of the Board Member of Board In-Committee	5/7 5/8	
		Member of the People and Culture Committee	3/4	
		Member of the Charitable Funds Committee	5/5	
		Member of the Delivery and Performance Committee then Finance and Performance Committee	6/6	
Ian Thomas	Independent Member	Member of the Board Member of Board In-Committee	7/7 7/8	
		Member of Audit, Risk and Assurance Committee (from June 2025)	5/5	
		Member of the People and Culture Committee	4/4	
		Member of the Charitable Funds Committee	5/5	
		Member of Patient Experience, Quality and Safety Committee	3/4	

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Chris Walsh	Independent Member [Local Authority]	Member of the Board	4/7	
		Member of Board In-Committee	5/8	
		Member of People and Culture Committee	2/4	
		Member of Audit, Risk and Assurance Committee (to May 2025)	1/1	
		Member of Patient Experience, Quality and Safety Committee (from June 2026)	2/3	
		Member of Charitable Funds Committee	4/5	
Kirsty Williams	Vice Chair (to 30.09.2025)	Vice Chair of the Board	3/3	Infection Prevention and Control
		Vice-Chair of the Board In-Committee	4/4	
		Chair of the Patient Experience, Quality and Safety Committee	2/2	Armed Forces and Veterans
		Vice Chair of the Remuneration and Terms of Service Committee	2/2	
		Member of the Delivery and Performance Committee then Finance and Performance Committee	3/3	Mental Health Children and Young People
		Member of the Planning, Partnerships and Population Health Committee (attended to ensure a quorum)	1/1	
		Member of the Audit, Risk and Assurance Committee (from June 2026)	2/3	
Simon Wright	Independent Member [University]	Member of the Board	5/7	Infection Prevention and Control
		Member of Board In-Committee	5/8	
		Member of the Delivery and Performance Committee then Finance and Performance Committee (from June 2025)	3/3	Armed Forces and Veterans
		Member of People and Culture Committee	3/4	
		Vice-Chair of the Planning, Partnerships and Population Health Committee (to May 2025)	1/1	Mental Health (From 01.10.2025)
		Chair of Pharmaceutical Applications Committee	1/1	

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Hayley Thomas	Chief Executive	Board	7/7	
		Board In-Committee	8/8	
		Remuneration and Terms of Service Committee	2/4	
		Committees attended: Audit, Risk and Assurance Committee Delivery and Performance Committee then Finance and Performance Committee Patient Experience, Quality and Safety Committee People and Culture Committee Planning, Partnerships and Population Health Committee	5/6 3/6 2/4 2/4 1/4	
Mererid Bowley	Executive Director of Public Health	Board	7/7	Emergency Planning
		Board In-Committee	8/8	
Pete Hopgood	Executive Director of Finance, Estates and Support Services	Planning, Partnerships and Population Health Committee	4/4	
		Board	7/7	
		In-Committee	8/8	
		Audit, Risk and Assurance Committee	6/6	
Nicola Johnson	Deputy Chief Executive	Charitable Funds Committee	5/5	
		Delivery and Performance Committee then Finance and Performance Committee	6/6	
		Board	5/7	
		Board In-Committee	6/8	
Elaine Lorton	Executive Director of Primary, Community Care & Mental Health	Delivery and Performance Committee then Finance and Performance Committee	3/6	
		Planning, Partnerships and Population Health Committee	3/4	
		Board	7/7	
Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	Board In-Committee	8/8	
		Charitable Funds Committee	2/4	
Claire Roche	Executive Director of Nursing, Quality, Women and Family Health (to 05.10.2025)	Board	3/3	Children and Young People
		Board In-Committee	4/4	
Powell Bethan 12/05/2026 15:11:29		Patient Experience, Quality and Safety Committee	2/2	Putting Things Right

Paul Hooton	Executive Director of Nursing, Quality, Women and Family Health (from 06.10.2025)	Board Board In-Committee	4/4 4/4	Children and Young People
		Patient Experience, Quality and Safety Committee	2/2	Putting Things Right
Debra Wood-Lawson	Executive Director of People & Culture (to 15.12.2025) Executive Director of People, Culture & Transformation (from 16.12.26)	Board Member of Board In-Committee	7/7 8/8	Health and Safety and Fire Safety
		People and Culture Committee	4/4	Equality
Kate Wright	Executive Medical Director	Board Board In-Committee	7/7 8/8	Caldicott Guardian
Helen Bushell	Director of Corporate Governance / Board Secretary	Board Board In-Committee	7/7 8/8	Counter Fraud
		Charitable Funds Committee	4/4	
		Audit Risk and Assurance Committee	6/6	
		Delivery and Performance Committee then Finance and Performance Committee	4/6*	
		Patient Experience, Quality and Safety Committee	3/4*	
		Planning, Partnerships and Population Health Committee	1/4*	
		People and Culture Committee	3/4*	

*All meetings are attended by the Board Secretary or, in their absence, the Deputy Board Secretary, to ensure appropriate governance advice is provided.

Executive Director attendance is provided where the Executive Director is a Lead Officer at a Committee. Other Executive Directors or deputies attend Committee meetings as required.

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APPENDIX 3A: WELSH HEALTH CIRCULARS 2025/2026 (APRIL 25 – MARCH 26)

Welsh Health Circular	Date/Year of Adoption	Action to Demonstrate Implementation/Response	Status
2022/019 Non-Specialised Pediatric Orthopedic Services	2022	The Provider shall provide assurance that Welsh Health Guidance is being adhered to by signposting the Commissioner to relevant Provider Board reports and policy updates	Complete
2022/006 Direct Paramedic referral to same day emergency care	2022	PTHB has confirmed with Welsh Government and WAST that in the absence of Type 1 urgent care services, this action is not directly applicable to Powys. Outside of this barrier, a number of actions have been taken. Critical to this WHC is that because we do not ourselves have acute services, this is not an action for Powys. Although not relevant we have reviewed our own services and updated and enhanced some of our flow actions.	Closed
2022/022 Role of the Community Dental Service and Services for vulnerable people Powell Bethan 12/05/2026 15:11:29	2022	Expansion of salaried roles to support GDS, 1.0 WTE SDO approved and 1.) WTE band 5 dental nurse subject to successful recruitment - Recruitment of 0.2 WTE level 2 DES in special care dentistry - Increased paediatric sedation workforce by 0.2 WTE to reduce waiting times for paediatric referrals - Frailty dental nurse recruited and in post - Endodontic consultant in post - Paediatric consultant to start 1st April 2026	Complete

2023/003	2023	It has been confirmed that PTHB Community Pediatricians are using EDI guidelines in terms of assessment and first line investigations although North Powys patients' genetics go to the Birmingham lab.	Partially Complete
Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability			
2023/006	2023	Action in Progress	Partially Complete
Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020			
2024/005	2024		Partially Complete
Private obesity surgery and the Welsh NHS			
2024/002	2024	PTHB has strengthened its arrangements for Non-Medical Prescribing. The policy was formally consulted on in July 2025 and provides a clear framework. A local implementation plan is in place, developed with HEIW support, and routine engagement continues with all-Wales NMP leads to ensure consistency. All NMPs are required to maintain an up-to-date annual scope of practice, evidence of ongoing competency, and undergo regular appraisal and prescribing review in line with the policy. A centrally maintained NMP register and defined processes for approval, return-to-practice and change in scope provide organisational assurance.	Not Yet Due
Standards for Competency Assurance of Non-Medical Prescribers in Wales		These arrangements ensure that PTHB is on track to deliver full compliance by 31st March 2026.	
2024/011	2024	Some focused work is planned to be undertaken with Pediatric Dietetics in Q1/2 2026/27.	Not Yet Due
Changes to dietary advice on feeding young children aged 1-5 years			

2024/012 Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	2024	An annual rolling programme is mandated for all newly qualified nurses and is offered to all new starters in PTHB including AHP's. Attendance by our 'grow your own' staff/students has increased and is being demonstrated as beneficial f across all fields of Nursing. We await the All-Wales Preceptorship policy and workbook from the Education Leads group, based on PTHB's workbook described as an exemplary version.	Partially Complete
2024-016 Healthy Child Wales Programme for school aged children	2024	PTHB continues to participate in the national work supporting the delivery of the framework. Workforce requirements remain a challenge as there remains an absence of consensus across Wales with regards to caseload numbers. PTHB continues their development programme of supporting more nurses to become Specialist Community Public Health Nurses, School Age Children. Continue actions to increase resilience of a programme for children educated other than school.	Partially Complete
2024/024 Implementation the agreed approach to preventing Violence and Aggression towards NHS staff in Wales	2024	All actions completed	Complete
2024/035 Standardising the management of acute deterioration	2024	NEWS2 has been fully implemented in physical health inpatient wards. Training has been completed to 93% with local plans to reach 95% in place for Q4. The local policy has been reviewed for a second time with the implementation of NEWS2 across NHS Wales to ensure that the policy is aligned.	Partially Complete
2024/040	2024	Action in Progress	Partially Complete

Adopting a patient and family-initiated escalation approach			
2024/042 Introduction of the 'Dictionary of Medicine and devices	2024	PTHB will meet these requirements through procurement and implementation of the BetterMeds ePMA system, which is built natively on dm+d and therefore enforces compliance by design. The BetterMeds rollout is scheduled to commence in March 2026, with phased implementation and full completion by July 2026.	Partially Complete
2024/030 Published Weight Management Medication Pathway	2024	Weight Management Medications are now available through the Powys Living Well Service to people who meet phase 1 or 2 of the priority guidance.	Partially Complete
2024/044 Mandatory E-Learning Module – Anti-Racism	2024	E learning module is now live on ESR, and compliance is being monitored as part of our workforce performance reporting. Recommendation to close.	Complete
2025/005 Climate Emergency Leadership Day and adaption	2025	Work programme being led by Environment Team who have developed in conjunction with other health boards a common overarching Risk Register. Department-level risk assessments will sit underneath and are being completed through bespoke workshop sessions to be run across 2026 by the Environment Team.	Complete
2025/004 NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26	2025	UPDATE WILL BE ADDED PRIOR TO ANNUAL REPORT FINALISATION	No Progress
2025/002 Timelines and responsibilities for Early Warning Scores (EWS)	2025	NEWS2 has been fully implemented in physical health inpatient wards. Training has been completed to 93% with local plans to reach 95% in place for Q4. In addition, NEWS2 will be implemented in District	Partially Complete

		Nursing in Q4, training is at 90% for this area.	
2025/007 Amendments following interim review to the Model Standing Orders for Local Health Boards, NHS Trusts, and Special Health Authorities in Wales	2025	Action completed and Standing Order amendments approved at the March 2025 Board meeting.	Complete
2024/015 People's Experience Framework and People's Experience Survey	2024	A standardised People's Experience survey has been embedded as the primary mechanism for capturing feedback, with core questions and equality monitoring in place to support consistency and comparability across NHS Wales.	Partially Complete
2025/026 NHS Wales National Clinical Audit Annual Rolling Programme for 2025/26	2025	All audits are resourced appropriately.	Not Yet Due
2025/006 Recording of Mental Health Outcome Measures	2025	UPDATE WILL BE ADDED PRIOR TO ANNUAL REPORT FINALISATION	Not Yet Due
2025/010 Arrangements for the prescribing of antiviral and neutralising monoclonal antibody treatments for COVID-19.	2025	Updated national arrangements for COVID-19 therapeutics, aligning with NICE guidance. COVID-19 treatments are now managed through primary care, with nirmatrelvir/ritonavir (Paxlovid®) as first-line therapy and molnupiravir as second line where clinically appropriate. Both medicines are prescribed on WP10 and supplied via community pharmacies.	Complete
2025/011	2025	Practice processes in place, linked to contract obligations	Complete

Introduction of the NHS Wales digital health identity standard for primary care			
2025/016 Update on NHS Wales vaccination programme against respiratory syncytial virus (RSV)	2025	RSV programme implemented from September 2025 to all eligible groups.	Complete
2025/017 Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)	2025	Procedures in Powys will not be for those for which TXA is routinely indicated. It was reviewed and actioned.	Complete
2025/018 Tirzepatide (Mounjaro®) for the management of obesity and overweight	2025	Tirzepatide (Mounjaro®) is being made available in line with the relevant Welsh Health Circular and NICE guidance, recognising the approved extended implementation period. Access within PTHB is through Health Board-run Living Well Clinics, ensuring prescribing is limited to the eligible cohort of patients and delivered within a structured, multidisciplinary weight-management pathway.	Complete
2025/019 Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme from 01 July 2025	2025	Changes implemented. Immunisation Coordinator worked with Child Health team and GP practices to manage the changes.	Complete
2025/012 SFI - Changes to Public Procurement reform	2025	Action completed and SO amendments approved at the July 2025 Board meeting.	Complete
2025/021	2025	We cannot offer vaccinations at all in Sexual Health currently. The vaccination team are aware as	Complete

Introduction of routine vaccination programmes for the prevention of mpox and gonorrhoea		challenges have been highlighted aligned to the provision of Mpox vaccination. All our patients who may require any vaccination (Hep B, HPV etc.) are currently signposted out to level 3 services which is reflected in our SOP	
2025/020	2025	Central Procurement of Flu programme implemented across Powys with primary Care contractors.	Complete
The National Influenza Immunisation Programme			
2025/26			
2025/023	2025		Closed
PPE Stockpile volumes in Wales			
2025/022	2025	Covid-19 programme was delivered. Campaign ends 31 January 2026	Complete
National COVID-19 Vaccination Programme			
2025/008	2025	Powys County Council have implemented and established processes for the statutory guidance to implement and approve the Licensing Scheme for special procedures. WHC distributed to GPs as independent practitioners/businesses.	Complete
Introduction of a National Mandatory License scheme for special procedures in Wales			
2025/025	2025	Alert notification issued to all contractor professions on 11/07/26	Complete
Overseas Visitors' Eligibility to receive free Primary Care			
2025/028	2025	GP informed about expansion of programme and commenced implementation of call and recall for eligible patients from September 2025	Complete
Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49			

2025/029	2025	Action completed	Complete
Introduction of Nirsevimab passive immunisation against Respiratory Syncytial Virus (RSV) in at risk infants for upcoming 2025/26 RSV season			
2025/026	2025	Initial scoping is 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
The safe and responsible adoption of ambient voice technologies (AI Scribes') in clinical and practice settings			
2025/038	2025	National conversations are ongoing as to how to monitor compliance with the standards and contractor expectations. Local implementation will follow.	No Progress
All-Wales NHS Accessible Communication and Information Standards			
2025/034	2025	Planned Care Referrals are complete, and we are submitting the data through the switching service.	Complete
Implementation of the Planned Care Referrals DSCN			
2025/037	2025	Actions in progress.	Partially Complete
Infected Blood Enquiry, Implementation of Recommendation 7e. Implementing SHOT reports.			

2025/031 3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting	2025	Waiting Well SPOC is due to be submitted from 1st April 2026. Working through data capture processes. On Track no issues forecast.	No Progress
2025/039 AMR & HCAI IMPROVEMENT GOALS FOR 2025-2027	2025	PTHB has an established Antimicrobial Stewardship governance structure aligned to the UK National Action Plan (NAP) and Welsh Health Circular requirements. An Antimicrobial Stewardship Group is in place and meets quarterly. Regular audit and feedback cycles are embedded across primary and secondary care.	Complete
2025/043 New clinical pathway for treating and managing obesity	2025	PTHB has implemented the relevant clinical pathway for the treatment and management of obesity in line with NICE guidance and associated Welsh Health Circulars.	Complete
2025/046 The introduction of a routine NHS varicella (chickenpox) vaccination programme for young children in Wales from 1 January 2026	2025	MMRV introduced 01 January 2026	Complete
2025/049 Development and Implementation of a Patient Travel Policy	2025	WHC has been implemented and is complete	Complete
2025/051 Safety netting discharge leaflets for adults and	2025	UPDATE WILL BE ADDED PRIOR TO ANNUAL REPORT FINALISATION	No Progress

children			
2025/054 A change of Vaccine product for the routine adult pneumococcal vaccine programme, and those with certain clinical risk conditions	2025		Complete
2025/055 2026-2027 Health Board Allocation	2025	Allocation noted and being used to inform development of Financial Plan component of the Annual Plan for 2026/27	No Progress

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APPENDIX 3B: MINISTERIAL DIRECTIONS 2025-26

Ministerial Directions (MDs)	Date/Year of Adoption	Action to demonstrate implementation/response	Status
WG24-01 Wales Eye Care Services-Directions 2024	2024	NWSSP are managing this process on behalf of Health Boards.	Complete
WG24-02 The National Health Service (Wales Eye Care Services) (Wales) Directions 2024	2024	WGOS 3 - 5 pathways implemented including patient redirection from secondary care for WGOS	Complete
WG24-17 Managed Introduction of New Medicines into the NHS in Wales directions 2009 (amendment Wales Directions 2024)	2024	Formulary Working Group processes are in place to add NICE Technology Appraisals to the PTHB formulary as they are published, in line with national timescales and any approved implementation extensions.	Complete
WG24-39 The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024	2024	Action in Progress	Partially Complete
WG25-02 The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-03	2025	Financial entitlement applied as per SFE statement	Complete

The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025			
WG25-07 The Directions to Local Health Boards as to General Dental Services Statement of Financial Entitlements (Amendment No 3) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-08 The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment No 3) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-12 The Wales Infected Blood Support Scheme (Amendment) Directions 2025	2025	Only applicable to Velindre NHS Trust	Closed
WG25-17 Directions to the Local Health Boards as to the Statement of Financial Entitlements (Amendment No 2) Directions 2025	2025	Action complete	Complete
WG25-28 The Primary Medical Services (Minor Surgery) (Directed Supplementary Services) (Wales) Directions 2025	2025	All practices currently participating in old DES and LES have been served notice for PTHB to withdraw on 31/03/26. Consulting with practices for signing up to new DSS specification for implementation from 01/04/26.	Partially Complete

WG25-30 The Primary Care (Contracted Services: Immunisations) Influenza Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-33 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) No 3 Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-38 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025	2025	Financial Entitlement applied as per SFE statement	Complete
WG25-39 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025	2025	Payments implemented as part of GMS contract payment agreements.	Complete
WG25-40 The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) (Amendment) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-44 The Directions to Local Health Boards as to the General Dental Services Statement of Financial	2025	Financial entitlement applied as per SFE statement	Complete

Entitlements (Wales) (Amendment) (No.4) Directions 2025			
WG25-45 The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-56 The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) Directions 2025	2025	Not required to implement the DSS as already covered in Community Resource Team/Virtual Ward LSS. Welsh Government aware.	Complete
WG25-72 The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	2025	Patient lists prepared and Expressions of interest being sought from practices. Planned go-live date 01/02/26	Partially Complete
WG25-84 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete

WG25-85 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2026	2025	Financial entitlement applied as per SFE statement	Complete
WG25-88 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 7) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-91 The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No. 5) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete
WG25-92 The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No. 5) Directions 2025	2025	Financial entitlement applied as per SFE statement	Complete

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PART B: REMUNERATION AND STAFF REPORT 2025/26

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

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Background

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

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

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

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

In 2025/2026, the Remuneration and Terms of Services Committee was chaired by the Health Board's Chair, Carl Cooper, and the membership included the following Independent Members:

- Kirsty Williams, Vice Chair of the Board (to 30/09/2025)
- Steve Elliot, Independent Member (Finance)
- Jennifer Owen Adams, Independent Member (Third Sector)
- Rhiannon Beaumont-Wood, Vice-Chair of the Board (from 09/02/2026)

Meetings are minuted and decisions fully recorded.

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

Independent Members' Remuneration

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

Executive Directors' and Independent Members' Remuneration

Details of Directors' and Independent Members' remuneration for the 2025-26 financial year, together with comparators are given in the Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2025-26, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Chief Executive sets objectives with Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. Assurance in relation to performance is provided to the Remuneration and Terms of Service Committee. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions were set by Welsh Government as part of the NHS Reform Programme of 2009.

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Table 1: Salary and Pension Disclosure Table: Salaries and Allowances, Single Total Figure of Remuneration

Name and Title	2025-26						2024-25					
	Salary	Bonus Payments	Taxable Benefits *****	Pension Benefits	Single Total Remuneration	Other Remuneration	Salary	Bonus Payments	Taxable Benefits *****	Pension Benefits	Single Total Remuneration	Other Remuneration
	(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(to nearest £1000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(to nearest £1000)	(bands of £5,000)	(bands of £5,000)
	£000	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000
Executive Directors												
Hayley Thomas - Chief Executive *	180 - 185	0	23	53	235 - 240	0	175 - 180	0	12	54	235 - 240	0
Stephen Powell - Interim Director of Planning, Performance and Commissioning (from 17th July 2023 to 20th October 2024)	0	0	0	0	0	0	65 - 70	0	0	0	65 - 70	0
Pete Hopgood - Director of Finance, Information and IT Services and Interim Deputy Chief Executive (to 16th May 2024) and Deputy Chief Executive, Executive Director of Finance, Capital and Support Services and Interim Executive Director of Primary Care (to 29th September 2024) and Director of Finance, Capital and Support Services and Deputy Chief Executive (from 30th September 2024) * and *****	140 - 145	0	11	120	265 - 270	0	130 - 135	0	57	68	205 - 210	0

Debra Wood Lawson - Director of Workforce and OD (to 30th April 2024), Director of People and Culture (from 1st May 2024 to 15th December 2025 and Director of People, Culture and Transformation (from 15th December 2025) *, ***** and *****	130 - 135	0	16	48	180 - 185	0	120 - 125	0	12	149	270 - 275	0
Kate Wright - Medical Director	160 - 165	0	0	54	215 - 220	0	155 - 160	0	0	56	210 - 215	0
Claire Madsen - Director of Therapies and Health Sciences including Health and Safety and Support Services (to 30th April 2024) and Director of Allied Health Professions, Health Sciences and Digital (from 1st May 2024) *****	130 - 135	0	0	56	185 - 190	0	130 - 135	0	0	99	230 - 235	0
Mererid Bowley - Director of Public Health	135 - 140	0	0	49	180 - 185	0	130 - 135	0	0	64	195 - 200	0
Claire Roche - Director of Nursing and Midwifery (to 30th April 24) and Director of Nursing, Quality, Women and Family Health (from 1st May 2024 to 5th October 2025) *, ** and *****	65 - 70	0	12	0	70 - 75	0	125 - 130	0	16	100	225 - 230	0
Helen Bushell - Director of Corporate Governance and Board Secretary *	110 - 115	0	17	31	145 - 150	0	105 - 110	0	12	32	140 - 145	0
Joy Garfitt - Interim Director of Operations, Community Care and Mental Health (to 30th September 2024) *** and *****	0	0	0	0	0	0	100 - 105	0	5	0	100 - 105	0

David Farnsworth - Interim Director of Operations, Community Care and Mental Health (to 2nd June 2024) ***	0	0	0	0	0	0	20 - 25	0	0	0	20 - 25	0
Nicola Johnson - Director of Planning, Performance and Commissioning (from 7th October 2024) *****	130 - 135	0	0	149	280 - 285	0	60 - 65	0	0	50	110 - 115	0
Elaine Lorton - Director of Primary, Community Care and Mental Health (from 30th September 2024) * and *****	120 - 125	0	46	67	195 - 200	0	60 - 65	0	19	21	80 - 85	0
Paul Hooton - Director of Nursing, Quality, Women and Family Health (From 6th October 2025) * , **, ***** and *****	65 - 70	0	14	10	75 - 80	0	0	0	0	0	0	0
Associate Members												
Nina Davies – Interim Director of Social Services and Housing, Powys County Council	0	0	0	0	0	0	0	0	0	0	0	0
Chair of Healthcare Professional Forum (TBC)	0	0	0	0	0	0	0	0	0	0	0	0
Non-Officer Members												
Carl Cooper - Chair *****	45 - 50	0	0	0	45 - 50	0	40 - 45	0	0	0	40 - 45	0
Kirsty Williams - Vice Chair (To 30th September 2025)	15 - 20	0	0	0	15 - 20	0	30 - 35	0	0	0	30 - 35	0
Rhiannon Beaumont-Wood - Vice Chair (from 9th February 2026) ** and *****	5 - 10	0	0	0	5 - 10	0	0	0	0	0	0	0
Ian Phillips - Independent Member (ICT - to 22nd August 2024) *****	0	0	0	0	0	0	0 - 5	0	0	0	0 - 5	0

Cathie Poynton - Independent Member (Trade Union)	0	0	0	0	0	0	0	0	0	0	0	0
Rhobert Lewis - Independent Member (General) *****	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Ronnie Alexander - Independent Member (General) *****	5 - 10	0	3	0	5 - 10	0	5 - 10	0	2	0	5 - 10	0
Chris Walsh - Independent Member (Local Authority) *****	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Jennifer Owen Adams - Independent Member (Third Sector) *****	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Simon Wright - Independent Member (University held post relating to health) *****	5 - 10	0	3	0	5 - 10	0	5 - 10	0	7	0	10 - 15	0
Michael Giannasi - Independent Member (Capital and Estates - from 26th February 2024) **** and *****	5 - 10	0	1	0	5 - 10	0	10 - 15	0	3	0	10 - 15	0
Steve Elliot - Independent Member (Finance - from 17th April 2024) *****	5 - 10	0	3	0	5 - 10	0	5 - 10	0	5	0	5 - 10	0
Ian Thomas - Independent Member (General - from 6th January 2025) *****	5 - 10	0	2	0	5 - 10	0	0 - 5	0	0	0	0 - 5	0

* Please note that the salary for Pete Hopgood excludes £3,000 in relation to a leased car (in 2024/25 the figure was £10,000), the salary for Claire Roche excludes £4,000 in relation to a leased car (in 2024/25 the figure was £8,000), the salary for Debra Wood Lawson includes £8,000 in relation to a leased car (in 2024/25 the figure was £8,000), the salary for Joy Garfitt in 2024/25 excludes £4,000, the salary for Helen Bushell excludes £9,000 in relation to a leased car (in 2024/25 the figure was £9,000), the salary for Elaine Lorton excludes £8,000 in

relation to a leased car (in 2024/25 the figure was £4,000), the salary figure for Hayley Thomas excludes £9,000 (in 2024/25 the figure was £6,000) and the salary figure for Paul Hooton excludes £2,000.

** Please note that the full year equivalent salary banding, in bands of £5,000, for starters and leavers during 2025/26 was as follows; Claire Roche £140,000 - £145,000, Paul Hooton £135,000 - £140,000 and Rhiannon Beaumont-Wood £35,000 - £40,000

*** David Farnsworth was appointed on an interim basis to cover for Joy Garfitt during a period of absence from work

**** This includes both benefits in kind and other taxable benefits on items such as mileage claims where payments have been made above the agreed HMRC rate of £0.45 pence per mile

***** The salary figure for 2024/25 includes arrears pay of £1,000 for 2023/24

***** The salary figure includes £10,000 which was paid in 2025/26 for annual leave days not taken

"***** Pete Hopgood held the accountability for Primary Care until the 29 September 2024 when the substantive Director was appointed.

***** There was a period of handover between Claire Roche and Paul Hooton. Paul Hooton started on 29/09/2025 and Claire Roche left on 10/10/2025. Claire Roche handed over Board member responsibility to Paul Hooton as of 06/10/2025

***** The salary figure includes arrears pay of £3,000 for 2024/25

***** The salary banding includes a deduction for purchase of additional annual leave, the salary banding before this deduction was Claire Madsen £135,000 - £140,000, Debra Wood-Lawson £135,000 - £140,000, Elaine Lorton £125,000 - £130,000 and Nicola Johnson £135,000 - £140,000

***** The salary banding includes a payment of £2,000 in relation to relocation expenses

***** The salary banding includes an amount in relation to changes to remunerations rates for NHS Wales Public Appointees which were announced in April 2026 but will be implemented from 1st January 2026. The payment will be made in 2026/27

The value of pension benefits is calculated as follows: (real increase in pension* x20) + (real increase in any lump sum*) - (contributions made by member) to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes, and is based on information received from NHS BSA Pensions Agency.

The remuneration report now contains a Single Total Figure of remuneration, this is a different way of presenting the remuneration for each individual for the year. The table used is similar to that used previously, and the salary and benefits in kind elements are unchanged. The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes, and is based on information received from NHS BSA Pensions Agency.

The Single Total Figure of remuneration is not an amount which has been paid to an individual by the THB during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation’s workforce. The 2025-26 financial year is the fifth-year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

Table 2: Salary and Pension Disclosure table: Pension Benefits

	Real increase in	Real increase in pension	Total accrued pension at	Lump sum at pension age related	Cash Equivalent transfer	Cash Equivalent transfer	Real increase in Cash	Employer’s contribution to

Name and title	pension at pension age (bands of £2,500) £000	lump sum at pension age (bands of £2,500) £000	pension age at 31 Mar 2026 (bands of £5,000) £000	to accrued pension at 31 Mar 2026 (bands of £5,000) £000	value at 31 Mar 2026 £000	value at 31 Mar 2025 £000	Equivalent transfer value £000	stakeholder pension £000
Hayley Thomas *	2.5 - 5.0	0.0 - 2.5	65 - 70	155 - 160	1,426	1,326	54	0
Pete Hopgood *	5.0 - 7.5	10.0 - 12.5	60 - 65	150 - 155	1,425	1,252	133	0
Debra Wood-Lawson	2.5 - 5.0	0.0	45 - 50	0	890	808	51	0
Kate Wright *	2.5 - 5.0	0.0 - 2.5	45 - 50	100 - 105	1,073	977	60	0
Claire Madsen	2.5 - 5.0	2.5 - 5.0	55 - 60	140 - 145	1,392	1,284	69	0
Mererid Bowley *	2.5 - 5.0	0.0 - 2.5	50 - 55	120 - 125	1,159	1,068	56	0
Claire Roche*and**	0.0	0.0	45 - 50	135 - 140	0	0	0	0
Helen Bushell	0.0 - 2.5	0.0	10 - 15	0	196	160	20	0
Nicola Johnson	7.5 - 10.0	12.5 - 15.0	50 - 55	135 - 140	1,270	1,070	164	0
Elaine Lorton	2.5 - 5.0	2.5 - 5.0	35 - 40	90 - 95	852	757	66	0
Paul Hooton	0.0 - 2.5	0.0 - 2.5	20 - 25	60 - 65	535	498	13	0

* These officers are affected by the Public Service Pensions Remedy and their membership between 1st April 2015 and 31st March 2022 was moved back into the 1995/2008 Scheme on 1st October 2023. Negative values are not disclosed in this table but are substituted with a zero.

** Member claiming pension as at 31st March 2026

The above calculations are provided by the NHS Pensions Agency and are based on the standard pensionable age for the relevant pension scheme. The calculations are based upon the annual salary after the pay award for 2025/26 was granted in February 2026.

As Non officer members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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Cash Equivalent Transfer Values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff Numbers

Number of Employed Staff

As at 31 March 2026, the Health Board employed a total of 2,130.41 Whole Time Equivalents (WTE). This includes 67.27 WTE Health Care Support Workers (HCSWs) participating in the Aspiring Nurse programme, of which 40.63 WTE are undertaking training and 26.64 WTE are deployed within ward and community settings.

The table below sets out the WTE staff employed by the Health Board in 2024/25 and 2025/26, analysed by staff group. This excludes the hosted service, Health and Care Research Wales.

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Staff Group	2024/25	2025/26
Add Prof Scientific and Technic	83.21	96.64
Additional Clinical Services	431.13	449.16
Administrative and Clerical	576.84	568.50
Allied Health Professionals	162.24	173.06
Estates and Ancillary	165.81	162.99
Healthcare Scientists	10.21	10.21
Medical and Dental	39.55	38.29
Nursing and Midwifery Registered	595.15	629.56
Students	1	2.00
Grand Total	2065.15	2130.41

Overall, the Health Board recorded an increase of 65.26 WTE staff during 2025/26 compared to 2024/25.

Despite this growth, recruitment to certain clinical roles remains challenging, resulting in continued reliance on variable pay.

There has, however, been a positive increase of 34.41 WTE in Registered Nurse staffing. This has contributed to a reduction in ward-based Registered Nurse vacancy levels, with the overall vacancy rate (excluding absence) decreasing from 19% at March 2025 to 14% at March 2026.

The Health Board has also continued to develop the Aspiring Nurse programme to support the development of an internal workforce pipeline and address workforce deficits. (The reported vacancy rates exclude Aspiring Nurses.)

Staffing composition

As of 31 March 2026, the Health Board employed 2,569 substantive employees (excluding bank workers) which equated to 2130.41 WTE. The number (headcount) of female and male employees of the Health Board are as follows:

	Female	Male
Headcount	2,172	397
Percentage	84%	16%

Of this staffing composition, at 31 March 2026, the Executive Team consisted of ten members of the Board (inclusive of the Chief Executive Officer).

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

composition below:

	Female	Male
Headcount	9	2
Percentage	90%	10%

Sickness Absence Data

Information on sickness absence for 2024/2025 and 2025/2026 is provided within the table below:

Staff Group	2024/25	2025/26
WTE Days Lost Long Term	28,817.04	32,119.69
WTE Days Lost Short Term	10,689.17	9,825.11
Total WTE DaysLost	39,506.21	41,944.79
Total Staff Years (AVG WTE Staff Absent)	108.24	114.19
Average Working DaysLost	19.32	21.45
Total Staff Employed in Period (Headcount)	2,445	2,578
Total Staff Employed in Period with no Absence (Headcount)	951	1058
Percentage of Staff with no Sick Leave	39%	41%

The Health Board’s overall rolling sickness absence rate for 2025/26 was 5.44% compared to 5.29% in 2024/25.

Staff Policies

Powys Teaching Health Board maintains a comprehensive framework of workforce policies which are developed, reviewed and agreed in partnership with recognised Trade Union representatives.

The Health Board is committed to ensuring that its employment practices are fair, inclusive and compliant with the Equality Act 2010 and the Public Sector Equality Duty. Equality Impact Assessments are undertaken, as appropriate, in the development and review of policies to ensure that potential impacts on individuals with protected characteristics are identified and addressed.

- The Health Board has arrangements in place to:
- Ensure fair and equitable consideration of applications for employment from disabled persons.
 - Support employees who become disabled during their employment, including through reasonable adjustments and access to training and development.
 - Promote equality of opportunity in training, career development, and progression.

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Relevant All Wales policies, including those relating to recruitment and attendance management, support these arrangements and ensure a consistent and equitable approach to employment practices across the Health Board.

Other Employee Matters

Health and Safety Sub-Committee

Governance Development

During 2025/26, the Health Board strengthened its governance arrangements through the transition from the former Health and Safety Group to a formal Health and Safety Committee, established as a sub-committee of the Executive Team and chaired by the Chief Executive.

This change has enhanced:

- Clarity of roles, responsibilities and accountabilities;
- Executive oversight and leadership of health and safety;
- The robustness of assurance, reporting and escalation arrangements;
- Alignment with statutory requirements and NHS Wales governance expectations.

The establishment of the Committee has supported a more structured and consistent approach to the management of health and safety risks, strengthening internal controls and providing improved assurance to the Executive Team and Board.

Purpose

The Committee's primary role is to provide strategic oversight and assurance that:

- Appropriate systems are in place to manage health and safety risks;
- Statutory and regulatory requirements are met;
- Organisational arrangements support a positive and effective health and safety culture.

Key Areas of Oversight

The Committee's work is focused on providing assurance in relation to:

- Risk Management and Control - Oversight of key health and safety risks and the effectiveness of mitigation and control measures;
- Performance and Assurance - Monitoring of organisational performance through established indicators, including incident reporting, compliance, and audit activity;
- Workforce Capability - Assurance regarding training, competence, and the development of a positive safety culture;
- Policies and Systems - Approval and oversight of health and safety policies and supporting frameworks;
- Organisational Learning - Scrutiny of incident reporting, investigation,

and the embedding of learning across the organisation.

The Committee receives regular reports from directorates and specialist safety groups to support this assurance role.

Assurance and Effectiveness

The Committee operates within a defined governance framework and reporting structure, enabling effective oversight and escalation of risks where required.

There was no enforcement action from the Health and Safety Executive during the reporting period.

Future Focus

The Committee will continue to:

- Strengthen assurance arrangements and reporting;
- Support continuous improvement in risk management and organisational learning;

Embed a proactive and positive health and safety across the Health Board.

Expenditure on Consultancy

As disclosed in note 3.3 (page 30) of its financial statements, the Health Board spent £1.486M on consultancy services during 2025/26 compared to £0.479M in 2024/25.

Off Payroll Engagement

For all off-payroll engagements as of 31 March 2026, for more than **£245** per day:

	Number
No. of existing engagements as of 31 March 2026	3
Of which, the number that have existed:	0
for less than one year at time of reporting.	0
for between one and two years at time of reporting.	0
for between two and three years at time of reporting.	0
for between three and four years at time of reporting.	0
for four or more years at time of reporting.	3

	Number
Number. of new engagements, between 1 April 2025 and 31 March 2026	0
Of which...	
No. assessed as caught by IR 35	0

<i>No. assessed as not caught by IR 35</i>	<5
<i>No. engaged directly (via PSC contracted to department) and are on the departmental payroll.</i>	0
<i>No. of engagements reassessed for consistency / assurance purposes during the year</i>	0
<i>No. of engagements that saw a change to IR35 status following the consistency review</i>	0

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

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

There have been no-off payroll engagements of Board Members and/or senior officials with significant financial responsibility between 1 April 2025 and 31 March 2026.

Exit Packages and Severance Payments

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

Exit packages cost band (including any special payment element)				
Exit package Cost band	Number of compulsory redundancies (Whole numbers only)	Number of other departures (Whole numbers only)	Total number of exit packages (Whole numbers only)	Number of departures where special payments have been made (Whole numbers only)
less than £10,000	1	0	0	0
£10,000 to £25,000	0	0	0	0
£25,000 to £50,000	1	0	0	0

£50,000 to £100,000	0	0	0	0
£100,000 to £150,000	0	0	0	0
£150,000 to £200,000	0	0	0	0
more than £200,000	0	0	0	0
Total	2	0	0	0

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

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

Regularity of Expenditure

Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority, and the rules of Government Accounting. The Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation

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Fees and Charges

Where the Health Board undertakes activities that are not funded directly by the Welsh Government, the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 of the Annual Accounts. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

Compliance with Cost Allocation and Charging Requirements

Where the Health Board undertakes activities that are not funded directly by Welsh Government, the Health Board receives income to cover its costs, which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 of the Annual Accounts. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

Remote Contingent Liabilities

Remote contingent liabilities are made for three categories, comprising indemnities, letters of comfort and guarantees. The value of remote contingent liabilities for 2025-26 is £0.089m (2024-25 £0.110m) and is disclosed in note 21.2 of the Health Board's Annual Accounts.

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

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

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.1bi

Audit Risk and Assurance Committee		12 May 2026
Subject:	Draft Annual Accounts 2025-26	
Approved and presented by:	Executive Director of Finance, Capital Estates and Support Services	
Prepared by:	Assistant Director of Finance (Accounts and Services)	
Other Committees and meetings considered at:	None	
PURPOSE:		
The purpose of this paper is to provide the Audit, Risk & Assurance Committee with the draft Annual Accounts 2025-26		
RECOMMENDATION(S):		
The Audit Committee is asked to: - - to RECEIVE and NOTE the contents of the Annual Accounts; - to NOTE the accounts will be subject to a statutory audit by Audit Wales (External Audit) NOTE that following the audit process the audit accounts will return to ARAC at its meeting on 23rd June 2026 for further consideration and onward recommendation to the Board for signature of the Financial Accounts for year ended 31st March 2026		
Approve/Take Assurance	Discuss	Note
N	N	Y

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The Teaching Health Board (THB) was required to submit a draft unaudited set of annual accounts to the Welsh Government (WG) and Audit Wales by 1st May 2026. Audit Wales will undertake the statutory audit of the annual accounts.

The THB is required to submit an audited set of annual accounts to the Welsh Government by 30th June 2026. The final audited accounts are required to be approved by the Audit Risk and Assurance Committee and the THB Board; this is scheduled to take place on 23rd June 2026 for the ARAC and 24th June 2026 for the Board meeting. The Accounts will then be signed by the Auditor General for Wales prior to the 30th June 2026.

Financial targets and statutory duties

The THB has achieved/not achieved the following financial targets and statutory duties for 2025/26:

- Operational in-year financial balance has NOT been achieved, reporting a deficit of £33.275M (Achievement of Operational Financial Balance, Note 2.1 page 27).
- Cash contained within cash limit (Statement of Cash Flows, page 7) – Achieved.
- Capital financial balance (Note 2.2. page 27) – Achieved.

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

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

- The THB performance at 91.8% did not meet the administrative target of payment of 95% of the number of non-NHS creditors within 30 days this year. (Note 2.4 page 28).

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The THB has met the target dates for preparing and submitting the draft annual accounts to Welsh Government and Audit Wales by 1st May 2026.

The THB is currently on course to meet the target date to submit the audited accounts to be submitted to Welsh Government by the final submission date of 30th June 2026.

NEXT STEPS:

- Audit Wales to undertake statutory Audit of Annual Accounts
- Outcome of Audit work to be published in an ISA 260 Report to be provided to Audit Risk and Assurance Committee for its meeting on 23rd June 2026
- Board and Auditor General for Wales approval of the accounts prior to submission deadline to Welsh Government of 30th June 2026

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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POWYS TEACHING HEALTH BOARD

FOREWORD

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

Statutory background

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

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

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

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

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

Performance Management and Financial Results

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

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

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

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

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Statement of Comprehensive Net Expenditure
for the year ended 31 March 2026

	Note	2025-26 £000	2024-25 £000
Expenditure on Primary Healthcare Services	3.1	85,478	83,495
Expenditure on healthcare from other providers	3.2	266,566	246,036
Expenditure on Hospital and Community Health Services	3.3	171,197	151,717
		523,241	481,248
Less: Miscellaneous Income	4	(19,174)	(16,909)
LHB net operating costs before interest and other gains and losses		504,067	464,339
Investment Revenue	5	0	0
Other (Gains) / Losses	6	(10)	(9)
Finance costs	7	64	54
Net operating costs for the financial year		504,121	464,384

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

The notes on pages 8 to 75 form part of these accounts.

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Other Comprehensive Net Expenditure

	2025-26 £000	2024-25 £000
Net (gain) / loss on revaluation of property, plant and equipment	(7,518)	(1,206)
Net (gain)/loss on revaluation of right of use assets	0	0
Net (gain) / loss on revaluation of intangible assets	0	0
Net (gain) loss on revaluation of financial assets	0	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	0	0
Net (gain)/loss on revaluation of financial assets held for sale	0	0
Impairment and reversals	0	0
(Gain)/Loss on other reserve movements	0	0
Transfers between reserves	0	0
Release of reserves to SoCNE	0	0
Transfers (to) / from other NHS Wales bodies	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Other comprehensive net expenditure for the year	(7,518)	(1,206)
Total comprehensive net expenditure for the year	496,603	463,178

The notes on pages 8 to 75 form part of these accounts.

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Statement of Financial Position as at 31 March 2026

		31 March 2026 £000	31 March 2025 £000
	Notes		
Non-current assets			
Property, plant and equipment	11	109,628	109,189
Right of Use Assets	11.3	1,427	1,515
Intangible assets	12	227	154
Trade and other receivables	15	79	196
Other financial assets	16	0	0
Total non-current assets		111,361	111,054
Current assets			
Inventories	14	175	197
Trade and other receivables	15	9,021	10,991
Other financial assets	16	0	0
Cash and cash equivalents	17	846	629
		10,042	11,817
Non-current assets classified as "Held for Sale"	11	0	0
Total current assets		10,042	11,817
Total assets		121,403	122,871
Current liabilities			
Trade and other payables	18	(46,991)	(50,135)
Other financial liabilities	19	0	0
Provisions	20	(2,898)	(3,803)
Total current liabilities		(49,889)	(53,938)
Net current assets/ (liabilities)		(39,847)	(42,121)
Non-current liabilities			
Trade and other payables	18	(587)	(720)
Other financial liabilities	19	0	0
Provisions	20	(645)	(803)
Total non-current liabilities		(1,232)	(1,523)
Total assets employed		70,282	67,410
Financed by :			
Taxpayers' equity			
General Fund		12,156	16,781
Revaluation reserve		58,126	50,629
Total taxpayers' equity		70,282	67,410

The financial statements on pages 2 to 7 were approved by the Board on xx 2026 and signed on its behalf by:

Chief Executive and Accountable Officer Date: xx xx 2026

The notes on pages 8 to 75 form part of these accounts.

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Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2026

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2025-26			
Balance as at 31 March 2025	16,781	50,629	67,410
NHS Wales Transfer	0	0	0
RoU Asset Transitioning Adjustment	0	0	0
Impact of IFRS 16 on PPP/PFI Liability	0	0	0
Balance at 1 April 2025	16,781	50,629	67,410
Net operating cost for the year	(504,121)		(504,121)
Net gain/(loss) on revaluation of property, plant and equipment	0	7,518	7,518
Net gain/(loss) on revaluation of right of use assets	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale	0	0	0
Net gain/(loss) on revaluation of financial assets held for sale	0	0	0
Impairments and reversals	0	0	0
Net gain/(loss) on other reserve movements	0	0	0
Transfers between reserves	21	(21)	0
Release of reserves to SoCNE	0	0	0
Transfers (to) / from other NHS Wales bodies	145	0	145
Reclassification adjustment on disposal of available for sale financial assets	0	0	0
Total recognised income and expense for 2025-26	(503,955)	7,497	(496,458)
Net Welsh Government funding	491,071		491,071
Notional Welsh Government Funding	8,259		8,259
Balance at 31 March 2026	12,156	58,126	70,282

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

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £8.254m
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £0.005m

The notes on pages 8 to 75 form part of these accounts.

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Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2025

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

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

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1st April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply.

However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £7.579M

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

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The notes on pages 8 to 75 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2026

		2025-26	2024-25
		£000	£000
Cash Flows from operating activities	Notes		
Net operating cost for the financial year		(504,121)	(464,384)
Movements in Working Capital	27	3,313	(888)
Other cash flow adjustments	28	26,401	15,481
Provisions utilised	20	(2,727)	(1,851)
Net cash outflow from operating activities		(477,134)	(451,642)
Cash Flows from investing activities			
Purchase of property, plant and equipment		(13,043)	(10,514)
Proceeds from disposal of property, plant and equipment		16	15
Purchase of intangible assets		(232)	0
Proceeds from disposal of intangible assets		0	0
Payment for other financial assets		0	0
Proceeds from disposal of other financial assets		0	0
Payment for other assets		0	0
Proceeds from disposal of other assets		0	0
Net cash inflow/(outflow) from investing activities		(13,259)	(10,499)
Net cash inflow/(outflow) before financing		(490,393)	(462,141)
Cash Flows from financing activities			
Welsh Government funding (including capital)		491,071	462,906
Capital receipts surrendered		0	0
Capital grants received		0	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		0	0
Capital element of payments in respect of on-SoFP PFI		0	0
Capital element of payments in respect of Right of Use Assets		(461)	(351)
Cash transferred (to)/ from other NHS bodies		0	0
Net financing		490,610	462,555
Net increase/(decrease) in cash and cash equivalents		217	414
Cash and cash equivalents (and bank overdrafts) at 1 April 2025		629	215
Cash and cash equivalents (and bank overdrafts) at 31 March 2026		846	629

The notes on pages 8 to 75 form part of these accounts.

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Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHBs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2025-26 Manual for Accounts. The accounting policies contained in that manual follow the 2025-26 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

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

1.1. Accounting convention

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

1.2. Acquisitions and discontinued operations

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

1.3. Income and funding

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

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

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

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

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

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

1.4. Employee benefits

1.4.1. Short-term employee benefits

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

1.4.2. Retirement benefit costs

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

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1st April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

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

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

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

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1.4.3. NEST Pension Scheme

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

1.5. Other expenses

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

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

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

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

1.6.2. Valuation

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

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

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

- Specialised buildings – depreciated replacement cost

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

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

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

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

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

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

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

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

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

1.6.3. Subsequent expenditure

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

1.7. Intangible assets

1.7.1. Recognition

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

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

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

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1.7.2 Measurement

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

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

1.8. Depreciation, amortisation and impairments

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

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

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

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

1.9. Research and Development

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

1.10 Non-current assets held for sale

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

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

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

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

1.11 Leases

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

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

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

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

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

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

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

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

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

These include:

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

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

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

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

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

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

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

1.11.1 xx LHB as lessee

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

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

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

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

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

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

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

1.11.2 xx LHB as lessor

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

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

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

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

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

1.12. Inventories

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

1.13. Cash and cash equivalents

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

1.14. Provisions

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

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

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

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

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2024-25 and 2025-26. The WRPS is hosted by Velindre University NHS Trust.

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

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

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

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

1.15. Financial Instruments

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

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

1.16. Financial assets

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

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

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

1.16.1. Financial assets are initially recognised at fair value

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

1.16.2. Financial assets at fair value through SoCNE

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

1.16.3 Held to maturity investments

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

1.16.4. Available for sale financial assets

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

1.16.5. Loans and receivables

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

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

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

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

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

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

1.17. Financial liabilities

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

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

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

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

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

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

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

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

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

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

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

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

1.22. Pooled budgets

The NHS Wales organisation has/has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

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

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

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

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

1.24. Key sources of estimation uncertainty

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

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

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

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

1.24.1. Provisions

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

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

1.24.2. Probable & Certain Cases – Accounting Treatment

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

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

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

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

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

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

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1.25 Discount Rates

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

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1.26 Private Finance Initiative (PFI) transactions

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

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

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

1.26.1. Services received

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

1.26.2. PFI asset

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

1.26.3. PFI liability

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

Prior year treatment

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

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

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

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

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

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

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

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

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

The liability does not include estimated future indexation linked increases.

1.26.5. Lifecycle replacement

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

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

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

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

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

1.26.7. Other assets contributed by the LHB to the operator

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

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

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

1.27. Contingencies

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

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

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

1.28. Absorption accounting

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

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

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

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

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

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

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

1.30. Accounting standards issued that have been adopted early

During 2025-26 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

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1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the xxx University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Powys Teaching LHB NHS Charitable Fund as a subsidiary. The determination of control is an accounting standard test of control and there has been no change to the operation of the Powys Teaching LHB NHS Charitable Fund or its independence in its management of charitable funds.

Whilst there is a requirement to consolidate the results of the xxx University LHB NHS Charitable Fund within the statutory accounts of the LHB. The LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate.

Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

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

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2. Financial Duties Performance

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

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

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

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

2.1 Revenue Resource Performance

Annual financial performance

	2023-24	2024-25	2025-26	Total
	£000	£000	£000	£000
Net operating costs for the year	429,823	464,384	504,121	1,398,328
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,859	1,833	1,227	4,919
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0
Less any non funded revenue consequences of IFRS 16	0	0	0	0
Total operating expenses	431,682	466,217	505,348	1,403,247
Revenue Resource Allocation	419,699	450,464	472,073	1,342,236
Under /(over) spend against Allocation	(11,983)	(15,753)	(33,275)	(61,011)

Powys Teaching Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2023-24 to 2025-26.

The Health Board received £30m cash-only support from Welsh Government during 2025-26 with the accumulated cash-only support as at 31st March 2026 being £50.850m. This support has been provided by Welsh Government to assist the Health Board with making payments to staff and suppliers; there is no requirement for this funding to be repaid.

2.2 Capital Resource Performance

	2023-24	2024-25	2025-26	Total
	£000	£000	£000	£000
Gross capital expenditure	6,650	14,608	8,933	30,191
Add: Losses on disposal of donated assets	0	0	0	0
Less NBV on disposal of property, plant and equipment, right of use and intangible assets	0	0	0	0
Adjustment for transfers (to)/from NHS Trusts	0	0	0	0
Less capital grants received	0	0	0	0
Less donations received	(195)	(141)	(614)	(950)
Less IFRS16 Peppercorn income	0	0	0	0
Less initial recognition of RoU Asset Dilapidations	0	0	0	0
Charge against Capital Resource Allocation	6,455	14,467	8,319	29,241
Capital Resource Allocation	6,481	14,517	8,393	29,391
(Over) / Underspend against Capital Resource Allocation	26	50	74	150

Powys Teaching Health Board has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2023-24 to 2025-26.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2025-2028 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB did not submit an Integrated Medium Term Plan for the period 2025-2028 in accordance with section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and the NHS Wales Planning Framework.

Powys Teaching Health Board submitted an Annual Plan for 2025/26.

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

The Minister for Health and Social Services extant approval

Status	
Date	Not Approved

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

2.4 Creditor payment

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

	2025-26	2024-25
Total number of non-NHS bills paid	46,098	52,868
Total number of non-NHS bills paid within target	42,306	49,586
Percentage of non-NHS bills paid within target	91.8%	93.8%

The LHB has not met the target.

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3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2025-26 Total £000	2024-25 Total £000
General Medical Services	45,887		45,887	44,737
Pharmaceutical Services	5,809	(3,020)	2,789	2,330
General Dental Services	9,402		9,402	9,307
General Ophthalmic Services	943	1,793	2,736	2,331
Other Primary Health Care expenditure	2,193		2,193	1,894
Prescribed drugs and appliances	22,471		22,471	22,896
Total	86,705	(1,227)	85,478	83,495

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

Included within other notes to the accounts

Additional Primary Care Expenditure	Positive	0	0
Additional Primary Care Income	Negative	(1,212)	(1,202)
Overall total		84,266	82,293

1. The negative non cash limited balance on Pharmaceutical services relate to prescriptions for Powys residents being dispensed in non Powys pharmacies. The effect of this is a net outflow for Powys LHB.

3.2 Expenditure on healthcare from other providers

	2025-26 £000	2024-25 £000
Goods and services from other NHS Wales Health Boards	53,895	50,483
Goods and services from other NHS Wales Trusts	3,931	3,284
Goods and services from Welsh Special Health Authorities	1,338	1,235
Goods and services from other non Welsh NHS bodies	86,623	82,084
Goods and services from NHSW JCC	62,648	58,939
Local Authorities	2,244	3,067
Voluntary organisations	2,027	1,901
NHS Funded Nursing Care	2,876	2,782
Continuing Care	38,813	33,047
Private providers	6,859	4,868
Specific projects funded by the Welsh Government	0	0
Other	5,312	4,346
Total	266,566	246,036

From 1st April 2024, the 7 Health Boards in Wales have established the NHS Wales Joint Commissioning Committee (NWJCC) which is hosted by Cwm Taf Morgannwg University Health Board, secures the provision of highly specialised healthcare and commissions ambulance services. These arrangements include funding of services operated through a risk sharing arrangement. The LHB payment for the NWJCC commissioning arrangements for the year ended 31st March 2026 is £62.648m (2024/25: £58.939m).

The increase in goods and services from other non Welsh NHS bodies results from increased costs for contracts with English NHS providers. The most significant increases are Wye Valley NHS Trust £4.162m, Shrewsbury and Telford NHS Foundation NHS Trust £1.251m and offset by a decrease with Robert Jones and Agnes Hunt Orthopaedic Hospital £0.925m in comparison to 2024/25 expenditure.

The decrease in Local Authorities expenditure during 2025/26 is mainly in relation to pass through of funding in respect of 50 Day Winter Challenge in 2024/25 funded by Welsh Government where equivalent funding was not provided during 25/26 together with a S33 pooled budget for reablement ceasing at 31st March 2025.

The increase in Continuing Health Care expenditure during 2025/26 has resulted from an increase in the number of cases compared to 2024/25.

The increase in Private Providers is due to the lack of capacity within NHS settings for more complex needs placements. The THB has seen increasing demand in this area in comparison to 24/25.

Other Expenditure includes Regional Integration Fund expenditure of £6.854M (2024/25: £6.712M) which aims to drive and enable integrated and collaborative working between social services, health, housing, the third and independent sectors to support underpinning principles of integration and prevention.

Other Expenditure also includes a negative balance which relates to the write back of liabilities from the Statement of Financial Position that have been assessed as no longer payable, which relate to previous years.

3.3 Expenditure on Hospital and Community Health Services

	2025-26	2024-25
	£000	£000
Directors' costs	1,756	1,876
Operational Staff costs	136,235	126,749
Single lead employer Staff Trainee Cost	0	0
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	6,018	6,290
Supplies and services - general	1,845	1,680
Consultancy Services	1,486	479
Establishment	2,276	2,128
Transport	820	867
Premises	6,085	6,988
External Contractors	0	0
Depreciation	6,031	4,979
Depreciation Right of Use assets (RoU)	474	363
Amortisation	5	0
Fixed asset impairments and reversals (Property, plant & equipment)	10,048	706
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	341	326
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	692	188
Research and Development	0	0
Expense related to short-term leases	0	0
Expense related to low-value asset leases (excluding short-term leases)	0	0
Other operating expenses	(2,915)	(1,902)
Total	171,197	151,717

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

	2025-26	2024-25
	£000	£000
Increase/(decrease) in provision for future payments:		
Clinical negligence;		
Secondary care	531	619
Primary care	(2,190)	75
Redress Secondary Care	81	50
Redress Primary Care	0	0
Personal injury	1,652	950
All other losses and special payments	450	1
Defence legal fees and other administrative costs	264	99
Gross increase/(decrease) in provision for future payments	788	1,794
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	146	(1)
Less: income received/due from Welsh Risk Pool	(242)	(1,605)
Total	692	188

	2025-26	2024-25
	£	£
Permanent injury included within personal injury £:	24,017	103,987

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4. Miscellaneous Income

	2025-26 £000	2024-25 £000
Local Health Boards	2,697	2,172
NHSW Joint Commissioning Committee	65	56
NHS Wales trusts	1,290	1,053
Welsh Special Health Authorities	3,881	988
Foundation Trusts	0	0
Other NHS England bodies	785	1,020
Other NHS Bodies	0	0
Local authorities	0	0
Welsh Government	5,345	6,131
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	1,212	1,202
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	26	42
Other income from activities	1,508	1,533
Patient transport services	0	0
Education, training and research	176	437
Charitable and other contributions to expenditure	0	0
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	614	105
Receipt of Government granted assets	0	36
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care income generation schemes	0	0
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	285	75
Right of Use Asset Sub-leasing rental income	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	111	69
Other income:		
Provision of laundry, pathology, payroll services	0	0
Accommodation and catering charges	240	203
Mortuary fees	0	0
Staff payments for use of cars	0	0
Business Unit	0	0
Scheme Pays Reimbursement Notional	0	24
Other	939	1,763
Total	19,174	16,909

The increase in income from Welsh Special Health Authorities relates to increased income in respect of digital funding from Digital Health Care Wales and Education and Training funding from Health Education Improvement Wales in comparison to 24/25

Welsh Government miscellaneous income includes funding received on behalf of the hosted function of Health and Care Research Wales within the THB. This has increased to £5.099m from an amount of £4.777M received in 24/25.

The Receipt of Donated and Government Grant Assets of £0.614m (2024/25: £0.141m) relates to contributions from Charitable Organisations and Welsh Government Energy Service to capital schemes and equipment. This is further detailed in Note 11.

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5. Investment Revenue

	2025-26 £000	2024-25 £000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	0	0

6. Other gains and losses

	2025-26 £000	2024-25 £000
Gain/(loss) on disposal of property, plant and equipment	10	9
Gain/(loss) on disposal other than by sale of right of use assets	0	0
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	10	9

7. Finance costs

	2025-26 £000	2024-25 £000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	49	40
Interest on obligations under PFI contracts;		
main finance cost	0	0
contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	49	40
Provisions unwinding of discount	15	14
Other finance costs	0	0
Total	64	54

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

LHB as lessee

As at 31st March 2026 the Health Board had 25 leases agreements in place; 12 arrangements in respect of vehicles as Lessee and 13 arrangements in respect of property as Lessor

	2025-26	2025-26	2025-26	2024-25
	Low Value & Short Term	Other	Total	Total
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	24	0	24	51
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	24	0	24	51
Total future minimum lease payments				
Payable	£000	£000	£000	£000
Not later than one year	30	0	30	56
Between one and five years	11	0	11	65
After 5 years	0	0	0	0
Total	41	0	41	121

LHB as lessor

	2025-26	2024-25
	£000	£000
Rental revenue		
Rent	26	55
Contingent rents	0	0
Total revenue rental	26	55
Total future minimum lease payments		
Receivable	£000	£000
Not later than one year	26	55
Between one and five years	39	39
After 5 years	14	17
Total	79	110

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9. Employee benefits and staff numbers

9.1 Employee costs	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	96,700	642	8,006	0	0	0	105,348	102,690
Social security costs	11,761	0	0	0	0	0	11,761	8,428
Employer contributions to NHS Pension Scheme	20,882	0	0	0	0	0	20,882	19,174
Other pension costs	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	129,343	642	8,006	0	0	0	137,991	130,292
Charged to capital							512	442
Charged to revenue							137,479	129,850
							137,991	130,292
Net movement in accrued employee benefits (untaken staff leave)							0	0

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	648	6	0	0	0	0	654	651
Medical and dental	40	1	10	0	0	0	51	49
Nursing, midwifery registered	623	2	20	0	0	0	645	633
Professional, Scientific, and technical staff	93	0	4	0	0	0	97	87
Additional Clinical Services	440	0	13	0	0	0	453	453
Allied Health Professions	166	0	11	0	0	0	177	166
Healthcare Scientists	10	0	1	0	0	0	11	12
Estates and Ancillary	166	0	0	0	0	0	166	167
Students	3	0	0	0	0	0	3	1
Total	2,189	9	59	0	0	0	2,257	2,219

9.3. Retirements due to ill-health

	2025-26	2024-25
Number	9	6
Estimated additional pension costs £	725,871	726,940

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

9.4 Employee benefits

The Teaching Health Board does not have an employee benefit scheme

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9.5 Reporting of other compensation schemes - exit packages

9.5.1 Exit Packages Costs and Numbers

	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Number of departures where special payments have been made	Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	1	0	1	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	1	0	1	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	2	0	2	0	1

	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages
	£	£	£	£	£
less than £10,000	6,982	0	6,982	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	31,555	0	31,555	0	42,882
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	38,537	0	38,537	0	42,882

Total Exit Costs Paid in Year	Total paid in year	Total paid in year
	2025-26	2024-25
	£	£
Exit costs paid in year	81,418	0
Total	81,418	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

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9.5 Reporting of other compensation schemes - exit packages continued

9.5.2 Analysis of other departures	2025-26	2025-26
	Agreements	Total value of
Type of other departures	Number	agreements
		£
Voluntary redundancies including early retirement contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring Welsh Government Approval**	0	0
Other please specify	0	0
Total	0	0

There have been no other exit packages agree in year.

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9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

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

Total Pay and benefits	£'000			£'000		
Chief Executive Total pay and benefits range	190 - 195			185 - 190		
Highest paid Director Total pay and benefits range	190 - 195			185 - 190		
	2025-26 £	2025-26 £	2025-26	2024-25 £	2024-25 £	2024-25
	Chief Executive	Employee	Ratio	Chief Executive	Employee	Ratio
Total pay and benefits mid-point						
25th percentile pay ratio	192	30	6.5:1	187	28	6.7:1
Median pay	192	39	5.0:1	187	37	5.1:1
75th percentile pay ratio	192	50	3.9:1	187	49	3.8:1
Salary component of total pay and benefits						
25th percentile pay ratio	192	30		187	28	
Median pay	192	39		187	37	
75th percentile pay ratio	192	50		187	49	
	Highest Paid Director	Employee	Ratio	Highest Paid Director	Employee	Ratio
Total pay and benefits mid-point						
25th percentile pay ratio	192	30	6.5:1	187	28	6.7:1
Median pay	192	39	5.0:1	187	37	5.1:1
75th percentile pay ratio	192	50	3.9:1	187	49	3.8:1
Salary component of total pay and benefits						
25th percentile pay ratio	192	30		187	28	
Median pay	192	39		187	37	
75th percentile pay ratio	192	50		187	49	

In 2025-26, 5 (2024-25, 6) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £24,833 to £210,813 (2024-25, £23,970 to £221,386).

The all staff range includes directors with the exception of the highest paid CEO Director as appropriate and excludes the non-executive directors and excludes pension benefits of all employees

Financial Year Summary

There has been an increase in year in the median remuneration of the workforce, which was mainly the result of all staff receiving a 3.6% consolidated pay uplift in year. There has been a decrease in the pay ratio which is attributable to the increase in the chief executive / highest paid director salary being less than the increase in the employee median salary. The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes

	2024-25 to 2025-26	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	3	6
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	3	6
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	5	2
Performance pay and bonuses	0	0

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9.7 Pension costs

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

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

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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c) National Employment Savings Trust (NEST)

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

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

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

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

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2025-26 tax year (2024-25 £6,240 and £50,270).

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

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10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

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

	2025-26	2025-26	2024-25	2024-25
NHS	Number	£000	Number	£000
Total bills paid	2,797	211,051	2,023	201,408
Total bills paid within target	2,356	198,527	1,527	191,401
Percentage of bills paid within target	84.2%	94.1%	75.5%	95.0%
Non-NHS				
Total bills paid	46,098	142,047	52,868	126,874
Total bills paid within target	42,306	113,977	49,586	118,081
Percentage of bills paid within target	91.8%	80.2%	93.8%	93.1%
Total				
Total bills paid	48,895	353,098	54,891	328,282
Total bills paid within target	44,662	312,504	51,113	309,482
Percentage of bills paid within target	91.3%	88.5%	93.1%	94.3%

The Teaching Health Board performance at 91.8% has not met the administrative target of payment 95% of the number of non-nhs creditors paid within 30 days nor did it in 2024/25

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

	2025-26	2024-25
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

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11.1 Property, plant and equipment

2025-26

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	12,765	86,022	1,628	10,347	9,478	498	6,007	0	126,745
Indexation	402	7,921	202	0	0	0	0	0	8,525
Additions									
- purchased	0	2,823	44	3,288	594	0	1,492	0	8,241
- donated	0	433	0	0	181	0	0	0	614
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	(36)	181	0	0	145
Reclassifications	0	8,750	0	(8,750)	0	0	0	0	0
Revaluations	61	(4,256)	0	0	0	0	0	0	(4,195)
Reversal of impairments	1	2,740	0	0	0	0	0	0	2,741
Impairments	0	(12,685)	(104)	0	0	0	0	0	(12,789)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(518)	0	(772)	0	(1,290)
At 31 March 2026	13,229	91,748	1,770	4,885	9,699	679	6,727	0	128,737
Depreciation at 1 April 2025	0	8,422	193	0	6,033	369	2,539	0	17,556
Indexation	0	1,045	23	0	0	0	0	0	1,068
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(4,256)	0	0	0	0	0	0	(4,256)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(518)	0	(772)	0	(1,290)
Provided during the year	0	3,877	78	0	890	41	1,145	0	6,031
At 31 March 2026	0	9,088	294	0	6,405	410	2,912	0	19,109
Net book value at 1 April 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Net book value at 31 March 2026	13,229	82,660	1,476	4,885	3,294	269	3,815	0	109,628
Net book value at 31 March 2026 comprises :									
Purchased	13,229	78,871	1,476	4,885	3,013	269	3,815	0	105,558
Donated	0	3,789	0	0	281	0	0	0	4,070
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2026	13,229	82,660	1,476	4,885	3,294	269	3,815	0	109,628
Asset financing :									
Owned	13,229	82,660	1,476	4,885	3,294	269	3,815	0	109,628
On-SoFP PPP/PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2026	13,229	82,660	1,476	4,885	3,294	269	3,815	0	109,628

The net book value of land, buildings and dwellings at 31 March 2026 comprises :

	£000
Freehold	84,136
Long Leasehold	0
Short Leasehold	0
	84,136

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

0

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

The reclassification in year relates to the bringing into use of buildings that were previously Assets under construction. The main part of this reclassification relates to the Refit Decarbonisation Project at £3.408m and the Llandrindod Hospital Phase 2 reconfiguration at £3.168M

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11.1 Property, plant and equipment

2024-25

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	12,631	81,633	1,565	4,575	7,912	410	5,315	0	114,041
Indexation	134	1,145	28	0	0	0	0	0	1,307
Additions									
- purchased	0	1,660	35	8,343	2,009	102	1,250	0	13,399
- donated	0	89	0	0	52	0	0	0	141
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	2,571	0	(2,571)	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	327	0	0	0	0	0	0	327
Impairments	0	(1,403)	0	0	0	0	0	0	(1,403)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(495)	(14)	(558)	0	(1,067)
At 31 March 2025	12,765	86,022	1,628	10,347	9,478	498	6,007	0	126,745
Depreciation at 1 April 2024	0	5,478	122	0	5,833	357	2,113	0	13,903
Indexation	0	99	2	0	0	0	0	0	101
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(370)	0	0	0	0	0	0	(370)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(485)	(14)	(558)	0	(1,057)
Provided during the year	0	3,215	69	0	685	26	984	0	4,979
At 31 March 2025	0	8,422	193	0	6,033	369	2,539	0	17,556
Net book value at 1 April 2024	12,631	76,155	1,443	4,575	2,079	53	3,202	0	100,138
Net book value at 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Net book value at 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Net book value at 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
comprises :									
Purchased	12,765	74,386	1,435	10,347	3,311	129	3,468	0	105,841
Donated	0	3,214	0	0	134	0	0	0	3,348
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
Asset financing :									
Owned	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189
On-SoFP PPP/PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2025	12,765	77,600	1,435	10,347	3,445	129	3,468	0	109,189

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

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

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

0

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

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

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

Powys LHB has received the following donated assets during the year:

£0.300m from Welshpool League of Friends towards the extension of the staff dining room at Welshpool Hospital
 £0.100m from the Jack and Iris Lloyd legacy for ophthalmology and endoscopy medical equipment at Brecon Hospital
 £0.077m from Powys THB Charity towards works undertaken at Twymyn Ward, Machynlleth Hospital
 £0.067m from Llandrindod League of Friends for an OCT ophthalmology scanner for Llandrindod outpatients department
 £0.056m from the Welsh Government Energy service to implement EV charging points at Llandrindod and Bronllys Hospitals
 £0.014m of various contributions from the LHB charity for provision of medical equipment

(ii) Valuations

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

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

There has also been a valuation of Brecon Hospital, Llandrindod Hospital, Westdene dwelling and Spa Road Building at Llandrindod on being brought into use during the year

There has also been a desktop exercise via the Valuation Office Agency of smaller schemes undertaken since the last quinquennial full valuation in 2022 that had not previously been subject to a formal valuation..

Details of these valuations are included in Note 13.

(iii) Asset Lives

Property, plant and equipment is depreciated using the following asset lives:

- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment between 5-15 years.

(iv) Compensation

There has not been any compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

(v) Write Downs

There have not been write downs.

(vi) Open Market Value

The Health Board does not hold any property where the value is materially different from its open market value.

(vii) Assets Held for Sale or sold in the period

There are not assets held for sale or sold in the period.

(viii) IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

(ix) Transfers from and to other bodies

During 25-26 the THB transferred medical equipment with Net Book Value of £0.036m to Aneurin Bevan University Health Board. The THB received the transfer of a mobile dental clinic with a Net Book Value of £0.181M during the year from Cardiff and Vale University Health Board.

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11. Property, plant and equipment**11.2 Non-current assets held for sale**

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2025	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2026	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Balance brought forward 1 April 2024	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2025	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

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11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most are individually insignificant, however, two are significant in their own right:

- Glan Irfon held under Land and Buildings - NBV at 31 March 2026 is £0.392m
- Presteigne Health Centre lease held under Land and Buildings - NBV at 31st March 2026 is £0.374m

2025-26	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	0	2,009	0	0	1,051	0	0	0	3,060
Additions	0	94	0	0	356	0	0	0	450
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(64)	0	0	0	(64)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2026	0	2,103	0	0	1,343	0	0	0	3,446
Depreciation at 1 April 2025	0	935	0	0	610	0	0	0	1,545
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	193	0	0	281	0	0	0	474
At 31 March 2026	0	1,128	0	0	891	0	0	0	2,019
Net book value at 1 April 2025	0	1,074	0	0	441	0	0	0	1,515
Net book value at 31 March 2026	0	975	0	0	452	0	0	0	1,427
RoU Asset Total Value Split by Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercorn Leases	0	392	0	0	0	0	0	0	392
Other Public Sector Market Value Leases	0	176	0	0	0	0	0	0	176
Private Sector Peppercorn Leases	0	19	0	0	0	0	0	0	19
Private Sector Market Value Leases	0	388	0	0	452	0	0	0	840
Total	0	975	0	0	452	0	0	0	1,427

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11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most are individually insignificant, however, two are significant in their own right:

- Glan Irfon held under Land and Buildings - NBV at 31 March 2025 is £0.424m
- Presteigne Health Centre lease held under Land and Buildings - NBV at 31st March 2025 is £0.430m

2024-25	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	0	1,574	0	0	671	0	0	0	2,245
Additions	0	505	0	0	409	0	0	0	914
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(70)	0	0	(29)	0	0	0	(99)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2025	0	2,009	0	0	1,051	0	0	0	3,060
Depreciation at 1 April 2024	0	735	0	0	447	0	0	0	1,182
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	200	0	0	163	0	0	0	363
At 31 March 2025	0	935	0	0	610	0	0	0	1,545
Net book value at 1 April 2024	0	839	0	0	224	0	0	0	1,063
Net book value at 31 March 2025	0	1,074	0	0	441	0	0	0	1,515
RoU Asset Total Value Split by Lessor									
	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercom Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercom Leases	0	424	0	0	0	0	0	0	424
Other Public Sector Market Value Leases	0	123	0	0	0	0	0	0	123
Private Sector Peppercom Leases	0	38	0	0	0	0	0	0	38
Private Sector Market Value Leases	0	489	0	0	441	0	0	0	930
Total	0	1,074	0	0	441	0	0	0	1,515

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11.3 Right of Use Assets continued

Quantitative disclosures

	2025-26	2025-26	2025-26	2025-26	2024-25
	Land	Buildings	Other	Total	Total
Maturity analysis	£000	£000	£000	£000	£000
Contractual undiscounted cash flows relating to lease liabilities					
Less than 1 year	0	168	195	363	365
2-5 years	0	364	131	495	597
> 5 years	0	135	0	135	209
Less finance charges allocated to future periods	0	(73)	(14)	(87)	(126)
Total	0	594	312	906	1,045
Lease Liabilities (net of irrecoverable VAT)				2025-26	2024-25
Current				319	325
Non-Current				587	720
Total				906	1,045
Amounts Recognised in Statement of Comprehensive Net Expenditure				2025-26	2024-25
Depreciation				474	363
Impairment				0	0
Variable lease payments not included in lease liabilities - Interest expense				49	40
Sub-leasing income				0	0
Expense related to short-term leases				0	0
Expense related to low-value asset leases (excluding short-term leases)				0	0
Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)					
Interest expense				(49)	(40)
Repayments of principal on leases				(461)	(351)
Total				(510)	(391)

The Teaching Health Board leases land, buildings and equipment where required to deliver core services.

Where an extension option exists within a lease, the Teaching Health Board has assessed on an individual contract basis and reflected any extension period within the reported liabilities where it is reasonably certain that the option will be exercised

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12. Intangible non-current assets

2025-26

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2025	0	0	0	0	0	154	154
Revaluation	0	0	0	0	0	0	0
Reclassifications	154	0	0	0	0	(154)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	78	0	0	0	0	0	78
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Gross cost at 31 March 2026	232	0	0	0	0	0	232
Amortisation at 1 April 2025	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	5	0	0	0	0	0	5
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Amortisation at 31 March 2026	5	0	0	0	0	0	5
Net book value at 1 April 2025	0	0	0	0	0	154	154
Net book value at 31 March 2026	227	0	0	0	0	0	227
NBV at 31 March 2026							
Purchased	232	0	0	0	0	0	232
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2026	232	0	0	0	0	0	232

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12. Intangible non-current assets

2024-25

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	0	0	0	0	0	154	154
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Gross cost at 31 March 2025	0	0	0	0	0	154	154
Amortisation at 1 April 2024	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Amortisation at 31 March 2025	0	0	0	0	0	0	0
Net book value at 1 April 2024	0	0	0	0	0	0	0
Net book value at 31 March 2025	0	0	0	0	0	154	154
NBV at 31 March 2025							
Purchased	0	0	0	0	0	154	154
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2025	0	0	0	0	0	154	154

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Additional Disclosures re Intangible Assets**Disclosures:****(i) Donated Assets**

The LHB has not received any donated intangible assets during the year.

(ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

(iii) Asset Lives

The Useful Economic Lives (UEL) of intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL with the UEL of any internally generated software being based on the professional judgement of Health Board professionals and finance staff.

(iv) Additions during the period

There is currently one intangible asset addition during the year relating to the Radiology Informatics System Programme(RISP) which went live during 2025/26.

(v) Disposals during the period

There have been no disposal of intangible assets during the year.

vi) Transfers into other NHS Bodies

The LHB has not received any intangible assets transferred from another NHS body.

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13 . Impairments

	2025-26 Property, plant & equipment £000	2025-26 Right of Use Assets £000	2025-26 Intangible assets £000	2025-26 Held for sale assets £000	2025-26 Financial Assets £000	2025-26 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	12,789	0	0	0	0	12,789
Reversal of Impairments	(2,741)	0	0	0	0	(2,741)
Total of all impairments	10,048	0	0	0	0	10,048

Analysis of impairments charged to reserves in year :

Impairments charged to the Statement of Comprehensive Net Expenditure	10,048	0	0	0	0	10,048
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	10,048	0	0	0	0	10,048

	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	1,033	0	0	0	0	1,033
Reversal of Impairments	(327)	0	0	0	0	(327)
Total of all impairments	706	0	0	0	0	706

Analysis of impairments charged to reserves in year :

Impairments charged to the Statement of Comprehensive Net Expenditure	706	0	0	0	0	706
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	706	0	0	0	0	706

Within the healthcare segment of the Teaching Health Board, there is three downward impairments in year totalling £12.790m charged to the statement of Comprehensive Net Expenditure. This includes the downward valuation of £1.365m as a result of the initial valuation for the bringing into use the numerous projects at Brecon Hospital. There was also a downward revaluation of the properties of Llandrindod, Westdene and Spa Road of £3.802m due to the initial valuation for the bringing into use numerous projects at these buildings. A desktop exercise was undertaken by the Valuation Office Agency of all small schemes not subject to a formal valuation since the last quinquennial valuation in 2022. The result of this desktop valuation was an impairment of £7.623m across many sites within the THB.

There is a reversal of impairment of £2.741m during 2025/26 which has occurred as a result of an increase arising on revaluations due to indexation applied during the year that reversed an impairment for the same assets previously recognised as impairments in expenditure. In these cases it is credited to expenditure to the extent of the decrease previously charged there

Impairment funding to cover adjustments required is provided to the Teaching Health Board by Welsh Government on an annual basis.

14.1 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	144	156
Consumables	25	35
Energy	0	0
Work in progress	0	0
Other	6	6
Total	175	197
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2026 £000	31 March 2025 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	0	0

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15. Trade and other Receivables

Current	31 March 2026 £000	31 March 2025 £000
Welsh Government	332	1,935
NHSW JCC Joint Commissioning Committee	23	132
Welsh Health Boards	198	201
Welsh NHS Trusts	1,075	736
Welsh Special Health Authorities	514	299
Non - Welsh Trusts	1,295	421
Other NHS	35	39
2019-20 Scheme Pays - Welsh Government Reimbursement	0	5
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	1,598	1,277
NHS Wales Primary Sector FLS Reimbursement	211	2,383
NHS Wales Redress	218	117
Other	0	0
Local Authorities	1,185	801
Other receivables	1,847	2,460
Provision for irrecoverable debts	(548)	(612)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	661	671
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	377	126
Intangibles capital receivables	0	0
Other capital prepayments	0	0
Sub total	9,021	10,991
Non-current		
Welsh Government	0	0
NHSW JCC Joint Commissioning Committee	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	32	43
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	42	127
NHS Wales Primary Sector FLS Reimbursement	5	26
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Other receivables	0	0
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	0	0
Intangibles capital receivables	0	0
Other capital prepayments	0	0
Sub total	79	196
Total	9,100	11,187

Sub total

Total

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2026 £000	31 March 2025 £000
By up to three months	291	200
By three to six months	244	22
By more than six months	25	28
	<u>560</u>	<u>250</u>

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(612)	(613)
Transfer to other NHS Wales body	0	0
Amount written off during the year	210	0
Amount recovered during the year	125	68
(Increase) / decrease in receivables impaired	(271)	(67)
Bad debts recovered during year	0	0
Balance at 31 March	<u>(548)</u>	<u>(612)</u>

In determining whether a debt should be impaired, consideration is given to the age of the debt, historic collectability rates and the results of actions already taken including referral to the Health Board's credit agencies.

Receivables VAT

Trade receivables	0	0
Other	0	0
Total	<u>0</u>	<u>0</u>

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16. Other Financial Assets

	Current		Non-current	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Deposits	0	0	0	0
Loans at amortised cost	0	0	0	0
Derivatives	0	0	0	0
Other (Specify)				
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Capital Financial Assets				
Loans at amortised cost	0	0	0	0
Right of Use Asset Finance Sublease	0	0	0	0
Total	0	0	0	0

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	2025-26	2024-25
RoU Sub-leasing income	0	0

17. Cash and cash equivalents

	2025-26	2024-25
	£000	£000
Balance at 1 April	629	215
Net change in cash and cash equivalent balances	217	414
Balance at 31 March	846	629
Made up of:		
Cash held at GBS	788	568
Commercial banks	56	59
Cash in hand	2	2
Cash and cash equivalents as in Statement of Financial Position	846	629
Bank overdraft - GBS	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in Statement of Cash Flows	846	629

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18. Trade and other payables

Current	31 March 2026 £000	31 March 2025 £000
Welsh Government	0	67
NHSW Joint Commissioning Committee	1,615	781
Welsh Health Boards	4,587	5,661
Welsh NHS Trusts	965	1,045
Welsh Special Health Authorities	0	0
Other NHS	7,689	4,023
Taxation and social security payable / refunds	1,192	956
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	1,525	1,087
Non-NHS payables - Revenue	6,404	6,742
Local Authorities	4,442	2,791
Overdraft	0	0
Rentals due under operating leases	0	0
Pensions: staff	1,802	1,710
Non NHS Accruals	13,823	18,176
Deferred Income:		
Deferred Income brought forward	320	111
Deferred Income Additions	246	284
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	(298)	(75)
Other creditors	0	0
Payments on account	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Right of Use asset payables	319	325
Capital asset payables		
Tangibles - Payables	2,360	6,297
Intangibles - Payables	0	154
Obligations under finance leases, HP contracts	0	0
Imputed finance lease element of on SoFP PFI contracts	0	0
PFI assets – deferred credits	0	0
Capital Payments on account	0	0
Sub Total	46,991	50,135
Non-current		
Welsh Government	0	0
NHSW Joint Commissioning Committee	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Other NHS	0	0
Taxation and social security payable / refunds	0	0
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	0	0
Non-NHS payables - Revenue	0	0
Local Authorities	0	0
Overdraft	0	0
Rentals due under operating leases	0	0
Pensions: staff	0	0
Non NHS Accruals	0	0
Deferred Income :		
Deferred Income brought forward	0	0
Deferred Income Additions	0	0
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	0	0
Other creditors	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Impact of IFRS 16 on SoFP PFI contracts	0	0
Right of Use asset payables	587	720
Capital asset payables		
Capital Creditors - Tangibles	0	0
Capital Creditors - Intangibles	0	0
Obligations under finance leases, HP contracts	0	0
Imputed finance lease element of on SoFP PFI contracts	0	0
PFI assets – deferred credits	0	0
Capital Payments on account	0	0
Sub Total	587	720
Total	47,578	50,855

The THB aims to pay all invoices within the 30 day period directed by the Welsh Government.

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	31 March	31 March
	2026	2025
	£000	£000
Between one and two years	238	359
Between two and five years	270	255
In five years or more	79	106
Sub-total	587	720

19. Other financial liabilities

Financial liabilities	Current		Non-current	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Financial Guarantees:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Derivatives at fair value through SoCNE	0	0	0	0
Other:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Total	0	0	0	0

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20. Provisions

	At 1 April 2025	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2026
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
Clinical negligence:-									
Secondary care	596	0	0	(15)	561	(469)	(15)	0	658
Primary care	2,327	0	(60)	0	137	(20)	(2,327)	0	57
Redress Secondary care	101	0	0	0	115	(25)	(34)	0	157
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	77	0	0	57	1,628	(1,075)	0	15	702
All other losses and special payments	0	0	0	0	450	(450)	0	0	0
Defence legal fees and other administration	134	0	0	1	371	(91)	(12)		403
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	5			4	0	(5)	0	0	4
Restructuring	0			0	0	0	0	0	0
Other	563		0	0	973	(578)	(41)	0	917
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	3,803	0	(60)	47	4,235	(2,713)	(2,429)	15	2,898
Non Current									
Clinical negligence:-									
Secondary care	0	0	0	15	0	0	(15)	0	0
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	545	0	0	(57)	24	0	0	0	512
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	216	0	0	(1)	54	(14)	(149)		106
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	42			(4)	0	0	(11)	0	27
Restructuring	0			0	0	0	0	0	0
Other	0		0	0	0	0	0	0	0
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	803	0	0	(47)	78	(14)	(175)	0	645
TOTAL									
Clinical negligence:-									
Secondary care	596	0	0	0	561	(469)	(30)	0	658
Primary care	2,327	0	(60)	0	137	(20)	(2,327)	0	57
Redress Secondary care	101	0	0	0	115	(25)	(34)	0	157
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	622	0	0	0	1,652	(1,075)	0	15	1,214
All other losses and special payments	0	0	0	0	450	(450)	0	0	0
Defence legal fees and other administration	350	0	0	0	425	(105)	(161)		509
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	47			0	0	(5)	(11)	0	31
Restructuring	0			0	0	0	0	0	0
Other	563		0	0	973	(578)	(41)	0	917
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	4,606	0	(60)	0	4,313	(2,727)	(2,604)	15	3,543

Expected timing of cash flows:

	In year to 31 March 2027	Between 1 April 2027 31 March 2031	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	658	0	0	658
Primary care	57	0	0	57
Redress Secondary care	157	0	0	157
Redress Primary care	0	0	0	0
Personal injury	702	248	266	1,216
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	403	104	0	507
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
2019-20 Scheme Pays - Reimbursement	4	7	20	31
Restructuring	0	0	0	0
Other	917	0	0	917
Capital provisions				
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Total	2,898	359	286	3,543

The Teaching Health Board estimates that in 2026/27 and beyond it will receive £2.074m from the Welsh Risk Pool in respect of Losses and Special Payments.

£0.721m (2024/25: £0.082m) of the provision total relates to the probable liabilities of former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust)

Contingent Liabilities are directly linked to these claims in Note 21.

Included within the Redress Secondary Care line and Defence Legal Fees and Other Administration is a provision for expected payments in respect of redress arrangements under National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The amount of provision in relation to this at 31st March 2026 is £0.168m including defence costs (2024/25: £0.103m) and all payments are expected to be fully reimbursed from the Welsh RiskPool.

There is an amount of £0.032m (2024/25: £0.048m) in respect of 2019-20 Scheme Pays - Reimbursement. The discharge of this provision in future years will be funded by Welsh Government.

20. Provisions (continued)

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	297	0	0	0	721	(320)	(102)	0	596
Primary care	2,252	0	0	0	75	0	0	0	2,327
Redress Secondary care	70	0	0	0	75	(19)	(25)	0	101
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	482	0	0	0	961	(1,324)	(55)	13	77
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	277	0	0	(46)	116	(50)	(163)		134
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0			0	9	(4)	0	0	5
Restructuring	0			0	0	0	0	0	0
Other	543		0	0	300	(114)	(166)	0	563
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	3,921	0	0	(46)	2,258	(1,832)	(511)	13	3,803
Non Current									
Clinical negligence:-									
Secondary care	0	0	0	0	0	0	0	0	0
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	501	0	0	0	44	0	0	0	545
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	43	0	0	46	146	(19)	0		216
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	32			0	10	0	0	0	42
Restructuring	0			0	0	0	0	0	0
Other	0		0	0	0	0	0	0	0
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	576	0	0	46	200	(19)	0	0	803
TOTAL									
Clinical negligence:-									
Secondary care	297	0	0	0	721	(320)	(102)	0	596
Primary care	2,252	0	0	0	75	0	0	0	2,327
Redress Secondary care	70	0	0	0	75	(19)	(25)	0	101
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	983	0	0	0	1,005	(1,324)	(55)	13	622
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	320	0	0	0	262	(69)	(163)		350
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	32			0	19	(4)	0	0	47
Restructuring	0			0	0	0	0	0	0
Other	543		0	0	300	(114)	(166)	0	563
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	4,497	0	0	0	2,458	(1,851)	(511)	13	4,606

The Teaching Health Board estimates that in 2025/26 and beyond it will receive £3.930m from the Welsh Risk Pool in respect of Losses and Special Payments.

£0.082m (2023/24: £0.667m) of the provision total relates to the probable liabilities of former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust)

Contingent Liabilities are directly linked to these claims in Note 21.

Included within 'other' at 31st March 2025 is £0.316m relating to a liability for two historic continuing care cases with the Local Authority. Also included within 'other' at 31st March 2025 is £0.247m relating to retrospective continuing health care claims (2023/24 £0.113m).

Included within the Redress Secondary Care line and Defence Legal Fees and Other Administration is a provision for expected payments in respect of redress arrangements under National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The amount of provision in relation to this at 31st March 2025 is £0.103M including defence costs (2023/24: £0.072m) and all payments are expected to be fully reimbursed from the Welsh Risk Pool.

There is an amount of £0.048m (2023/24: £0.032m) in respect of 2019-20 Scheme Pays - Reimbursement. The discharge of this provision in future years will be funded by Welsh Government.

21. Contingencies

21.1 Contingent liabilities

	2025-26	2024-25
	£'000	£'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	5,173	5,101
Primary care	1,574	883
Redress Secondary care	0	0
Redress Primary care	0	0
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	294	377
Continuing Health Care costs	0	0
Other	13,100	5,000
Total value of disputed claims	20,141	11,361
Less amounts recoverable in the event of claims being successful	(6,775)	(6,333)
Net contingent liability	13,366	5,028

Legal Claims for alleged medical or employer negligence: £2.179M of the £7.041m relates solely to the former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust). £3.287M of the £7.041M relates to Powys Teaching Health Board cases. Legal advice has established that these claims are not likely to result in payments. In the unlikely event that amounts are payable, all payments over a threshold of £0.025M will be reimbursed to Powys Teaching Health Board by the Welsh Risk Pool for Powys Teaching Health Board cases and reimbursed in full for former Health Authority and Primary Care cases.

An invoice for £5m from Wye Valley NHS Trust has been received during March 2025. It has the description "Recognition of discussions regarding parity of funding with English commissioners inc remoteness uplift, PFI and inflation". During 2025/26 Wye Valley NHS Trust continued to further invoice on a quarterly basis an amount of £2.025m with the narrative 'remoteness and parity fund with english commissioners' which has added a further amount of £8.100m during 2025/26 taking the overall total to £13.100m. The Health Board strongly refutes the charges and is awaiting backing information giving the rationale for the sums sought.

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21.2 Remote Contingent liabilities

	2025-26 £000	2024-25 £000
Guarantees	0	0
Indemnities	94	110
Letters of Comfort	0	0
Total	94	110

All of the £0.094m relates solely to the former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust). Legal advice has established that these claims are not likely to result in payments. In the unlikely event that amounts are payable, all payments will be reimbursed in full by the Welsh Risk Pool.

21.3 Contingent assets

	2025-26 £000	2024-25 £000
The Health Board does not have any Contingent assets	0	0
Total	0	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2025-26 £000	2024-25 £000
Property, plant and equipment	3,244	1,423
Right of Use Assets	0	133
Intangible assets	0	77
Total	3,244	1,633

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23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2026	
	Number of cases	£
Clinical negligence:-		
Secondary Care	12	534,087
Primary Care	0	0
Redress Secondary Care	11	33,474
Redress Primary Care	0	0
Personal injury	8	520,491
All other losses and special payments	168	450,315
Total	199	1,538,367

23.2 Analysis of number of cases and associated amounts paid out during the financial year

Case Type	In year cases in excess of £300,000		Cumulative amount
	L&R Case reference number	£	£
Cases in excess of £300,000:			
Clinical Negligence	SSPLR154114	444,039	521,363
Personal Injury	SSPLR153016	440,371	440,783

	Number of cases	£	£
Sub-total	2	884,410	962,145
All other cases paid in year	197	653,957	1,507,489
Total cases paid in year	199	1,538,367	2,469,634

23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	Number of cases	£
Cumulative amount up to £300k	7	105,457
Cumulative amount greater than £300k	1	8,245,767
Total	8	8,351,224

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24. Right of Use lease obligations**24.1 Obligations (as lessee)****Amounts payable under right of use asset leases:****2025-26**

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2026	2026	2026	2026
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	168	195	363
Between one and five years	0	364	131	495
After five years	0	135	0	135
Less finance charges allocated to future periods	0	(73)	(14)	(87)
Minimum lease payments	0	594	312	906
Included in:				
Current borrowings	0	132	188	320
Non-current borrowings	0	463	124	587
	0	594	312	906
Present value of minimum lease payments				
Within one year	0	132	181	313
Between one and five years	0	364	131	495
After five years	0	99	0	99
Present value of minimum lease payments	0	594	312	906
Included in:				
Current borrowings	0	132	181	313
Non-current borrowings	0	463	131	594
	0	594	312	906

2024-25

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	141	224	365
Between one and five years	0	357	240	597
After five years	0	209	0	209
Less finance charges allocated to future periods	0	(102)	(24)	(126)
Minimum lease payments	0	605	440	1,045
Included in:				
Current borrowings	0	117	208	325
Non-current borrowings	0	488	232	720
	0	605	440	1,045
Present value of minimum lease payments				
Within one year	0	117	208	325
Between one and five years	0	295	232	527
After five years	0	193	0	193
Present value of minimum lease payments	0	605	440	1,045
Included in:				
Current borrowings	0	117	208	325
Non-current borrowings	0	488	232	720
	0	605	440	1,045

24.2 Right of Use Assets receivables (as lessor)

The Health Board did not hold any Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets :

	31 March 2026 £000	31 March 2025 £000
Gross Investment in leases		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Minimum lease payments	0	0
Included in:		
Current financial assets	0	0
Non-current financial assets	0	0
Present value of minimum lease payments		
Within one year	0	0
Between one and five years	0	0
After five years	0	0
Less finance charges allocated to future periods	0	0
Present value of minimum lease payments	0	0
Included in:		
Current financial assets	0	0
Non-current financial assets	0	0

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25.3 Charges to expenditure

	2025-26	2024-25
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

25.5 Public Private Partnerships

The Health Board did not have any Public Private Partnerships during the year

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26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Health Board is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Health Board has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Health Board in undertaking its activities.

Currency risk

The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the United Kingdom and Sterling based. The Health Board does not have any overseas operations. The Health Board therefore has low exposure to currency rate fluctuations.

Interest rate risk

Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk

The Health Board is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The Health Board is not, therefore, exposed to significant liquidity risks.

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27. Movements in working capital

	2025-26 £000	2024-25 £000
(Increase)/decrease in inventories	22	14
(Increase)/decrease in trade and other receivables - non-current	117	(164)
(Increase)/decrease in trade and other receivables - current	1,970	(674)
Increase/(decrease) in trade and other payables - non-current	(133)	453
Increase/(decrease) in trade and other payables - current	(3,144)	3,022
Total	(1,168)	2,651
Adjustment for accrual movements in fixed assets - creditors	4,091	(3,107)
Adjustment for accrual movements in fixed assets - debtors	251	68
Adjustment for accrual movements in right of use assets - creditors	139	(500)
Adjustment for accrual movements in right of use assets - debtors	0	0
Other adjustments	0	0
	3,313	(888)

28. Other cash flow adjustments

	2025-26 £000	2024-25 £000
Depreciation	6,505	5,342
Amortisation	5	0
(Gains)/Loss on Disposal	(10)	(9)
Impairments and reversals	10,048	706
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	(183)	(105)
Government Grant assets received credited to revenue but non-cash	0	(36)
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	0
Non-cash movements in right of use assets	113	40
Non-cash movements in provisions	1,664	1,960
Other movements	8,259	7,583
Total	26,401	15,481

Other movements of £8.259m(2024-25 £7.583m) is made up of notional funding received for:

- LHB notional 9.4% Staff Employer Pension Contributions;
- the 2019-20 Pensions Annual Allowance Charge Compensation Scheme (PAACCS);

which are both funded directly to the NHSBA Pensions Division by Welsh Government.

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29. Events after the Reporting Period

Since the 31st March 2026 it has been communicated that the Welsh Government has revised the payscales for Chairs, Deputy Chairs and Independent Members of Health Boards to be backdated to 1st January 2026. Payments in this regard will be made during the early months of 2026/27. This is not material to the financial statements but is material in nature due to remuneration reporting requirements of Board Members.

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on xx xx xxxx; post the date the financial statements were certified by the Auditor General for Wales.

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30. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material revenue and capital transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Party	Board Member Interests	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government		31	496,665	0	332
Aneurin Bevan University Health Board		16,015	231	1,189	0
Betsi Cadwaladr University Health Board		4,940	565	381	49
Cardiff & Vale University Health Board		2,314	61	313	44
Cwm Taf Morgannwg University Health Board		8,245	49	242	48
Hywel Dda University Local Health Board		11,357	275	773	32
Public Health Wales NHS Trust		219	1,192	29	280
Swansea Bay University Health Board		12,972	1,601	1,688	24
Velindre University NHS Trust (inc. WRP)		5,284	1,657	898	791
Welsh Ambulance Services Trust		100	84	37	4
NHS Wales Joint Commissioning Committee (NWJCC)		62,892	65	1,615	23
Health Education and Improvement Wales (HEIW)		0	3,152	0	456
Digital Health & Care Wales (DHCW)		1,837	733	0	57
Shrewsbury and Telford Hospital NHS Trust		36,375	0	488	0
Wye Valley NHS Trust		34,382	0	6,655	65
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust		9,855	0	77	655
NHS Dorset Integrated Care Board	Rhiannon Beaumont-Wood, Non-Executive Member NHS Dorset ICB	0	4	0	2
Powys County Council	Councillor Chris Walsh, Councillor, Powys County Council	19,037	2,910	4,442	1,185
Powys Association of Voluntary Organisations	Jennifer Owen Adams Vice Chair and Co-opted Member of Powys Association of Voluntary Organisations	1,326	0	393	0
Freedom Leisure	Jennifer Owen Adams Close relative is senior manager for Freedom Leisure with lead responsibility for	1	0	0	0
		227,182	509,244	19,220	4,047

Powys LHB has hosted the following functions on behalf of NHS Wales on which it receives income from the Welsh Government and other LHB's:

- Residual Clinical Negligence
- Community Health Councils
- Health and Care Research Wales (HCRW)

Powys LHB has also received items donated from the Powys LHB Charitable Fund, for which the Board is the Corporate Trustee.

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31. Third Party assets

The LHB held £160 cash at bank and in hand at 31 March 2026 (31st March 2025, £160) which relates to monies held by the LHB on behalf of patients. This has been excluded from the Cash and Cash equivalents figure reported in the accounts. None of this cash was held in Patients' Investment Accounts in either 2025-26 or 2024-25.

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32. Pooled budgets

Provision of Care Home Accommodation Functions (Funded Nursing Care)

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 31 of the Health Act 1999. The health related function which is subject to these arrangements is the provision of care by a registered nurse in care homes, which is a service provided by the NHS Body under section 2 of the National Health Service Act 1977. In accordance with the Social Care Act 2001 Section 49 care from a registered nurse is funded by the NHS regardless of the setting in which it is delivered. (Circular 12/2003) The agreement will not affect the liability of the parties for the exercise of their respective statutory functions and obligations. The partnership agreement operates in accordance with the

	2025-26	2024-25
	£ 000	£ 000
Pooled Budget contributions		
Powys County Council	0	0
Powys Teaching Health Board	2,782	2,449
Other	0	0
Total Pooled Budget contributions for the year	2,782	2,449
Expenditure		
Staff Costs	0	0
Equipment Purchases	0	0
Operating Expenditure	2,876	2,782
Non Operating Expenditure	0	0
Total Expenditure for the year	2,876	2,782
Net Surplus/(Deficit) on the Pooled Budget for the Year	(94)	(333)

Provision of Community Equipment

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in respect of lead commissioning from a pooled fund for the provision of community equipment in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the host partner for the purposes of the Regulations. The purpose of the agreement is to facilitate the provision of a community equipment service and the development of this service in Powys. The service is provided from a pooled fund and is within the THB's and the Council's powers.

	2025-26	2024-25
	£ 000	£ 000
Pooled Budget contributions		
Powys County Council	675	675
Powys Teaching Health Board	675	675
Other	0	0
Total Pooled Budget Contributions	1,350	1,350
Expenditure		
Staff Costs	0	0
Equipment Purchases	0	0
Operating Expenditure	1,466	1,350
Non Operating Expenditure	0	0
Total Expenditure	1,466	1,350
Net Surplus/(Deficit) on the Pooled Budget for year	(116)	0
Cumulative Net Surplus/(Deficit) on the Pooled Budget	(116)	0

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32. Pooled budgets

Provision of Section 33 Joint Agreement for the provision of Tier 2/3 Psycho-social Treatment Services

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the lead commissioner and the host partner for the purposes of the Regulations. The agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations. The purpose of the agreement is to provide a Tier 2 and 3 service provision for drug and alcohol users and their concerned others.

	2025-26	2024-25
	£ 000	£ 000
Pooled Budget contributions		
Powys County Council	673	845
Powys Teaching Health Board	122	130
Other	0	0
Total Pooled Budget contributions for the year	795	975
Expenditure		
Staff Costs	0	0
Equipment Purchases	0	0
Operating Expenditure	795	967
Non Operating Expenditure	0	0
Total Expenditure for the year	795	967
Net Surplus/(Deficit) on the Pooled Budget for the Year	0	8

Provision of Section 33 Joint Agreement for the provision of Personal Care at Glan Irfon Integrated Health and Social Care Unit, Builth Wells

Powys Teaching Health Board (PTHB) and Powys County Council (PCC) have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006. The agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations. The purpose of the agreement is to facilitate the provision of person centred care at Glan Irfon, for 12 residents within the short stay shared care reablement unit with in-reach clinical, nursing and reablement support (registered under CSSIW for Residential Care).

	2025-26	2024-25
	£ 000	£ 000
Pooled Budget contributions		
Powys County Council	367	305
Powys Teaching Health Board	367	305
Other	0	0
Total Pooled Budget Contributions	734	610
Expenditure		
Staff Costs	0	0
Equipment Purchases	0	0
Operating Expenditure	734	680
Non Operating Expenditure	0	0
Total Expenditure	734	680
Net Surplus/(Deficit) on the Pooled Budget for year	0	(70)
Cumulative Net Surplus/(Deficit) on the Pooled Budget	0	0

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33. Operating segments

Accounting standard IFRS 8 defines an operating segment as a component of an entity:

2025-26

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note					
Expenditure on Primary Healthcare Services	3.1	85,478	0	0	0	85,478
Expenditure on healthcare from other providers	3.2	266,148	0	418	0	266,566
Expenditure on Hospital and Community Health Services	3.3	165,217	26	6,135	(181)	171,197
		516,843	26	6,553	(181)	523,241
Less: Miscellaneous Income	4	13,833	0	5,522	(181)	19,174
THB net operating costs before interest and other gains and losses		503,010	26	1,031	0	504,067
Investment Income	5	0	0	0	0	0
Other (Gains) / Losses	6	(10)	0	0	0	(10)
Finance costs	7	64	0	0	0	64
THB Net Operating Costs		503,064	26	1,031	0	504,121
Add Non Discretionary Expenditure	3.1	1,227	0	0	0	1,227
Revenue Resource Limit	2.1	471,016	26	1,031	0	472,073
Under / (over) spend against Revenue Resource Limit		(33,275)	0	0	0	(33,275)

2024/25

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note					
Expenditure on Primary Healthcare Services	3.1	83,495	0	0	0	83,495
Expenditure on healthcare from other providers	3.2	245,678	0	358	0	246,036
Expenditure on Hospital and Community Health Services	3.3	146,181	25	5,592	(81)	151,717
		475,354	25	5,950	(81)	481,248
Less: Miscellaneous Income	4	11,854	0	5,136	(81)	16,909
THB net operating costs before interest and other gains and losses		463,500	25	814	0	464,339
Investment Income	5	0	0	0	0	0
Other (Gains) / Losses	6	(9)	0	0	0	(9)
Finance costs	7	54	0	0	0	54
THB Net Operating Costs		463,545	25	814	0	464,384
Add Non Discretionary Expenditure	3.1	1,833	0	0	0	1,833
Revenue Resource Limit	2.1	449,610	25	829	0	450,464
Under / (over) spend against Revenue Resource Limit		(15,768)	0	15	0	(15,753)

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34. Other Information**34.1. 9.4% Staff Employer Pension Contributions - Notional Element**

The value of notional transactions is based on estimated costs for the twelve month period 1st April 2025 to 31st March 2026. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2025 and February 2026 alongside Health Board data for March 2026.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

	2025-26 £000	2024-25 £000
Statement of Comprehensive Net Expenditure for the year ended 31 March 2026		
Expenditure on Primary Healthcare Services	112	109
Expenditure on healthcare from other providers	0	0
Expenditure on Hospital and Community Health Services	8,142	7,470

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

Net operating cost for the year	8,254	7,579
Notional Welsh Government Funding	8,254	7,579

Statement of Cash Flows for year ended 31 March 2026

Net operating cost for the financial year	8,254	7,579
Other cash flow adjustments	8,254	7,579

2.1 Revenue Resource Performance

Revenue Resource Allocation	8,254	7,579

3. Analysis of gross operating costs**3.1 Expenditure on Primary Healthcare Services**

General Medical Services	3	3
Pharmaceutical Services	0	0
General Dental Services	102	94
Other Primary Health Care expenditure	7	12

3.2 Expenditure on healthcare from other providers

	0	0
	0	0

3.3 Expenditure on Hospital and Community Health Services

Directors' costs	110	116
Staff costs	8,142	7,354

9.1 Employee costs**Permanent Staff**

Employer contributions to NHS Pension Scheme	8,254	7,579
Charged to capital	32	26
Charged to revenue	8,222	7,553

18. Trade and other payables**Current**

Pensions: staff	0	0

28. Other cash flow adjustments

Other movements	8,254	7,579

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

Other

34.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the annual contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

(Signage as per provision note disclosure)	£000
Liability for incurred claims @ 1 April 2025	0
Liability for remaining payments @ 31 March 2026	0
	0
Arising during year	0
Utilised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE

(Signage as per income and expenditure note disclosure)	£000
Insurance Income	0
Insurance expenditure	0

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12/05/2026 15:11:29

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)¹, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst

Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

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Powys Teaching
Health Board

Agenda Item: 5.2

Audit, Risk and Assurance Committee		12 May 2026
Subject:	Draft Head of Internal Audit Opinion & Annual Report 2025/2026	
Approved and presented by:	Director of Corporate Governance / Board Secretary Head of Internal Audit	
Prepared by:	Head of Internal Audit	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
To provide the Audit, Risk and Assurance Committee with information regarding the draft Head of Internal Audit Opinion for 2025/26 and the draft Annual Report.		
RECOMMENDATION(S):		
The Audit, Risk & Assurance Committee are requested to:		
Consider and note the Draft Head of Internal Audit Opinion and Annual Report for 2025/26.		
Approve/Take Assurance	Discuss	Note
	Y	Y

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

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EXECUTIVE SUMMARY:

The draft HIA Opinion for 2025/26 is that 'The Board can take **reasonable** assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively'.

From the individual audits completed at the time of producing the draft Annual Report, the following ratings have been provided:

- 3 Substantial Assurance
- 11 Reasonable Assurance
- 1 Limited Assurance.
- 2 Assurance Not Applicable

The Report also includes details of the 6 audits that have been removed from the plan during 2024/25, as reported to previous meetings of the Committee. These audits and the reason for their removal / deferment have been considered when compiling the draft HIA Opinion.

The draft Annual Report includes a number of highlighted areas where reference is made to audits that were work in progress (WiP) at the time of writing. These will be updated to reflect the position when the final HIA Opinion and Annual Report are produced.

The HIA Opinion will need to be reflected within the Health Board's Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the one Limited Assurance report issued so far during the year and the significance of the recommendations made.

BACKGROUND AND ASSESSMENT:

In accordance with the Global Internal Audit Standards (GIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

This is achieved through delivery of the annual audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2025/26 plan was formally approved by the Audit Committee at its March 25 meeting.

The draft Annual Report sets out the draft HIA Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the GIAS.

The report also details the outcome of audits undertaken at NWSSP, DHCW, and JCC that support the overall opinion for the Health Board.

NEXT STEPS:

The final Head of Internal Audit Opinion and Annual Report will be submitted to the Committee and Board in June 2026.

Head of Internal Audit Opinion & Annual Report 2025/26

Powys Teaching Health Board



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Report status:	Draft
Draft report issued:	XX
Final report issued:	XX
Author:	Ian Virgill
Audit Committee:	May 2025

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12/05/2026 15:11:29



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WALES

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



1. Executive Summary

1.1 Purpose of this Report

Powys Teaching Health Board (the 'Health Board') Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Global Internal Audit Standards (GIAS).

1.2 Head of Internal Audit Opinion 2025/26

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2025/26 is: (To be confirmed pending completion of remaining audits)

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the GIAS.

The Internal Audit Plan for 2025/26 year, was presented to the Committee in March 2025. Changes to the plan have been made during the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, and the NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we 'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the

requirements of the GIAS for 2025/26. We can therefore state that our service ‘conforms to the IIA’s professional standards and to GIAS.’

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2025/26

Substantial Assurance	• Staff Development Programme • Primary Care - Clusters Project Management • Catering Services – Food Safety Standards
Reasonable Assurance	• Duty of Candour • Continuing Healthcare • MH and LD Triage and Assessment Process • Core Financials – General Ledger Management & Accounts Receivable • Decontamination • Clinical Supervision • Anti-Racism Action Plan • Policy Management • North Powys Integrated Wellbeing Hub • Risk Management & Assurance • Estates Assurance Asbestos Management
Limited Assurance	• Digital Systems Uptake
Unsatisfactory	•
Advisory/Non-Opinion	• Follow-up DoLS • Mattresses Follow-up
Assurance yet to be determined	• Mortality Reviews – Work in Progress • Budget Setting - Work in Progress

	• Vaccine Storage - Work in Progress • Learning Disabilities Eligibility Assessment & Care Co-ordination Processes – Work in Progress

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board’s risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the GIAS, the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Powys Teaching health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of GIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Committee, and other information obtained during the year that we deem to be relevant

to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control is set out below.

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there was **one** Limited audit in 2025/26) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2025/26, and reported to the Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.

Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).

- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified the majority of reviews carried out during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, **three** were allocated Substantial Assurance, **eleven** were allocated Reasonable Assurance, **one** was allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. **Two** reports were also issued where an assurance rating wasn't applicable.

At the time of producing the draft Annual Report, four audits were still work in progress but had not been sufficiently progressed to reliably determine the assurance rating. It is anticipated that the majority of the work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Committee for consideration and approval.

The audits of the Route Map to Sustainability and Strategic Commissioning were removed from the plan due to an overlap with the scope of the external support commissioned by the Health Board. The Head of Internal Audit has reviewed the final report provided by the external consultant and has considered the impact of the issues raised in relation to the stated areas, along with the actions proposed by the Health Board to address them. Specific audit work to review the implementation of the agreed actions has been included within the Internal Audit plan for 2026/27.

Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken two reviews in this area:

- **Policy Management:** A comprehensive governance framework for the development, approval and management of policies is in place, supported by an up-to-date Board approved policy, clear guidance for staff, and effective oversight arrangements within the Corporate Governance function. While the overall framework is sound, we did identify areas requiring management attention, primarily relating to out-of-date policies and accessibility. A significant proportion of policies recorded on the central database were overdue for review. In addition, weaknesses were noted in the consistency of document format, availability and accessibility across clinical and non-clinical libraries. We concluded **Reasonable** assurance on this area.
- **Risk Management & Assurance:** Significant progress has been made during the year following approval of the revised Risk Management Framework, including the introduction of a Board owned Strategic Risk Register, an Executive led Organisational Risk Register, revised Risk Appetite Statements, and the development of a Board Assurance Framework dashboard. Risk reporting and escalation arrangements are

largely effective, with clear links between strategic and operational risks and routine scrutiny by the Board, Executive Committee and sub committees. We did however identify areas requiring further management attention to ensure consistent and effective application of the Framework. Delays to the full implementation of the Datix risk management system have constrained the updating of guidance and delivery of training and limited the corporate oversight of risks. In addition, weaknesses were identified in elements of Primary Care and Public Health risk registers, including inconsistent scoring of risk impact, incomplete records and evidence of review. We concluded **Reasonable** assurance on this area.

A review of the Annual Governance Statement highlighted that it was generally consistent with our knowledge of the HB through the audit work performed in the Internal Audit plan and a review of other organisational documents. *- Still to be confirmed by review of the draft AGS to be submitted to the May AC.*

Strategic Planning, Performance Management & Reporting

The planned audits of Strategic Commissioning and Route Map to Sustainability were removed from the 2025/26 plan due to a duplication of scope with the coverage of the external support being procured by the Health Board.

We have reviewed the report produced by the external provider, along with the Health Board's responses, and taken that into account when determining the overall opinion. We have also included an audit within our 2026/27 plan to review the progress the Health Board is making towards the implementation of the agreed actions from the external review.

Financial Governance and Management

We have undertaken two reviews in this area.

- **Core Financials – General Ledger Management & Accounts Receivable:** The fundamental controls over access to the Oracle Financial System, authorisation of journals, feeder system interfaces and management of intra NHS debt are well established, with several areas receiving substantial assurance. Month-end processes are generally operating as intended, and invoices and receipts are appropriately generated and recorded, supporting the integrity of financial reporting and statutory returns. We did however identify weaknesses in balance sheet reconciliations, incorrect use of accrual codes, delays and inaccuracies in the Periodic Income Register, and long-standing weaknesses in the management of aged debt. We also noted that some financial control procedures and guidance are out of date and do not fully reflect current practice. We concluded **Reasonable** assurance on this area.
- **Budget Setting (WiP):** . We concluded **???** assurance on this area.

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The audit of Payroll received substantial assurance with Accounts Payable receiving Reasonable Assurance. The audit of PCS Ophthalmology Services received substantial assurance.

Quality & Safety

We have undertaken six reviews in this area, one of which is work in progress, but is planned for inclusion within the 2025/26 opinion.

- **Duty of Candour:** The Health Board's processes are broadly aligned with Welsh Government guidance and embedded within the Incident Management Framework, supported by use of the Datix system and reporting through established quality governance structures. In most cases, Duty of Candour incidents are appropriately identified, assessed and managed, and initial harm assessments by managers are generally consistent and accurate. Arrangements for Board level awareness are in place through inclusion of Duty of Candour activity and learning within the Integrated Quality Report and the Annual Duty of Quality reporting. We identified a few areas requiring further management attention, primarily relating to clarity of accountability, consistency of documentation and the effectiveness of training and reporting arrangements. We concluded **Reasonable** assurance on this area.
- **Decontamination:** Comprehensive and up-to-date decontamination policies and procedures are in place, and they are aligned with national legislation and Welsh Government guidance, with clear evidence that decontamination of reusable medical devices is generally undertaken in accordance with required standards. Strong arrangements were noted in relation to endoscopy traceability systems, audit activity and external sterilisation services provided on behalf of the Health Board, providing assurance that patient safety risks are largely well controlled. We identified a need to improve consistency of governance records and attendance, formalise and actively monitor a decontamination risk register, address gaps in staff training compliance, and strengthen monitoring of endoscopy water testing records to ensure anomalies are promptly investigated. We concluded **Reasonable** assurance on this area.
- **Clinical Supervision:** We assessed compliance with the Health Board's updated Clinical Supervision and Reflective Practice Policy and focused on the frequency, recording and quality of supervision, alongside the adequacy of supervisor training. We found that clinical supervision is generally valued by staff and widely undertaken, with most supervisees receiving supervision at least quarterly and reporting that it meets their developmental needs. Arrangements are in place for monitoring supervision frequency at a local level, supported by line management and appraisal processes. However, we identified a few areas requiring management attention to ensure consistent compliance with policy requirements. These included gaps in the frequency of annual live supervision, inconsistent recording of supervision sessions and limited use of standard documentation, and low uptake of clinical supervision training provided by the Health Board. We concluded **Reasonable** assurance on this area.
- **Deprivation of Liberties Safeguards Follow-up:** We were able to confirm that all the agreed management actions from the previous Limited assurance DoLS audit have been fully implemented, and the key findings from the original report have therefore been addressed.
- **Mattresses Follow-up:** We were able to confirm that all the agreed management actions from the previous Limited assurance Mattresses audit have been fully implemented, and the key findings from the original report have therefore been addressed.
- **Mortality Reviews (WiP):** . We concluded **???** assurance on this area.

Information Governance & Security

We have undertaken one review in this area:

- **Digital Systems Uptake:** We assessed how effectively digital systems are adopted and utilised following implementation and whether anticipated benefits are realised. While the Health Board has recognised weaknesses in this area and has taken steps to strengthen arrangements, most notably through the development of a Benefits Realisation Framework, implementation remains inconsistent. Benefits realisation plans were not routinely in place, user engagement varied between projects, and responsibility for realising benefits was not always clearly transferred to operational services following go live. More significant weaknesses were identified in relation to change management, training and the monitoring of system adoption. There was no overarching change management framework, limited dedicated change resource within projects, and training arrangements were often informal and inconsistent. Monitoring of digital system uptake is fragmented and largely project specific, with limited Board level visibility once projects close. We concluded **Limited** assurance on this area.

The planned audit of Digital Operating Model & Strategy was removed from the 2025/26 plan due to the digital deep dive undertaken by Audit Wales which included coverage of these areas.

Operational Service and Functional Management

We have undertaken six reviews in this area, two of which are work in progress, but are planned for inclusion within the 2025/26 opinion.

- **Continuing Healthcare:** The Health Board procured additional external support during 2025/26, linked to its escalation status, which included coverage of CHC. The scope of our audit, and the associated assurance provided, was therefore restricted to the specific objectives agreed and did not cover the wider CHC processes.

The Health Board has experienced significant and increasing demand pressures on CHC, with a material growth in case numbers and associated costs over the past year. Strong arrangements are in place in respect of the new electronic process for authorising CHC packages, which is compliant with the Health Board's Scheme of Delegation and the Welsh National Framework, and has improved timeliness by removing reliance on face-to-face approvals. Placement review activity is also largely effective, with review compliance meeting internal targets despite increasing caseloads per caseworker, and robust clinical assessment documentation underpinning decisions. We did identify several issues including outdated procedural documentation that does not fully reflect current practice, weaknesses in the consistency and accessibility of placement review records, and the absence of consolidated action tracking arising from reviews. In addition, while a comprehensive Complex Care Improvement Plan is in place to address CHC activity and cost pressures, reporting of progress at programme level was not sufficiently transparent to provide full assurance. We concluded **Reasonable** assurance on this area.

- **MH and LD Triage and Assessment Process:** The development and implementation of Phase 1 of the service was supported by strong project management arrangements and received appropriate Health Board approval and recurrent funding. Triage activity is undertaken in line with the Colgate Triage Categories and associated priority

timescales, and patient records evidence appropriate decision making. The service is operationally stable, with an appropriate staffing model in place and early evidence of reduced reliance on agency nursing staff. Identified weaknesses included an absence of formal governance arrangements for the Single Point of Access (SPOA) service within the MH & LD Directorate, delays in final approval of the SPOA Standard Operating Procedure, data quality issues arising from interface errors between WCCIS and Power BI, and limited reporting of service demand, capacity and performance to senior management. We concluded **Reasonable** assurance on this area.

- **Primary Care – Clusters Project Management:** The Health Board has developed a comprehensive and robust project management framework in the absence of detailed national guidance, with well documented procedures, standardised approval processes and effective monitoring of delivery, risks and financial performance. Reporting arrangements to Cluster Business Meetings and the Regional Partnership Board, and Executive Committee were found to be timely, structured and informative. We identified one area requiring management attention, relating to the wording of Cluster Terms of Reference, which do not accurately reflect the practical arrangements for voting on project approvals when conflicts of interest or non-responses reduce the number of eligible voters. We concluded **Substantial** assurance on this area.
- **Catering Services – Food Safety Standards:** Robust and comprehensive food safety policies, procedures and controls are in place across hospital catering services, supported by an effective Food Safety Management System aligned to statutory requirements and best practice. Staff were appropriately trained, food safety documentation was current and accessible, and operational practices observed during site visits demonstrated consistent compliance. Governance and reporting arrangements were assessed as strong, with clear escalation routes and evidence of effective oversight, including positive Environmental Health Officer inspection outcomes, with all sampled sites achieving the highest food hygiene ratings. One area requiring management attention was identified relating to inconsistent completion of management and supervisory self-assessment audits, for which formal expectations, roles and frequencies were not clearly defined within existing food safety procedures. We concluded **Substantial** assurance on this area.
- **Vaccine Storage (WiP):** . We concluded **???** assurance on this area.
- **Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (WiP):** We concluded **???** assurance on this area.

The planned audit of Site Co-ordination was deferred to the 2026/27 plan due to an on-going management refresh of the processes in place.

The planned audit of Community Care was deferred to the 2026/27 plan due to a change of scope to focus on Care at Home Services.

Workforce Management

We have undertaken two reviews in this area:

- **Staff Development Programme:** Robust processes are in place for programme development, aligned with Compassionate Leadership principles. There are clear governance arrangements for the programmes and effective communication and promotion across the organisation. Programmes are well embedded within the Health Board's strategic framework, with strong executive oversight and regular reporting

through established governance forums. The key area requiring management attention relates to the absence of a formalised feedback loop and action-tracking mechanism to ensure staff feedback is consistently reviewed, escalated, and used to inform continuous improvement. We concluded **Substantial** assurance on this area.

- **Anti-Racism Action Plan:** The Health Board has an approved and published Anti-Racism Action Plan aligned to the Welsh Government's Anti-Racist Wales Action Plan and integrated with the Strategic Equality Plan. Positive progress has been made in establishing governance arrangements, introducing relevant training, reviewing recruitment practices, and assessing local policies for inclusivity. The Plan has been endorsed by the Board and appropriately located within the People and Culture Directorate, with evidence of early progress in laying the foundations for delivery. However, we identified several areas requiring management attention to strengthen delivery and oversight. These included weaknesses in action plan management, infrequent formal reporting of progress to the People and Culture Committee, limited communication and visibility of anti-racism initiatives, and a lack of capacity and formality within the Black, Asian and Minority Ethnic Staff Network. We concluded **Reasonable** assurance on this area.

Capital & Estates Management

We have undertaken two reviews in this area:

- **North Powys Integrated Wellbeing Hub:** Appropriate systems and processes were in place and generally operating as intended during Phase 1 of the programme. Despite earlier delays against the original Programme Business Case timeline, the SOC/OBC was progressed at pace, delivered within the approved fee budget, and approved by Welsh Government in March 2026. Strong arrangements were observed in relation to project management, stakeholder engagement and design development, with clear leadership, well defined reporting structures, and effective partner working with Powys County Council. We did identify the need to refresh governance documentation, enhance clarity around delegated authorities and reporting, and consider the use of NEC Professional Services Contracts for future adviser appointments. We also highlighted ongoing risks relating to capital and revenue affordability, reflecting cost uncertainty at this stage of development and the absence of confirmed revenue costings. We concluded **Reasonable** assurance on this area.
- **Estates Assurance Asbestos Management:** While an approved asbestos management policy and supporting procedures were in place, with clear executive oversight and appropriate governance arrangements, weaknesses were identified in operational compliance and in the alignment between policy and practice. Although asbestos risks were generally identified and appropriately managed within sampled works, controls did not consistently provide assurance that statutory requirements were being met across the full estate. We concluded **Reasonable** assurance on this area.

The planned audit of Systems – Discretionary Capital was removed from the 2025/26 plan due to a shortage of Internal Audit resources to deliver the audit.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management actions and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the GIAS) and the level of overall assurance that we can give.

From the specific follow-up audits of DoLS and Mattresses undertaken in 2025/26, it was identified that progress had been made by management and all the agreed actions had been fully implemented.

Through 2025/26, the Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to each meeting of the Committee.

We undertook work towards the end of the year to validate the stated position for a sample of recommendations. We were able to confirm the recorded position for all of the sampled recommendations and therefore provide the Committee with additional assurance around the accuracy of the tracker. *This work is on-going so will need to confirm this wording as it is completed.*

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2025/26 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2025/26.

2.9 Statement of Conformance

The Welsh Government determined that the GIAS would apply across the NHS in Wales from 1 April 2025.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with GIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Committee that it has conducted its audit at the Health Board in conformance with the GIAS for 2025/26.

Our conformance statement for 2025/26 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2025/26 which will be reported formally in the Summer of 2026; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the GIAS and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2025/26 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2025/26.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit Committee and Chair of the Health Board.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Health Board

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other health bodies. These are set out below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the Purchase to Pay process.
PCS General Ophthalmic Services	Substantial	To evaluate the adequacy of controls in place to administer timely and accurate payments to general ophthalmic services (GOS) contractors
Payroll	Substantial	to evaluate the design and operation of the systems and controls in place within payroll services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. The overall Head of Internal Audit Opinion for NWSSP is **Reasonable Assurance**.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Programme Management	Reasonable	To provide assurance over the timely rollout of a sample of digital programmes / projects across Wales and steps taking place to overcome obstacles, challenges and manage the delivery of benefits.
Cyber Security	Reasonable	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
GMS Clinical System Migration Project	Reasonable	To assess the management and delivery of the GMS Clinical System Migration project.
CaNISC	Reasonable	To ensure the risks associated with the withdrawal / replacement of the Cancer Network Information System Cymru (CaNISC) are appropriately managed.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
IPFR	Substantial	To review the process and arrangements in place for making decisions on and monitoring spend relating to IPFRs.
Budget Management	TBC	The JCC’s Chief Commissioner is accountable for managing a commissioning budget of around £1.3 billion. This budget is not a separate Welsh Government allocation; it is a pooled budget made up of contributions from the seven Health Boards
High-Cost Drugs	TBC	Review of the processes and arrangements relating to high cost drugs commissioned by the JCC.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation’s activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2026/27 operational audit plan.

The audit plan approved by the Committee in March 2025 contained 27 planned reviews. Changes have been made to the plan with 6 audits removed or deferred. All these changes have been reported to, and approved by, the Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	March 2025	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2025/26	A	81% 17/21	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 17/17	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	G	82% 14/17	85%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 17/17	95%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 21 (table currently showing 17 and will need to be updated following completion of work in progress) audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

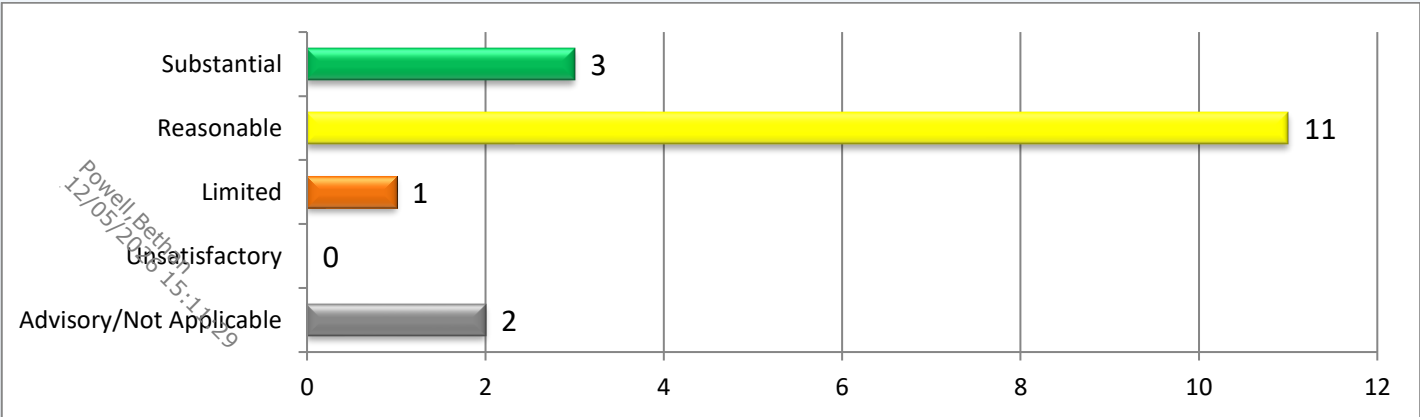


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Staff Development Programme	To review the processes for developing and delivering the staff development programme, linked into the Management Charter (the BTHB Manager) / Compassionate Leadership.
Primary Care - Clusters Project Management	To assess how the project management processes within the clusters are working to enable effective identification and implementation of developments.
Catering Services – Food Safety Standards	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.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Duty of Candour	To consider the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour
Continuing Healthcare	To review recent changes and future plans around continuing healthcare to address the current level of cases and costs and to provide assurance on the efficacy and timeliness of placement reviews.
MH and LD Triage and Assessment Process	To review the project management and implementation of Phase 1 of the new Single Point of Access (SPOA) Triage and Assessment Model for Mental Health & Learning Disabilities (MH & LD) Services in Powys Teaching Health Board
Core Financials – General Ledger Management & Accounts Receivable	To review the systems and controls in place for General Ledger Management and Accounts Receivable.
Decontamination	To review the Health Board's structures and processes for decontamination of equipment, to ensure compliance with relevant standards and legal requirements.
Clinical Supervision	To 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.
Anti-Racism Action Plan	To assess the systems and processes in place for implementation and embedding of the Health Board Anti-Racism Action Plan.
Policy Management	To review the arrangements and processes in place for the creation, management and review of Health Board Policies and procedures.
North Powys Integrated Wellbeing Hub	To evaluate the processes and procedures put in place by to support the management and control arrangements applied to deliver the project through to the Submission of the FBC.
Risk Management & Assurance	To assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risks.
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.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Digital Systems Uptake	To review the level of uptake and utilisation of digital systems once they have been introduced.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Deprivation of Liberties Safeguards Follow-up	To establish and validate the level of progress that has been made towards the implementation of the agreed management actions from previous Limited assurance audit.
Mattresses Follow-up	To establish and validate the level of progress that has been made towards the implementation of the agreed management actions from previous Limited assurance audit.

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5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for removal / deferral
Strategic Commissioning	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board.
Route Map to Sustainability	Removed due to duplication of scope with the coverage of the external support being procured by the Health Board.
Digital Operating Model & Strategy	Removed due to digital deep dive undertaken by Audit Wales which included coverage of these areas.
Systems – Discretionary Capital	Removed due to shortage of Internal Audit resources to deliver audit.
Site Co-ordination	Deferred to the 2026/27 plan due to an on-going management refresh of the processes in place.
Community Care	Deferred to the 2026/27 plan due to a change of scope to focus on Care at Home Services.

5.8 Work in progress

At the time of producing the draft Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. It is anticipated that the majority of this work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

Review Title	Objective
Budget Setting	To review how the Health Board allocates resources to meet its agreed budget.
Mortality Reviews	To review the adequacy of the systems and controls in place for mortality reviews, including the processes for dealing with deaths that are referred to the Health Board by the Medical Examiner for further review.
Vaccine Storage	Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.
Learning Disabilities Assessment & Care Co-ordination Processes	To review the eligibility assessment and care co-ordination processes operating within the Learning Disabilities service.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2025/26 plan.

Ian Virgill

Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

May 2026 / June 2026

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Appendix A

Internal Audit compliance with the Global Internal Audit Standards and the UK Public Sector Practice Note

Global Internal Audit Standards – Domains, Principles & Standards	Requirements & Response
Domain I: Purpose of Internal Auditing	Internal auditing strengthens the organisation’s ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight. Advice and assurance are provided primarily through a risk-based audit plan approved and monitored by the Audit Committee. Audit & Assurance uses the results of its audits, together with focused research, to provide insight and foresight.
Domain II: Ethics & Professionalism Principles 1 (Demonstrate Integrity), 2 (Maintain Objectivity), 3 (Demonstrate Competency), 4 (Exercise Due Professional Care), and 5 (Maintain Confidentiality). 13 individual standards.	Audit & Assurance has established processes for dealing with both the ethics and professionalism of Internal Audit and the need to maintain client confidentiality. This encompasses training, declarations of interest returns, our audit processes, and the requirements (where appropriate) of professional accounting and audit bodies.
Domain III: Governing the Internal Audit Function Principles 6 (Authorised by the Board), 7 (Positioned Independently), and 8 (Overseen by the Board). 9 individual standards.	How we interact and work with each NHS Wales organisation is set out in the Internal Audit Mandate and Charter which is updated annually. There are appropriate arrangements in place for Internal Audit to act independently and interact with the Board to ensure effective Governance arrangements.
Domain IV: Managing the Internal Audit Function Principles 9 (Plan Strategically), 10 (Manage Resources), 11 (Communicate Effectively), and 12 (Enhance Quality). 16 individual standards.	The Internal Audit function for NHS Wales is managed through the NHS Wales Shared Services Partnership (NWSSP). The Audit & Assurance service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual plan is developed for each NHS Wales organisation. The annual plan gives detail of specific assignments and sets out the overall resource requirement. The audit

	strategy and annual plan is approved by the Audit Committee. Quality assurance and control arrangements are in place and are subject to an external assessment at least once every five years. Policies and procedures which guide the Internal Audit activity are in place. There is structured liaison with Audit Wales, HIW and Counter Fraud.
Domain V: Performing Internal Audit Services Principles 13 (Plan Engagements Effectively), 14 (Conduct Engagement Work), and 15 (Communicate Engagement Results and Monitor Action Plans). 14 individual standards.	Audit & Assurance has a Quality Manual that sets out how we will conduct and monitor audit engagements and this is then replicated in our Electronic Working Paper system (ESRA) and other files. This ensures that we meet the requirements to plan, conduct and communicate audit engagement appropriately and follow-up management actions.

[Global Internal Audit Standards](#)

[UK Public Sector Application Note](#)

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Appendix B

Assurance Opinion

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee. Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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Prioritisation of Findings

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.3a

Audit, Risk and Assurance Committee		Date: 12 May 2026
Subject:	Risk Management Framework and Board Assurance Framework	
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 – 06 May 2026 who endorsed both frameworks.	
PURPOSE:		
To provide the Audit, Risk and Assurance Committee with the revised CGP 005 Risk Management Framework and CGP 014 Board Assurance Framework for recommendation to the Board in May 2025 for approval.		
RECOMMENDATION(S):		
The Audit, Risk and Assurance Committee is asked to RECOMMEND to the Board for approval the revised:		
- CGP 005 Risk Management Framework - CGP 014 Board Assurance Framework		
Approve/Take Assurance	Discuss	Note
Y	N	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The effective management of risk is a key enabler of the achievement of the Health Board's 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	

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EXECUTIVE SUMMARY:

CGP 005 The Risk Management Framework (RMF) sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities. A fundamental review of the RMF was undertaken in 2024 and a revised version was subsequently approved by the Board in March 2025.

CGP 014 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. The BAF was first published following approval by the PTHB Board in May 2024.

The Health Board recognises the BAF as a complex system comprising of a number of key elements including:

- CGP 005 the Risk Management Framework and the supporting documents produced under the auspices of the BAF to provide effective strategic risk assurance;
- The Integrated Quality and Performance Framework; and
- The overall system of governance deployed by the Board and the Chief Executive to ensure good governance within the organisation.

A review of both documents has been undertaken to ensure:

- both documents remain fit for purpose in the organisation's current context;
- consistency and read across between both documents as fundamental elements of the health board's overall governance, risk and assurance framework;
- currency with any revised organisational structures, systems and processes; and
- alignment with current risk management and assurance guidance and best practice.

NEXT STEPS:

If recommended by the Committee, CGP 005 the Risk Management Framework and CGP 014 the Board Assurance Framework will be presented to Board for approval on 20 May 2025.

APPENDICES

- a. CGP 005 Risk Management Framework
- b. CGP 014 Board Assurance Framework

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe			X		Effective management of risk enables proactive and preventative use of actions and mitigations to reduce undesired effects and promote a culture continuous improvement.
Timely			X		
Effective			X		
Efficient			X		
Equitable					
Person Centred			X		
Workforce			X		
Leadership			X		
Culture					
Information			X		
Learn, Improve, Research			X		
Whole Systems Approach			x		

EQUALITY:

	No impact	Negative	Positive	Both	
Age	X				There are no identified impacts on equality.
Disability	X				
Gender reassignment	X				
Marriage / civil partnership	X				
Pregnancy / maternity	X				
Race	X				
Religion or Belief	X				
Gender	X				
Sexual Orientation	X				
Welsh Language	X				
Socio-economic status	X				
Social exclusion	X				
Carers	x				

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	X				The Risk Management Framework sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.
Financial	x				
Corporate	X				
Operational	X				
Reputational	X				

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Risk Management Framework

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Document Type	Policy

Powys Teach Health Board is the operational name of Powys Teaching Local Health Board

To ensure that you are always using the latest version of this corporate policy, please refer to the version on the Corporate Governance SharePoint site

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Associated Policies and Written Control Documents
CGP014 Board Assurance Framework
PTHB Strategic Commissioning Framework and Commissioning Assurance Framework
PTHB Integrated Quality and Performance Framework

Version Control

Version	Summary of Changes/Amendments	Publication Date
2.2	2017 Version Updated to reflect changes in risk management arrangements and organisational realignment	September 2019
3.0	2019 Version Updated to reflect changes in risk management arrangements and	November 2021

	organisational realignment	
4.0	2021 Version Updated to reflect changes in risk management arrangements and organisational realignment	November 2022
5.0	2022 version updated to reflect changes in risk management arrangements and organisational realignment	March 2025
6.0	2025 version updated to improve alignment with Board Assurance Framework and transferred into new template	TBC

1. Scope

This framework applies to all employees of the Health Board; Board members; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services.

Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

2. Policy Statement

This document aims to set out the organisational arrangements for developing and embedding risk management processes in Powys Teaching Health Board.

3. Purpose

This document sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

The Framework seeks to ensure:

- that risk management is an integral element of the Health Board's culture;
- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised through effective risk management practices;
- that the wellbeing of patients, staff and visitors is optimised;
- that the resources of the Health Board are protected;
- the implementation and ongoing management of a comprehensive,

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integrated (clinical and non-clinical) approach to the management of risk across the organisation;

- that the Board receives adequate assurance to ensure that strategic and operational risks are being managed effectively; and
- clarity in regard to respective responsibilities for strategic and operational risk management for the Board, Board Committees, relevant groups and staff throughout the organisation.

Should you have any queries in relation to this framework or an associated document please contact:

powysdirector@corporategovernance@wales.nhs.uk

4. The Board's Statement

The Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board's governance framework and system of internal control.

The Board is committed to having an integrated risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is compliant with legal and regulatory requirements; meeting objectives; and, promoting its values.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic priorities;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's Appetite for Risk (see Risk Appetite Statement at Appendix A);
- Adopting an integrated approach to risk management that includes risks related to clinical care, professional standards, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is **everyone's** business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and appropriately managed, i.e. where possible terminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to

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report risks, incidents and near misses that is used for organisation-wide learning;

- Establishing clear and effective communication and escalation mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and
- Providing appropriate training to staff to ensure effective implementation of risk management arrangements.

5. The Board's Appetite for Risk

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

The Board places fundamental importance on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy: '*A Healthy, Caring Powys*'.

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - its risk appetite - and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.

The Board will seek to balance all categories of risk appetite, in reality complex decisions contain components that fall across the range of risk categories, for example financial sustainability, performance and service sustain ability and workforce could all be contained within any one decision.

The Board's Risk Appetite Statement, which is included at Appendix A, has been defined following consideration of key risks, issues and consequences. Appetite levels will vary, in some areas. Some areas risk appetite may be cautious, in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic priorities. The Health Board will always aim to operate organisational activities within the levels defined within the Risk Appetite Statement. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate escalation and

governance mechanisms to the Board for ratification.

6. The Risk Management Process

Risk Management is the systematic application of management policies, procedures and processes to support the identification, analysis, assessment, treatment and monitoring risk in a way that enables us to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:



The Orange Book (2023)

a. Risk Identification and Assessment

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care.

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

b. Treatment

Treatment is how the risk will be managed, and how we will modify our behavior or approach to achieve an acceptable level of risk. The actions introduced to mitigate (reduce the impact or likelihood of a risk materializing) are known as controls. Those additional actions that are underway to further increase control are known as planned actions. All risks are recorded on an appropriate risk register, which is a formal record of the risks that the Health Board has identified.

c. Monitoring

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

d. Reporting

Risk reporting supports the organisation to assess whether decisions are being made within its risk appetite to successfully achieve objectives, to review the adequacy and effectiveness of internal controls, and to decide whether any changes are required to re-assess strategy and objectives, revisit or change policies, reprioritise resources, improve controls, and/or reconsider their risk appetite/tolerance.

At a strategic level the Board Assurance Framework provides key tools for monitoring and reporting against the effectiveness of the management of our strategic risks.

Operationally, the Health Board's detailed guidance in support of the risk management process is included in the risk management toolkit on the staff [intranet](#) and includes guidance on how to identify, assess, treat and monitor risks. The toolkit remains extant but will continue to be revised in order to align to our maturing Risk Management and Board Assurance Frameworks.

7. Levels of Risk

The Risk Management Framework defines three levels of risk:

- a. **Strategic Risks** – Risks that represent a threat to achieving the Health Board's strategic priorities or its continued existence. Strategic risks are recorded in the Board's Strategic Risk Register (SRR). The SRR provides an organisation-wide summary of significant risks that have the potential to hinder achievement of one or more of the Health Board's strategic objectives. Strategic Risks are owned by the Board, and are reviewed and monitored by the Executive Committee

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- b. **Operational Risks** – Risks that represent a threat the day-to-day activities of the Health Board. Operational risk registers may include risks to the achievement of directorate or service objectives; the day-to-day operation of the directorate or service, i.e., delivering a safe and sustainable service for patients; and risks in regard to any legislation or standards that the directorate or service should be compliant with.

The Health Board is currently in a period of transition, with the transition to a digital system for recording, and reporting on operational risks.

There are three levels of operational risk register within the organisation:

- Organisational
- Directorate
- Service Level

Further information on the hierarchy of operational risk registers, and the relationship with strategic risk is included on pages 9 – 13 of this Framework.

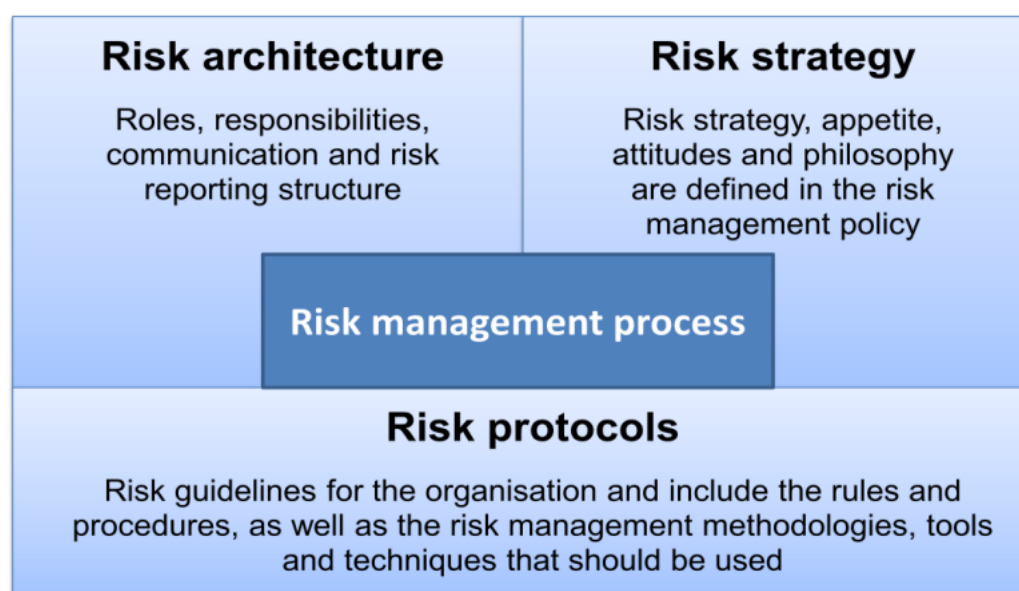
- c. **Project/Programme Risks** – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

Powys Teaching Health Board is predominantly a commissioning organisation, procuring services on behalf of the population from a wide range of providers including primary care contractors; independent sector care homes; ambulance services; district general hospitals; and other specialist hospitals. The Health Board's **Integrated Quality and Performance Framework** helps to identify and escalate and mitigate emerging patterns of poor performance and risk in health services used by Powys patients. Through this process, risks may be identified for recording in Service or Directorate risk registers or the Organisational Risk Register, dependent upon the level and type of risk.

8. Risk Architecture and Escalation routes

Risk architecture is the organisations structures established around risk management detailing the roles, responsibilities and the lines of communication for reporting on risk. A risk register provides an agreed, standardised approach to recording of the significant risks that have been identified through the risk assessment process, ownership of those risks, and will also serve as a record of the controls that are currently in place to manage or mitigate the risk. It will also provide a record of the additional

actions that are proposed to improve 'control' of risks (i.e., to treat the risk further), including responsibility and timescales for implementation. Effectively used, a risk register will not only drive risk management but should be integrated to inform decision-making, prioritisation and assurance processes. Risk registers are also used to provide assurance that risks are being managed appropriately and effectively.



Fundamentals of Risk Management (2020)

Recording of Strategic Risk

Strategic risks are recorded in the Board's Strategic Risk Register (SRR). The SRR provides an organisation-wide summary of significant risks that have the potential to hinder achievement of one or more of the Health Board's strategic priorities.

The risks contained in the SRR are further scrutinised via the Health Board's Board Assurance Framework (BAF) mechanisms such as the BAF Dashboard and Annual Review of Strategic Risk Assurance. In the risk management context the Board Assurance Framework provides a structure and process that enables the Health Board to focus on ensuring the effectiveness of Strategic Risk Management techniques by identifying the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic objectives. The BAF Dashboard provides assurance on the effectiveness and adequacy of the controls in place to manage the Health Board's Strategic Risks. It should support effective decision-making and inform Board agendas in addition to providing assurance on the system of internal control. It also ensures that the assurance mechanisms operating across the Health Board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives. Further detail can be found in the [Board Assurance Framework](#).

The SRR (alongside the BAF Dashboard) is reviewed by the Executive Committee in advance of presentation to the Board at each of its meetings. The Executive Committee is responsible for recommending risks for escalation to / de-escalation from the SRR for approval by the Board. The Executive Committee may also recommend to the Board the 'acceptance' of risks that cannot be brought within the Board's risk appetite/tolerance.

Each strategic risk is currently allocated to a Committee of the Board for additional scrutiny and oversight. Committee Risk Registers based on the most recent iteration of the SRR approved by the Board are reported to each Committee as a standing item. In 2026/27 it is the intention to integrate Organisational Risks into the Committee Risk Register, given the greater ability to influence and manage organisational level risks.

The Annual Review of Strategic Risk Assurance provide a more detailed analysis of each strategic risk, and its associated controls will be reviewed by the Executive Committee in advance of presentation to the Audit, Risk and Assurance Committee on an annual basis.

Recording of Operational Risk

The Health Board is currently in a period of transition, with the transition to a digital system for recording and reporting on operational risks.

There are three levels of operational risk register within the Health Board:

Organisational Risk Register (ORR)

The Organisational Risk Register is a log of significant risks to the organisation that have been identified from a top-down and bottom-up approach (for example these may be identified by the Board or an individual Executive Director or escalated through the organisation's risk architecture).

These are significant risks that affect the organisation's ability to achieve organisational/directorate objectives and significant operational risks affecting the delivery of healthcare services. Individual Executive Directors are responsible for identifying risks potentially requiring escalation from Directorate Level to the ORR. Whilst the Executive Committee is responsible for approving risks proposed for escalation to the SRR and subsequent de-escalation/closure of risks on the ORR.

Whilst each Director will be responsible for the ownership of their respective risk(s) and identifying current controls and developing action plans, it will be the role of the Executive Committee to review controls and ensure appropriate action plans are in place, which might include the development and agreement of corporate risk management strategies to manage risk(s).

The Organisational Risk Register will be reported to the Board as an appendix to the detailed BAF.

It will be the role of the Executive Committee to report by exception any risks on the ORR which require sightedness and/or additional scrutiny by the Board or Board Committees. The primary mechanism for reporting matters pertaining to risks to the Board will be the Risk Management and Board Assurance Framework report provided to each Board meeting by the Director of Corporate Governance, though information in regard to operational risks may also be included in individual papers and Committee Chairs Assurance Reports.

As noted above, in 2026/27 it is the intention to integrate Organisational Risks into Committee Risk Registers, given the greater ability to directly influence and manage organisational level risks.

Directorate Risk Registers (DRR)

Directorate level risks are any risks that affect the directorate and its objectives, or risks that have been escalated from service level.

The relevant Executive Director is responsible for approving the inclusion and closure of risks on directorate risk registers and de-escalation to the Service Level Risk Register (SLRR). Executive Directors may also highlight risks for possible escalation to ORR or request for acceptance of risk above appetite/tolerance.

Each Executive Director is responsible for ensuring appropriate representation and attendance at the Operational Leadership Group (OLG), a sub-group of the Executive Committee. The OLG provides the opportunity to collectively review of the ORR and DRRs, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate.

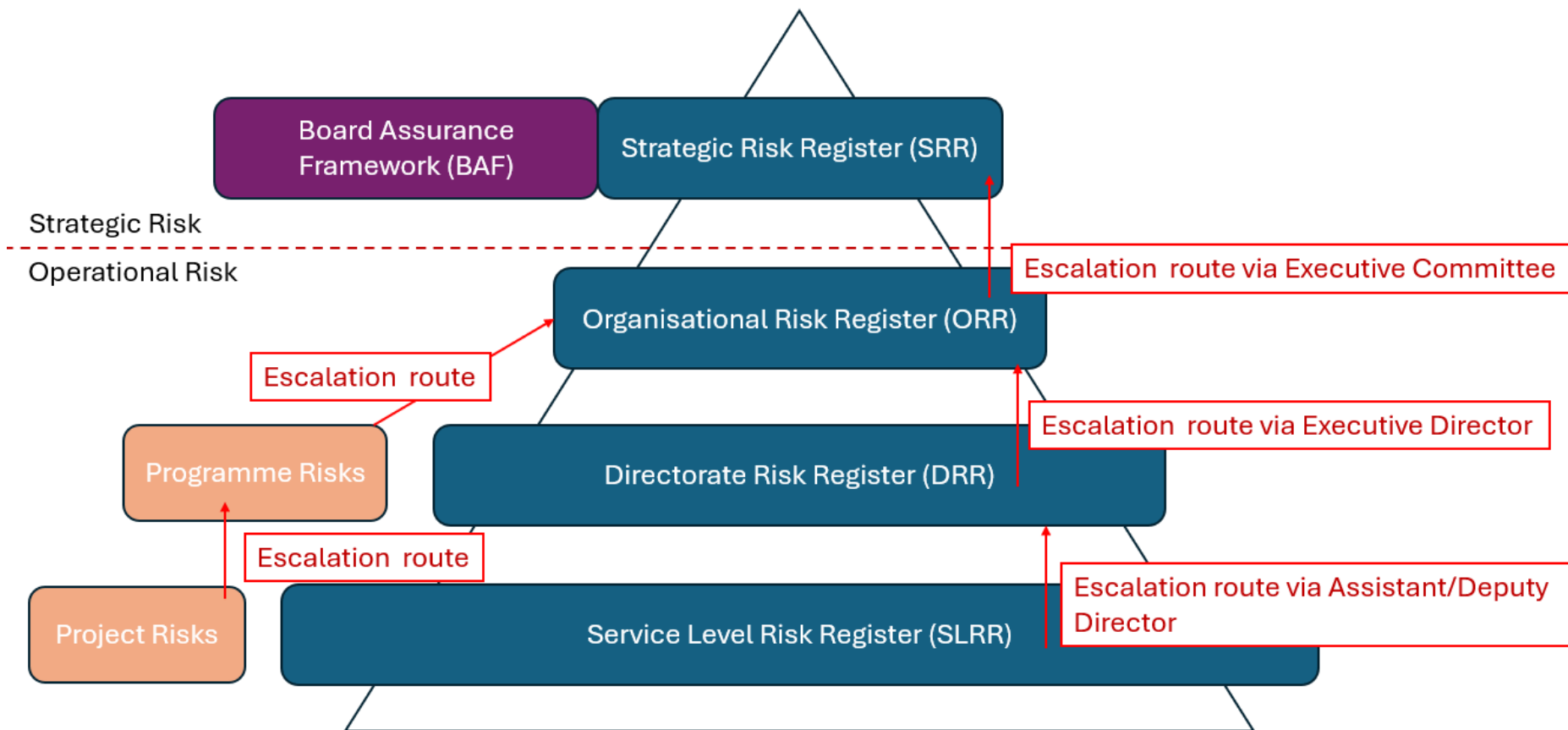
Whilst recognising that the primary mechanism for the escalation of risk is through management channels, as part of the ORR process managed by the Corporate Governance Team the OLG may identify risks for consideration for escalation and de-escalation from/to the ORR and make a recommendation to the Executive Committee as appropriate.

Service Level Risk Registers (SLRR)

Service level risks are risks which affect a service; the Deputy/Assistant Director/Head of Service is responsible for approving the inclusion and closure of operational risks on to the service risk register, as well as highlighting risks to the relevant Executive Director for possible escalation. The relevant Executive Director is responsible for approving service level risks that require escalation to directorate level.

The risk architecture used in the Health Board and the relationship between strategic and operational risk registers is provided below:

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9. Risk Escalation

The risk management system includes the opportunity for escalation through the levels of the organisation's risk architecture as outlined above. Risks should be managed by the identified owner, or a person otherwise appointed by the risk owner. There may however, be circumstances where the ability to manage a risk may exceed the authority of the risk owner.

Where significant risks have been identified which are deemed too challenging to manage, consideration should be given for the escalation of these risks to the next level of responsibility for additional consideration. These could include decisions for additional resources, increased oversight, review or the acceptance of the risk. Escalation also allows the opportunity for a risk to be considered against other risks at that level in terms of its potential individual and cumulative impact(s) e.g. organisation/directorate wide perspective. This allows for a higher level of authorisation to sanction continued tolerance or undertake additional actions to manage increasingly higher levels of risk.

Potential Reasons for escalation

- A risk is above appetite level and there is nothing that the risk owner can do to reduce it to within appetite
- Risk treatments are outside of the delegation of the risk owner
- A risk is shared by other areas of the organisation and risk treatment cannot be agreed
- Significant threat to patient safety, the achievement of the Health Board's plans, targets or the Health Board's reputation
- A risk is assessed to be of significant concern (for example a risk score of 20+ at Directorate Level or 16+ at Service Level)

To enable dynamic escalation and empowerment of risk owners and managers there are no minimum scoring requirements for escalation. Some risk owners may however find scoring useful as a guide when considering whether to escalate a risk.

De-escalation

Risks can be de-escalated when the higher-level risk register owner is satisfied with the management of the risk, e.g. the risk has been reduced or the risk has been accepted above appetite and there is no further benefit of higher-level oversight.

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10. Roles and Responsibilities

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. Specific duties and responsibilities are set out below. This includes governance bodies, individuals and staff groups with specific responsibility, accountability and authority for risk management, as part of their existing roles:

a. All PTHB Employees

All PTHB employees will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety, and all others that may be affected by the Health Board's business;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work, and the notification to their line manager of any perceived risk that may not have been assessed; and
- be aware of the Health Board's Risk Management Framework and any local processes and procedures and comply with them.

b. The Board

The Board (made up of our Executive Directors and Independent Members) have collective responsibility for the setting and ensuring delivery of strategic priorities, as detailed with our Annual Plan. Key strategic risks against the plan are identified and monitored by the Board. The BAF and SRR provide a central record of risks to the delivery of our strategic priorities. It is the duty of the Board to discuss and advise on the format and content of the RMF, BAF and SRR. It is also the duty of the Board to appropriately monitor the Health Board's significant risks, associated controls and assurances.

The Board is also responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driving the delivery of the Health Board's strategic priorities.

The workplans for the Board and each of its committees will be aligned to the BAF and SRR, ensuring appropriate focus on areas of most significant risk.

In the context of this Framework the Board will:

- demonstrate its continuing commitment to risk management through the endorsement of this Framework;
- ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
- take a lead role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic priorities, and ensuring that controls put in place in response, manage risks to an acceptable level;
- oversee and participate in the risk assurance process;
- ensure communication with partner organisations on problems of mutual concern including risks;
- ensure that appropriate structures are in place to implement effective risk management;
- commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
- ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data; and
- receive reports from the committees of the Board in line with terms of reference and workplans of those committees.

The Terms of Reference for the committees that report to the Board are included on the Health Board's website:

[Powys Teaching Health Board Committees - Powys Teaching Health Board \(nhs.wales\)](https://www.nhs.uk/healthboard/powys-teaching-health-board/committees/)

c. The Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee is responsible for overseeing the Health Board's governance framework and system of internal control, including risk management processes across the organisation. The Committee has a particular focus on seeking assurance that effective systems are in place to manage risk; that the organisation has an effective framework of internal controls to address strategic risks (those likely to directly impact on achieving strategic objectives); and, that the effectiveness of that framework is regularly reviewed.

The Committee is responsible for monitoring the assurance environment and challenging the levels of assurance in respect of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied upon, and reviewing the internal audit plan in-year as the risk profiles change.

d. Chief Executive Officer (CEO)

The CEO is the Accountable Officer of the Health Board and has overall

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accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and governance. The CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

e. Director of Corporate Governance / Board Secretary

The Director of Corporate Governance / Board Secretary is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the Board Assurance and Risk Management Frameworks. The Director of Corporate Governance/Board Secretary will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and, Executive Directors, to oversee an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Strategic, Organisational and Directorate level risk registers;
- oversee the effective execution of the Health Board's Assurance Framework and Risk Management Framework; and
- produce the Health Board's Annual Governance Statement.

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f. The Executive Committee

The Executive Committee has responsibility for ensuring implementation of the risk management process and has responsibility for agreeing the risks on the SRR and ORR, prior to consideration and approval by the Board.

The Executive Committee has the responsibility to discuss the BAF Dashboard and any amendments, to ensure there is appropriate scrutiny and challenge of strategic risks, the current controls and assurances in place and the actions to address any gaps in these, prior to the dashboard being submitted to the Board for consideration and assurance.

It is also the role of the Executive Committee to agree that strategic and organisational risks are being managed to an acceptable level, balancing priorities, resources and the risk to the Health Board, and recommending the best course of action to manage the risks, to the Board. The Board must be provided with assurance that all proportionate actions to reduce the risk are progressed, and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the Health Board. Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures will be regularly reviewed to ensure that they remain effective.

g. Operational Leadership Group (OLG)

The Operational Leadership Group is a sub-group of the Executive Committee. The Group reports to the Executive Committee and advises on a range of cross organisational issues, including any risk management and all significant operational risks.

The Group is responsible for supporting the implementation of the risk, control and assurance processes established within the organisation. The Group will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (service level, directorate and organisational) and the Board's SRR and BAF.

Specifically, the Group is responsible for:

- Embedding risk management promoting the integration of risk and assurance management.
- Regularly reviewing the Organisational Risk Register and Directorate Risk Registers, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate.

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- maintaining clear links with the Board Assurance Framework;
- Discussing and recommending the escalation and de-escalation of risks from/to the ORR for Executive Committee consideration when appropriate by ensuring significant risks are appropriately prioritised. Reviewing and monitoring closely risks that are identified by members as of potential significance organisationally however are not deemed to meet the criteria for inclusion within the ORR.
- Supporting the establishment of a 'Risk Champions' forum for support in relation to all aspects of risk management including sharing best practice and providing appropriate peer review and challenge to enable cross organisation consistency in the application of the Risk Management Framework and its supporting documents.

h. Deputy Board Secretary

The Deputy Board Secretary is accountable to the Director of Corporate Governance / Board Secretary, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the Health Board's Assurance Framework;
- develop and implement the Health Board's Assurance Framework;
- develop and implement the Health Board's Risk Management Framework; and
- lead the development of, and Chair, the Risk Champions Forum.

i. Corporate Governance Team

The Corporate Governance Team is accountable to the Deputy Board Secretary, and in relation to risk management will specifically:

- support the management and development of the Health Board's Assurance Framework and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Strategic Risk Register, Organisational Risk Register and Board Assurance Framework Dashboard, for Executive Committee and Board;
- support the development and functioning of the Risk Champions Forum;
- engage with Directorates to enable effective implementation of the Risk Management Framework and associated processes;
- and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers.

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j. Executive Directors

Executive Directors are accountable and responsible for ensuring that their respective directorates are implementing this Framework, and related procedures and processes. Each Director is accountable for the delivery of their particular area of responsibility, and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic priorities.

Specifically, they will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- communicate to their directorate, the Board's strategic objectives; and ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a mechanism for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;
- co-ordinate the risk management processes which include risk assessments; incident reporting; the investigation of incidents/near misses; and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- Identify and manage risks that cut across delivery areas;
- Communicate downwards what the Health Board's strategic risks are;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, **Clinical Executive Directors** (Executive Medical Director, Executive Director of Nursing, Quality, Women and Family Health, Executive Director of Allied Health Professions, Health Science and Digital, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this framework.

k. Independent Members

Independent Members have an important role in risk management. This role is restricted to seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to Executive Directors and senior management. The role of Independent Members is not to manage individual risks, but to understand and question risk on an informed and ongoing basis.

Additionally, Independent Members chair Board level committees, and in line with the relevant committee Terms of Reference, should provide assurance to the Board that risks within its remit (determined by the SRR), are being managed effectively by the risk owners, and report any areas of concern to the Board.

I. Clinical Directors, Deputy/Assistant Directors and Heads of Service

Clinical Directors, Deputy/Assistant Directors and Heads of Service are responsible for implementation of the Risk Management Framework and relevant policies and procedures, which support the Health Board's risk management approach.

As Senior Managers of the organisation, Clinical Directors, Deputy/Assistant Directors and Heads of Service take the lead on risk management and set an example through visible leadership of their staff. These responsibilities include:

- Taking responsibility for managing risk;
- Maintaining a Service Level Risk Register for their area of responsibility;
- Ensuring that risks are assessed where they are:
 - Identified within the working activities carried out within their management control or area of professional oversight;
 - Identified within the environment within their control;
 - Reported from the staff within their management control, or area of professional oversight.
- Identifying and managing risks that cut across delivery areas;
- Ensuring all incidents/accidents and near misses are reported;
- Monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- Discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focused approach;
- Ensuring risks are updated regularly and acted upon;
- Communicating downwards what the Health Board's strategic risks are;
- Using the risk management process to support prioritisation and

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- decision making;
- Ensuring staff are suitably trained in risk management;
- Promoting a risk aware culture in which staff are encouraged to identify and escalate risk;
- Ensuring that risk management is included in appraisals and development plans where appropriate;
- Ensuring the adoption and operation of the risk management framework across their work area.
- Escalating risks for further consideration where the ability to manage a risk exceeds the authority of the individual or the Board's risk appetite.

m. Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks within a structured risk management framework. Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers play an important role in managing and escalating operational risks and as such, must be fully conversant with the Health Board's and respective Directorate's approach to risk management and governance. They will support the application of this framework and its related processes and participate in the monitoring and auditing process.

n. Contractors employed by the Health Board e.g. capital and estates specialists

It is the responsibility of each contractor employed by the Health Board to ensure that any staff working on their behalf is fully conversant with both PTHB's and their own organisations risk management requirements for the activity for which they are engaged.

11. The Risk Management Toolkit and Training

To support delivery of the Risk Management Framework, a toolkit is available for staff on the [intranet](#). The toolkit is a means by which the Risk Management Framework is operationalised to put into effect the full range of activities outlined. The toolkit includes:

- Risk Management Process

- Risk Assessment Procedure
- Risk Scoring Matrix
- Risk Register Procedure
- Risk Register Template & Guidance

The Risk Management Toolkit remains extant but will be periodically updated to align to the organisation's maturing risk management processes. For any queries in relation to the Risk Management Toolkit or its content please contact:

powysdirector@corporategovernance@wales.nhs.uk

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members	Review of Risk Appetite	Annual
	Risk Awareness Training	Every 2 years
Risk and Assurance Group / Risk Register Coordinators	Risk Awareness Training, including Risk Assessment and Risk Register Training	Every 3 Years
Service Managers / Risk Owners	Bespoke training delivered on a needs-based approach	Ad hoc / as required
All Staff	Open invite Risk Awareness Training	Annual

12. Implementation Monitoring Compliance, Audit & Review

Compliance with this Framework is monitored by the Board, Executive Committee and the Audit, Risk and Assurance Committee.

The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process.

APPENDICES

Appendix A

Glossary of terms	
Term	Definition
Risk	The effect of uncertainty on objectives. An effect may be positive, negative, or a deviation from the expected. In addition, a risk is often described as an event; a change in circumstance; or a consequence.
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks, with a view to increasing the probability of success and reducing the likelihood of failure.
Risk management framework	Organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation.
Risk architecture	Risk architecture is the organisational arrangements for risk management detailing the roles, responsibilities and the lines of communication for reporting on risk management.
Risk assessment	A systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk treatment	The development, selection and implementation of risk treatment strategies and controls.
Risk appetite	The amount of risk that an organisation is willing to pursue in order to meet its strategic objectives.
Risk tolerance	Whilst risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can actually cope with.
Risk owner	The person with the authority and accountability to make the decision to treat, or not to treat the risk.
Strategic risks	Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence.
Operational risks	Risks that are by-products of the day-to-day running of the Health Board and may include risks such as to the achievement of directorate or service objectives; the day-to-day operation of the directorate or service, i.e. delivering a safe and sustainable service for patients; and risks in regard to any legislation or standards that the directorate or service should be compliant with.

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CGP 014 Board Assurance Framework

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Equality Impact Assessment

EIA is not optional, it is embedded in Equality legislation and therefore all policies must undergo an impact assessment as part of development and/or review.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65			
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes			

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People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical			
How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
procedures. Sometimes referred to as Trans or Transgender			
People who are married or who have a civil partner.			

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Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
People of a minority race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers			

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief			
People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)			
People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health			
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi poverty, travel poverty and fuel poverty.			
Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support			

disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc			
Well-being Goal – A healthier Wales			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales			

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			

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People in terms of social and community influences on their health:			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

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Board Assurance Framework

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Accountable Executive:	Director of Corporate Governance/Board Secretary
Approved By:	Board
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Document Type	Policy

Powys Teach Health Board is the operational name of Powys Teaching Local Health Board

To ensure that you are always using the latest version of this corporate policy, please refer to the version on the Corporate Governance SharePoint site

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Associated Policies and Written Control Documents
CGP 005 Risk Management Framework
Integrated Quality and Performance Framework (IQPF)

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial Issue	May 2024
2	2025 version updated to improve alignment with Risk Management Framework and transferred into new template	May 2026

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1. Scope

This framework applies to Board members and all employees of the Health Board.

The framework is informed by the Strategic and Operational plans of the organisation together with the Risk Management Framework which apply to all staff, agency staff; contractors brought in to undertake work on behalf of the health board, works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business.

The predominant users of the Board Assurance Framework will be the Board and its Committees.

2. Policy Statement

This document aims to set out the principles and components that provide the foundation and organisational arrangements for the Board Assurance Framework (BAF) within Powys Teaching Health Board.

3. Purpose

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.

The Health Board recognises the BAF as a complex system comprising of a number of key elements including:

- CGP 005 the Risk Management Framework and the supporting documents produced under the auspices of the BAF to provide effective strategic risk assurance;
- Quality and Performance Framework; and
- The overall system of governance deployed by the Board and the Chief Executive in ensuring good governance within the organisation.

The BAF has been developed in conjunction with the Health Board's risk management arrangements, as documented in the Health Board's CGP 005 Risk Management Framework and this document. The organisation remains committed to developing and maturing its board assurance arrangements as a process of continuous development.

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The effective application of board assurance arrangements to produce and maintain a BAF will help the Board to consider collectively the process of securing assurance that promotes good organisational governance and accountability. The specific benefits include:

- Gaining a clear and complete understanding of the risks faced by the organisation in the pursuit of its strategic objectives, the types of assurance currently obtained, and consideration as to whether they are adequate and effective;
- Identifying areas where assurance activities are not present, or are insufficient for our needs (assurance gaps);
- Identifying areas where assurance is duplicated, or is disproportionate to the risk of the activity being undertaken (i.e. there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resource);
- Identifying areas where existing controls are failing and as a consequence the risks that are more likely to occur;
- The ability to better focus existing assurance resources; and
- Providing an evidence base to assist the organisation in the preparation of its annual governance statement.

4. The Board's Statement

The Board is committed to the principles of good governance and recognises the importance of effective assurance and risk management as a fundamental element of the Health Board's governance framework and system of internal controls.

The Board recognises the crucial link between risk management, strategic priorities and plans and the role the Board Assurance Framework has in providing an overview of assurance.

The Board is committed to having a risk management culture that underpins and supports the business of the health board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and promoting its values.

Further information regarding the Health Board's approach to risk as an organization, including the Board's Appetite for Risk can be found in CGP 005 the Risk Management Framework.

5. The Board Assurance Framework

The PTHB Board Assurance Framework (BAF) is designed to provide the

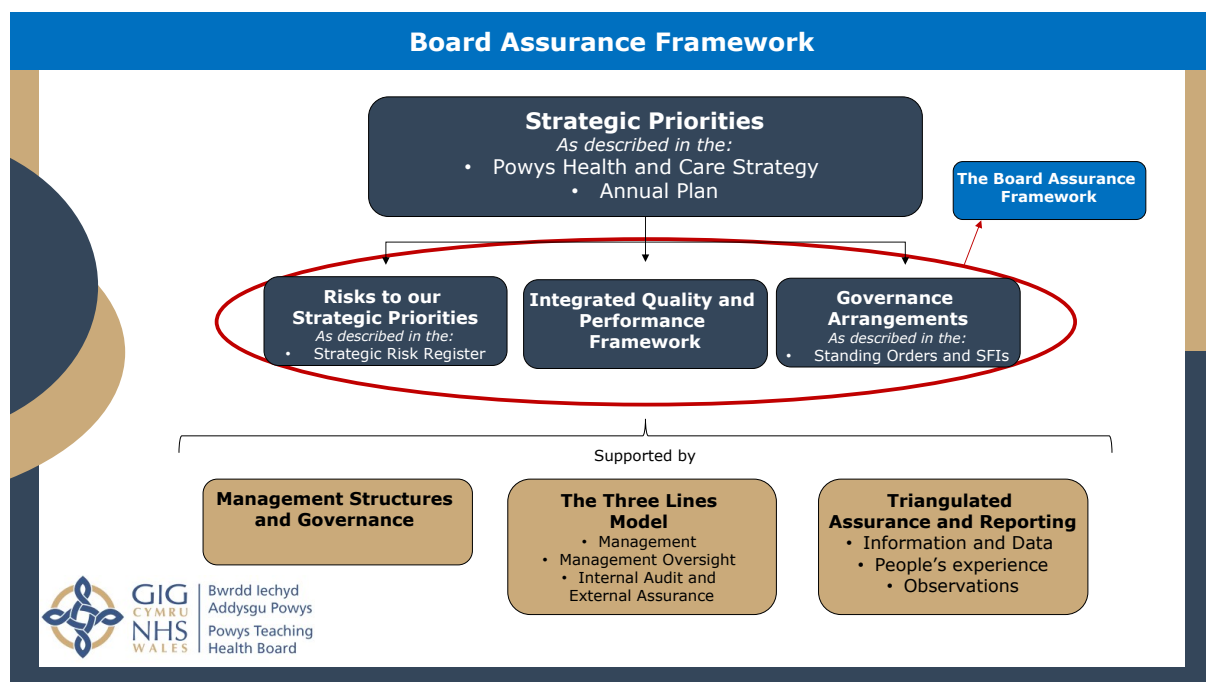
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Board with:

1. a systematic and coherent picture of the assurances in place to support the delivery of the organisation's strategic objectives. It essentially maximises the links between assurance, performance management and risk management;
2. an overview of assurance in relation to its governance framework;
3. the opportunity to undertake thematic reviews of assurance to support the Board in its role. For example, a thematic review of 'planning'.

The BAF includes the integration of the Three Lines Model. **The Health Board recognises that there is no singular Three Lines Model and that there are several interpretations of the model from different professional sources. Details of the Health Board's agreed approach to the Three Lines Model can be seen in section seven.**

The key components of the BAF are outlined in the diagram below:



There are six steps to supporting the development of the BAF:

1. Identify key priorities
2. Identify key risks to the delivery of priorities
3. Identify key controls in place to ensure delivery of priorities and manage/mitigate risks
4. Assess and monitor the adequacy and effectiveness of controls
5. Assess gaps in controls and gaps in assurance
6. Develop (Board) action plans to address gaps in controls and

assurance

The quality of assurance received by the Board is a key enabler as regards the Board's ability to effectively determine the best use of its resources and the effective achievement of strategic objectives. The BAF articulates the level of assurance required by the Board for each element, identifies gaps in controls and/or assurance and provides structured assurance in relation to risks which are being managed effectively and objectives that are on track to be delivered.

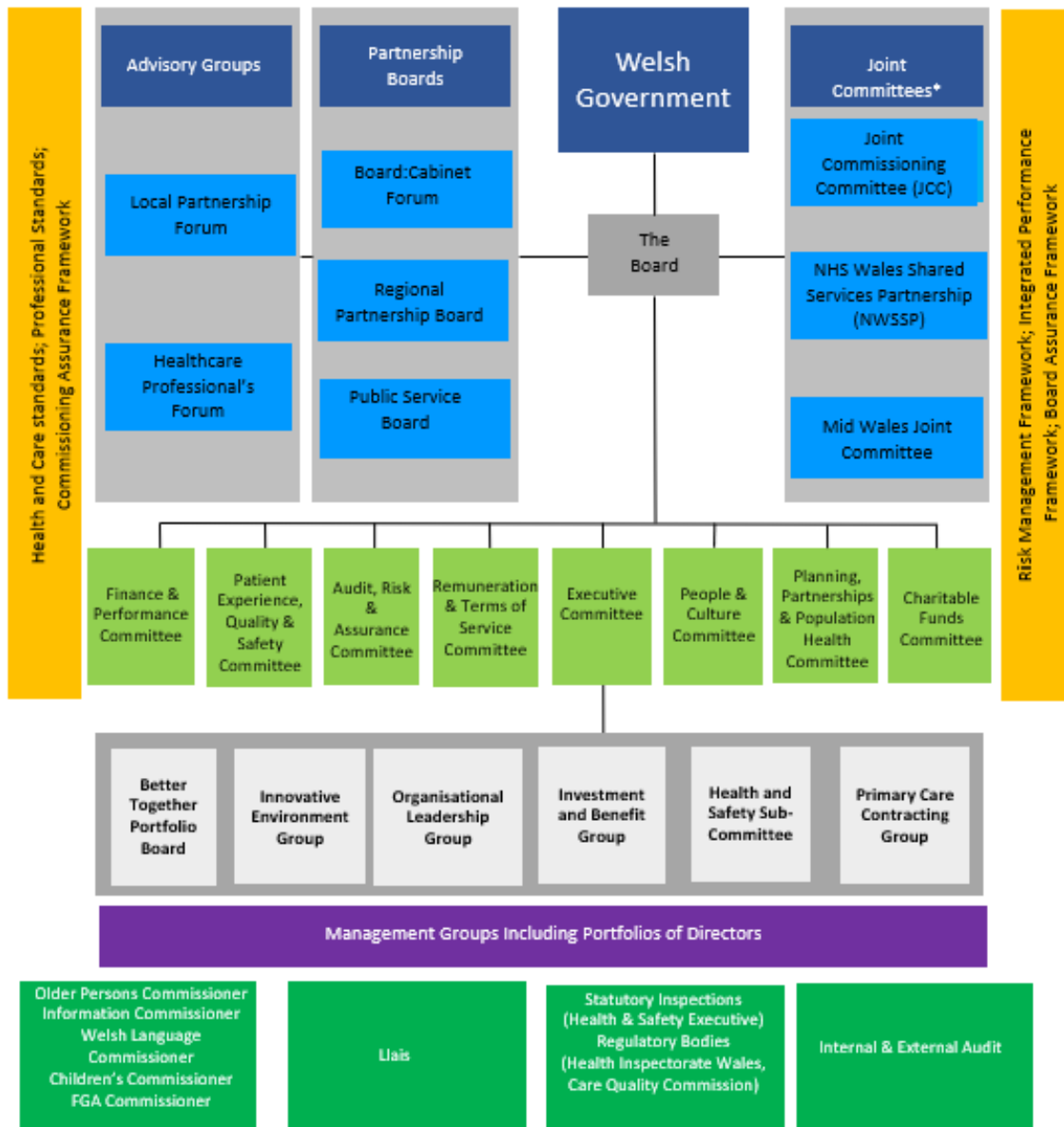
Scrutiny of the quality of assurances received is the responsibility of all Board Members and assessment of the effectiveness of internal controls and assurances will be a continuous process. As part of the development of the BAF, a review of assurance effectiveness will be undertaken.

The Health Board's **Integrated Quality and Performance Framework** helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients. Through this process, risks may be identified for recording in local or directorate risk registers or the Corporate Risk Register, dependent upon the level and type of risk.

The BAF contributes to the whole system of governance of the Health Board which is summarised below :

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Powys Teaching Health Board Governance and Assurance Framework



*The Health Board also sits on the following Joint Committees as an Associate Member:

- South East Wales Regional Joint Commissioning Committee
- South West Regional Joint Committee

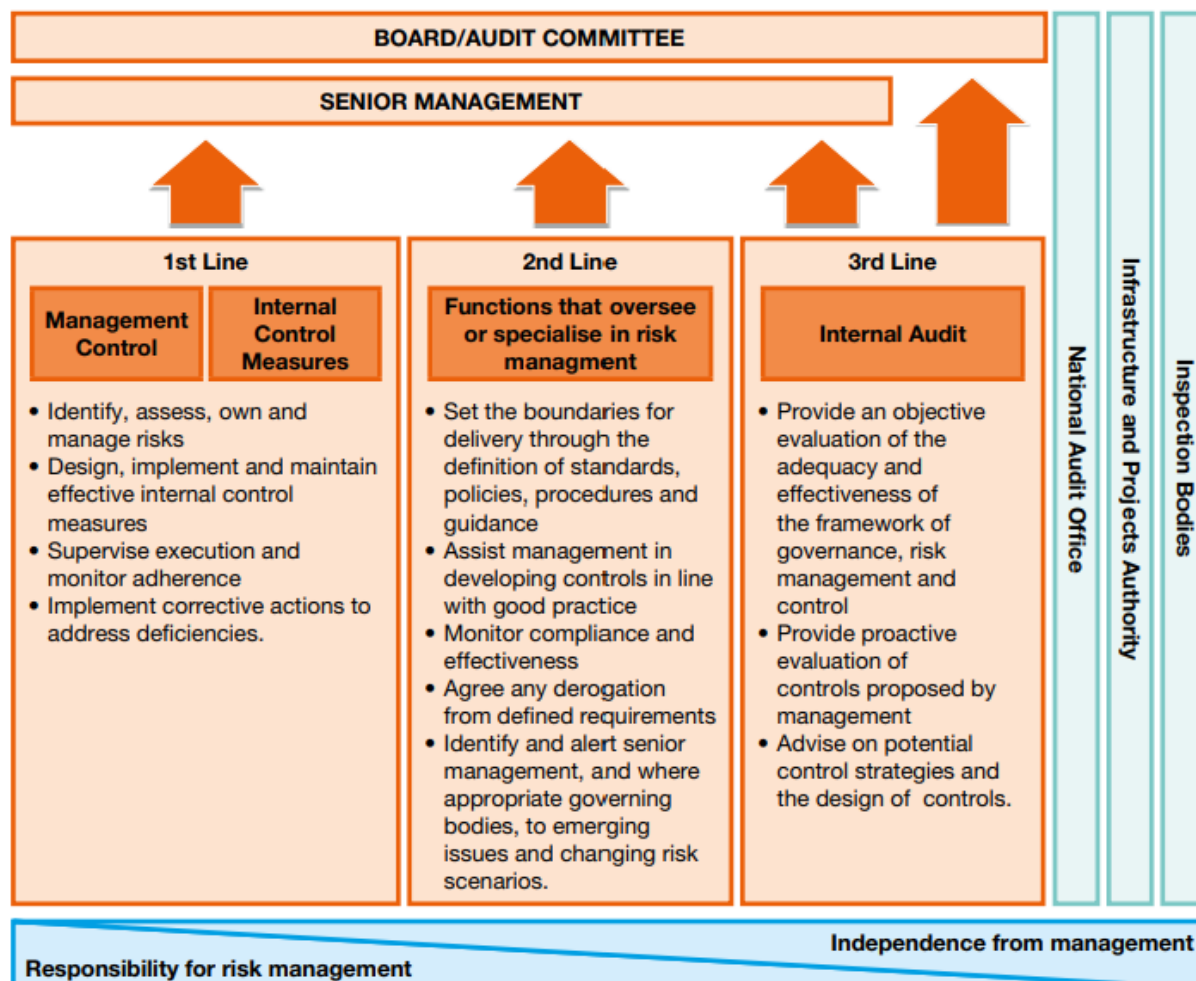
6. Three Lines Model

In accordance with the Orange Book (UK Government, 2023) The 'three lines model' provides a simple and effective way to help delegate and coordinate risk management

roles and responsibilities within and across an organisation.

The model is not intended as a blueprint or organisational design, but may provides a flexible structure that can be implemented in support of the risk management framework. Functions within each of the 'line roles'

may vary from organisation to organisation and may operate differently. Therefore, the BAF plays a key role in seeking an optimum mix of assurance. An overview of the Three Lines Model as described in the Orange Book is included below:



First line – Management

Under the 'first line role', management have primary ownership, responsibility and accountability for identifying, assessing and managing risks. Their activities create and/or manage the risks that can facilitate or prevent an organisation's objectives from being achieved.

The first line 'own' the risks and are responsible for execution of the organisation's response to those risks through executing internal controls on a day-to-day basis and for implementing corrective actions to address deficiencies. Through a cascading responsibility structure, managers design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise effective execution.

There should be adequate managerial and supervisory controls in place to ensure compliance and to highlight control breakdown, variations in or inadequate processes and unexpected events, supported by routine performance and compliance information

Second line– management oversight

The second line role consists of functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down the organisation. The second line should support management by bringing expertise, process excellence, and monitoring alongside the first line to help ensure that risks are effectively managed.

Third line– Audit and regulators (adapted for PTHB framework)

Internal and External audit is the third line of defence. An effective audit function through a risk-based approach to its work, provides an objective evaluation of how effectively the organisation assesses and manages its risks. The effectiveness of audit will depend on the extent of its terms of reference. These could be wide-ranging, covering operational efficiency and effectiveness, compliance and reliability of reporting. As well as looking at systems overall, audit can also focus on specific risks, particularly risks which the first two lines of defence identify gaps in assurance or control. Audit's role is also valuable if there are changes affecting the first two lines of defence, or changes in organisational structures, reporting processes and information systems.

Audit work has the significant benefit of being done by staff who are independent and separate from line management, who are not involved in operational work and, in the case of PTHB, are not employees of the Health Board. Auditors' independence is strengthened by being able to report directly to the Board, Audit, Risk and Assurance Committee (ARAC) and other board committees and being able to discuss issues with the Board and ARAC without operational management being present where required.

PTHB is also regulated by a number of regulators including Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) and the Medicines and Healthcare Products Regulatory Agency (MHRA), as well as being subject to a number of other compliance and legislative requirements by Welsh Government and other Commissioners, for example the Welsh Language Commissioner and the Future Generations Commissioner. All regulators will also be considered as the third line of defence.

**NB in other sectors internal and external audit are separated into the*

third and fourth line of defence, mainly due to internal audit being employees of the organisation. For the purpose of the PTHB BAF, internal and external audit have been combined into the third line of defence given the Health Board does not employ any auditors.

7. Assurance Reporting

7.1 Risk Management

A key area of focus is the assessment and reporting of the adequacy of the risk control and assurance mechanisms in place. The BAF will advise the Board on the control environment surrounding the Strategic Risks, as contained with the Strategic Risk Register based on the following criteria:

Adequacy of Controls	Effectiveness of Controls	Control Assurance
Are we doing enough to manage the risk?	Is what we're doing working?	Based on what evidence?
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

There are two main reporting elements of the BAF in regard to risk, the BAF Dashboard and the Annual Review of Strategic Risk Assurance.

The BAF Dashboard supports the Board’s Strategic Risk Register (SRR) and ‘closes the loop’ of the risk management process by seeking/providing assurance that the controls deployed by the Health Board to manage/mitigate its key risks are adequate and effective. It also provides an opportunity to undertake further scrutiny of risks and identify where gaps or weaknesses require further action.

The SRR and BAF Dashboard is reported to the Board three times per year and is reviewed by the Executive Committee in advance of presentation to the Board. The Board receives:

Three-times per year	• BAF dashboard • Strategic Risk Register • Summary of the Organisational Risk

	Register
Annually	• Risk appetite statement review

The Annual Review of Strategic Risk Assurance build upon the analysis of the BAF Dashboard and is reported to the Audit, Risk and Assurance Committee (ARAC) due to it's detailed and technical nature. The report provides an opportunity to consider whether controls and assurance are effective, adequate 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

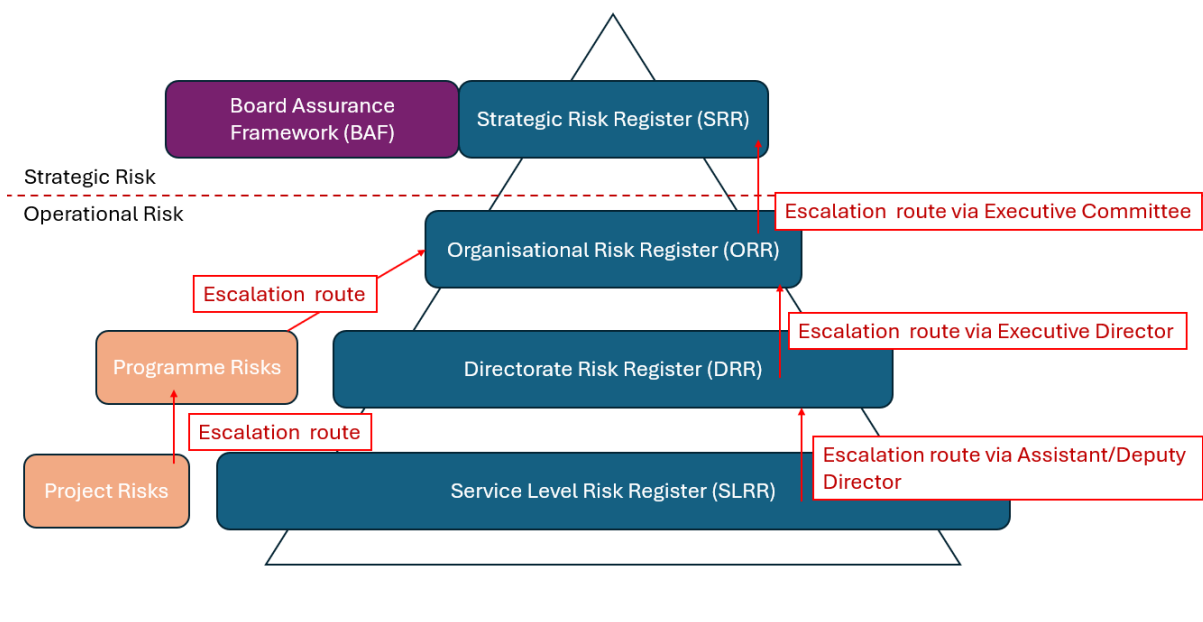
The report also assesses controls against the Three Lines model, as outlined in Section 6. To aid in simplicity of analysis for the purposes of the report Board and Committee oversight is included in Line 2 (L2) Risk Oversight, and all external assurance, including of internal audit will be categorised 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.

Finally the report provides the opportunity to assess the level of gaps on control and assurance for the ARAC to consider whether 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.

The hierarchy of risk registers as described CGP 005 the Risk Management Framework is provided below:

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7.2 Quality and Performance

The Health Board's Integrated Quality and Performance Framework (IQPF) is designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for.

The Integrated Quality & Performance Framework (IQPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence gathered across key domains including activity, finance, workforce, quality, safety, outcomes and performance indicators.

The IQPF is reviewed and refreshed on a yearly basis ensuring modernisation and compliance with developing aspects of health care. Key for the framework is the icsystem review, reporting, escalation and assurance process that aligns especially to the NHS Performance measures and any priority trajectories.

The Integrated Quality and Performance Report (IQPR) uses key NHS Performance Framework measures updated annually which include further timely local measures to provide robust assessment of the health boards performance as both a provider and commissioner of care focusing on key challenge and success. This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of the service area.

7.3 Governance

The Health Board is committed to a culture of good governance and a complex programme of work regarding the development of and assurance regarding organisations governance framework is well established in the Health Board, including but not limited to:

- Annual Review of Standing Orders
- Annual Review of Board and Committee Effectiveness
- Annual Review of Committee Work Programmes and Terms of Reference
- Audit Wales Structured Assessment
- Regular internal audit

As the BAF continues to mature and develop assurance and reporting mechanisms will also be developed to provide an singular overview of assurance in relation to its governance framework and enable the Board to undertake thematic reviews of assurance in key focus areas.

8. Roles and Responsibilities

The roles and responsibilities in regards to Board Assurance are referenced within Section 10 of CGP 005 the Risk Management Framework.

9. Operational and Training Implications

The operational and training requirements regarding the Board Assurance Framework are integrated with those requirements in relation to Risk Management, as reported in CGP 005 the Risk Management Framework.

As Risk Management Training and the Risk Management Toolkit continues to be developed, the offering will be expanded to include risk and control assurance mapping.

Knowledge of how to ensure effective assurances are in place and to manage risk are essential to the successful embedding and maintenance of both this framework and effective risk management. To support this, and complement the Risk Management Framework, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members	Governance and Assurance Training	Every 2 years
	Review of Risk Appetite	Annual
Audit, Risk and Assurance Committee	Risk and Assurance Training (as part of induction)	Every 2 years
Senior Managers and Risk Owners	Risk and Assurance Awareness Training, including Risk Assessment, Risk Register and Assurance Training	Every 3 Years

10. Monitoring the effectiveness of the Board Assurance Framework

The Board will receive the Board Assurance Framework and its relevant constituent parts at each of its meetings. as a regular feature of its annual programme of business.

Compliance with this Framework is also monitored by the Executive Committee and the Audit, Risk and Assurance Committee.

The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report, for the Boards approval.

The Health Board's Risk Management and Board Assurance arrangements are reviewed by Internal Audit annually and the Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The Health Board's assurance and risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process.

APPENDICES

Appendix A

Glossary of terms	
Term	Definition
Assurance	Assurance is confidence based on objective information or evidence.
Re-assurance	Re-assurance is often based on professional opinion and is the process of telling others that risks are controlled without providing supporting information/evidence.
Controls	Controls are actions we have implemented to maintain or modify the likelihood and or impact of a risk.

Internal Control	Internal Control is the dynamic and iterative framework of processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risk. Internal controls permeate and are inherent in the way the organisation operates and are affected by cultural and behavioural factors.
Risk	The effect of uncertainty on objectives. An effect may be positive, negative, or a deviation from the expected. In addition, a risk is often described as an event; a change in circumstance; or a consequence.
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks, with a view to increasing the probability of success and reducing the likelihood of failure.
Risk assurance	The process of seeking to 'close the loop' of the risk management process by seeking/providing assurance that the controls deployed by the Health Board to manage/mitigate its key risks are adequate and effective.
Risk management framework	Organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation.
Risk architecture	Risk architecture is the organisational arrangements for risk management detailing the roles, responsibilities and the lines of communication for reporting on risk management.
Risk assessment	A systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk treatment	The development, selection and implementation of risk treatment strategies and controls.
Risk appetite	The amount of risk that an organisation is willing to pursue in order to meet its strategic objectives.
Risk tolerance	Whilst risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can actually cope with.
Risk owner	The person with the authority and accountability to make the decision to treat, or not to treat the risk.
Strategic risks	Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence.
Operational risks	Risks that are by-products of the day-to-day running of the Health Board and may include risks such as to the achievement of directorate or service objectives; the day-to-day operation of the directorate or service, i.e. delivering a safe and sustainable service for patients; and risks in regard to any legislation or standards that the directorate or service should be compliant with.

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References and Bibliography

CGP 005 the Risk Management Framework

ISO 31000:2018: [ISO 31000:2018\(en\), Risk management — Guidelines](#)

Academi Wales (2017) [The Pocket Guide to Governance in NHS Wales](#). Available at: [Pocket Guide for NHS Wales Boards English.pdf](#)

UK Government (2023) [The Orange Book – Management of Risk – Principles and Concepts](#)

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Equality Impact Assessment

EIA is not optional, it is embedded in Equality legislation and therefore all policies must undergo an impact assessment as part of development and/or review.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65			
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes			

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People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical			
How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
procedures. Sometimes referred to as Trans or Transgender			
People who are married or who have a civil partner.			

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Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
People of a minority race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers			

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief			
People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)			
People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health			
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi poverty, travel poverty and fuel poverty.			
Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support			

disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc			
Well-being Goal – A healthier Wales			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales			Make reference to where the mitigation is included in the document, as appropriate

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			

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People in terms of social and community influences on their health:			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

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Agenda item: 5.3b

Audit, Risk and Assurance Committee		Date: 12 May 2026
Subject:	Risk Appetite Statement	
Approved and presented by:	Helen Bushell, Director of Corporate Governance	
Prepared by:	Deputy Board Secretary	
Other Committees and meetings considered at:	Board Development – 12 March 2026	
Appendices :	Appendix A – Risk Appetite Statement who endorsed the report to the Committee.	
PURPOSE:		
The report provides the proposed revisions to the Board’s risk appetite statement following review and refinement by the Board at the Board Development session on 12 March 2026.		
RECOMMENDATION(S):		
The Committee is asked to:		
• RECEIVE and ENDORSE the revised Board’s Risk Appetite Statement for onwards consideration for approval by the Board in May 2026.		
Approve/Take Assurance	Discuss	Note
X		

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

BACKGROUND

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms.

The concept of risk appetite is challenged in public sector organisations by the need to demonstrate, often over a spending period, that public funds achieve value for money. Risk appetite helps organisations establish a threshold of impacts they are willing and able to absorb in pursuit of objectives, which may include but is not limited to financial loss. If properly applied and maintained, however, understanding risk appetite can result in improved organisational health, as trade-offs are made allowing resources to be prioritised and allocated where most needed to support the management of risks to achieving objectives, whilst maintaining performance and demonstrating value for money.

Following engagement at a Board Development session on 12 March 2026 proposed updates to the Board's Risk Appetite Statement are presented which have been developed in alignment with the [Orange Book Risk Appetite Guidance Note](#).

There are no suggested changes to Risk Appetite level descriptors or the allocation of level against risk categories for 2026/27, however the statement had been updated to reflect the challenging operational context of the organisation and the resulting need for the Board to accept a level of risk in order to delivery services and value for money, as oppose to the active pursuit of risk. The full Risk Appetite Statement is appended to this paper as **Appendix A**.

NEXT STEPS:

If supported, the revised Risk Appetite Statement will be presented to the Board in May 2026 for approval and adoption.

It will then:

- be published to the Health Board's internet and integrated into key risk mechanisms and documents such as the Strategic Risk Register, risk register templates and the Risk Management Toolkit.
- The Risk Appetite Statement will be reviewed regularly, particularly in support of decision making.
- The Risk Appetite Statement will be reviewed by the Board at a Board Development session in the autumn, in the context of preparation for the Annual Plan 2026-27.

Appendix A – Risk Appetite Statement

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RISK APPETITE STATEMENT – MAY 2026

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

The Board places fundamental importance on the delivery of its strategic priorities and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy: 'A Healthy, Caring Powys'.

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its priorities - its risk appetite - and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.

In response to a number of complex pressures including demand for our services, system pressures, cost of living and inflation as well as national and international economic pressures the Board has, in principle, adopted an overall '**open**' appetite to risk, with the exception of Safety, in order to balance a complex risk environment with the need to deliver and commission services. Risk categories have been scrutinised in more detail against this baseline position and as a result risk appetite levels have been assigned to specific risk categories as detailed below.

In reality complex decisions contain components that fall across the range of risk categories, for example financial sustainability, performance and service sustain ability and workforce could all be contained within any one decision.

The Board also recognises that whilst the term 'appetite' may infer the pursuit of risk i.e. the level of risk with which an organisation aims to

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operate, in several instances the Health Board is operating in a scenario where the Board must make decisions regarding the level of risk the organisation is able to accept given the challenging operational context. This approach enables the Board to balance risks and opportunities, and act in the best interests of the population of Powys.

The risk appetite statement should be read in conjunction with the Health Boards Risk Management Framework which can be found here – [PTHB Risk Management Framework March 2025](#)

The Board has adopted the following Risk Appetite Matrix:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry very limited or virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that **could impact on the quality of the Health Board's financial governance arrangements.**

In recent years the Board has taken an increasingly open appetite to risk in respect of service sustainability, public confidence and financial investment order to effectively balance the increased pressure in relation to financial position with the provision of safe healthcare for the population of Powys.

The Board has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Health Board's risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk appetite may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic priorities. The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

Risk Category	Description
APPETITE FOR RISK: Averse	
Safety	We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of, incidents of avoidable harm to our patients or staff. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.
Financial Governance	We will not accept risks, nor any incidents or circumstances which may compromise to the integrity of financial reporting and associated processes; and risks relating to financial impropriety or fraud. We will maintain robust controls to ensure compliance with our Standing Financial Instructions financial propriety, to prevent fraud or error; and we will ensure remedial actions are enacted diligently should any concerns be identified.
APPETITE FOR RISK: Minimal	
Quality	The provision of high-quality services is of the utmost importance for the health board. The Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a low appetite for risks which may compromise the Duty of Quality and/or the quality of the care we deliver / could result in poor

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Risk Category	Description
	quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact on quality could adversely affect outcomes and experiences of our patients, service users and communities.
APPETITE FOR RISK: Cautious	
Regulation & Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.
Workforce	The Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and priorities to maximise the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. Our work will continue to be undertaken in partnership with our Trade Union colleagues.
Financial Sustainability	We recognise we have been entrusted with public funds and must remain financially viable. Our financial deficit means that robust controls are required to manage our exposure to risks which might increase our expenditure. We will make the best use of our resources for patients and staff ensuring maximum value is achieved. Though we recognise that some risk is inherent to achieving our priorities.
APPETITE FOR RISK: Open	
Performance and Service Sustainability	We have a low-moderate risk appetite for risks which may affect our performance and service sustainability. We are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19, workforce availability and limited resources) which may result in lower performance levels and unsustainable service delivery for a short period of time. We will also consider impacts on both short and long term performance and service sustainability in our decision making.
Financial Investment	Risks associated with investment or increased expenditure will only be considered when linked to delivery of core patient

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Risk Category	Description
	services supporting innovation and strategic change and/or legal or regulatory compliance. Though we are open to evidence-based innovations and investments which will significantly impact the drivers behind our financial deficit position, provided that these are aligned to our financial governance arrangements.
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, championing our Values and Behaviours Framework, and will not accept risks or circumstances that could unduly damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. Our communication and engagement will remain open and transparent. In light of the challenging environment related to public sector funding, we have a more open appetite for risks that may impact on the reputation of the Health Board when these arise as a result of the Health Board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory and financial environment.
Partnerships	The Health Board is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties at a local, regional and national level. We therefore have a high risk appetite for partnerships which may support and benefit the patients in our care. For example, the Health Board has a high appetite for risks associated with innovation and partnership with the third sector, industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Health Board will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.
APPETITE FOR RISK: Eager	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that

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Risk Category	Description
	could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

This Statement will be regularly reviewed and modified so that any changes to the organisation’s strategy, priorities or our capacity to manage risk are properly reflected. It will be communicated throughout the organisation in order to embed sound risk management and to ensure risks are properly identified and managed.

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Agenda item: 5.4a

AUDIT, RISK AND ASSURANCE COMMITTEE		DATE: 12 MAY 2026	
Subject:	Counter Fraud Work Plan 2026/27		
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services		
Prepared by:	Interim Head of Counter Fraud		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
The Counter Fraud Work Plan 2026/27 is presented to the Audit Risk & Assurance Committee to seek approval. Planned activity is set out around key areas of work intended to be undertaken by the Local Counter Fraud Specialists during 2026/27 and takes account of the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.			
RECOMMENDATION(S):			
The Audit Risk & Assurance Committee is asked to:			
• APPROVE the Counter Fraud Work Plan 2026/27 as presented.			
Approve/Take Assurance		Discuss	Note
Y		Y	N

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

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe					A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial					
Corporate					
Operational					
Reputational					

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Counter Fraud Work Plan 2026/27

R Neil Jones
Interim Head of Counter Fraud Services
May 2026

Counter Fraud Work Programme 2026-
27

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Audit Risk and Assurance Committee
12 May 2026
Agenda Item 5.4ai

Introduction

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

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 208 and reactive days - 100 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.

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INFORM AND INVOLVE

The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
I&I.1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	GovS 013 component 11	Throughout the Year
I&I.2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	GovS 013 component 11	Throughout the Year
I&I.3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	GovS 013 component 11	Q2 and Q4
I&I.4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	GovS 013 component 11	Throughout the Year
I&I.5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	GovS 013 component 11	Throughout the Year

COUNTER FRAUD WORK PLAN 2026/27

INFORM AND INVOLVE

The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
I&I.7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	GovS 013 component 11	Q2 and Q4
I&I.8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	GovS 013 component 11	Q2
I&I.9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	GovS 013 Components 4, 7 and 12	Throughout the Year
I&I.10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 Components 7 and 12	Throughout the Year
TOTAL DAYS ALLOCATED		60	

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PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.1	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 GovS 013 component 10	As Appropriate
P&D.2	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
P&D.3	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year

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PREVENT AND DETER

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TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.4	Review existing fraud risk assessments with Risk Owners.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5 FR01, FR02, FR03, FR04, FR05, FR06, FR07, FR25, FR34, FR59	Q2
P&D.5	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010.	GovS 013 component 12	Q2
P&D.6	Utilise National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10	Q2
P&D.7	Finalise fraud risk assessment around identified issue of False International English Language Testing System Certificates (IELTS)	FPN H-005-23	Q2

PREVENT AND DETER

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The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.8	Finalise fraud risk assessment centred on falsifying timesheets and expense claims	FPN – L-001-25	Q2
P&D.9	Finalise fraud risk assessment in relation to Mental Health Act s.12 Assessments claims	FPN – M-002-25	Q2
P&D.10	Review both FR08 & FR09 around updated issue of Mandate Fraud. Seek to amalgamate both risks into one comprehensive risk assessment to streamline future review of this ever evolving fraud risk	FPN – L002-23	Q1
P&D.11	Review FR22 in response to the identified issue of CEO/Unsolicited Payment Requests	FPN-M001-24	Q1
P&D.12	Review and update information sharing protocols currently in place.	Service level	Q1
P&D.13	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Service level	Throughout the Year
P&D.14	Record and respond to ad-hoc requests for assistance received.	Service level	Throughout the Year

PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.15	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
P&D.16	Issue of fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
P&D.17	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level	Throughout the Year
P&D.18	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	GovS 013 component 10	Throughout the Year
P&D.19	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required

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PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.20	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line.	GovS 013 component 10	Throughout the Year
P&D.21	Membership of Local Intelligence Network and attendance at meetings.	Service level	As Required
TOTAL DAYS ALLOCATED		103	

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HOLD TO ACCOUNT

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account.

The organisation must have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
HTA.1	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As Required
HTA.2	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 GovS 013 component 8	As Required
HTA.3	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	GovS 013 component 9	As Required
HTA.4	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	GovS 013 component 6 GovS 013 component 9	As Required
HTA.5	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	GovS 013 component 6 GovS 013 component 8	As Required

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COUNTER FRAUD WORK PLAN 2026/27

HTA.6	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1
TOTAL DAYS ALLOCATED		100	

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STRATEGIC GOVERNANCE

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation.

The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.1	Attendance at all Fraud Forum meetings held by CFS Wales.	Service Level	As Required
SG.2	Completion and agreement of the annual work plan with Director of Finance.	GovS 013 component 2	Q4
SG.3	Completion and agreement of the annual report with Director of Finance.	GovS 013 component 5	Q1
SG.4	Regular meetings/liaison with Director of Finance.	GovS 013 component 1	Throughout the Year
SG.5	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
SG.6	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service Level	Q4 and As Required
SG.7	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service Level	As Required

STRATEGIC GOVERNANCE

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation.

The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.8	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	GovS 013 component 8	Throughout the Year
SG.9	Provide regular reports and <i>ad hoc</i> information to NHS Counter Fraud Authority and Welsh Government as required	GovS 013 component 6	Throughout the Year
SG.10	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 GovS 013 component 7	Q2
SG.11	Attendance at Counter Fraud Joint Working Group monthly meetings.	Service Level	Throughout the Year
TOTAL DAYS ALLOCATED		45	

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SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	INFORM AND INVOLVE	60
B	PREVENT AND DETER	103
C	HOLD TO ACCOUNT	100
D	STRATEGIC GOVERNANCE	45
	TOTAL	308

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WALES

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Powys Teaching
Health Board

Agenda item: 5.4b

Audit Risk and Assurance Committee		12 May 2026
Subject:	Counter Fraud Update Report	
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Estates and Support Services Interim Head of Counter Fraud	
Prepared by:	Interim Head of Counter Fraud	
Other Committees and meetings considered at:		
PURPOSE:		
The purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2025/26 as contained within the Counter Fraud Update report and Counter Fraud Annual Report.		
RECOMMENDATION(S):		
The Audit Risk and Assurance Committee is asked to:		
• RECEIVE the update report for discussion; • Take ASSURANCE that appropriate counter fraud systems are in place; • APPROVE the Counter Fraud Annual Report 2024/25 following which the Committee Chair will be asked to approve the annual self assessment return.		
Approve/Take Assurance	Discuss	Note
Y		Y

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

EXECUTIVE SUMMARY:

The Counter Fraud Update Report updates the Committee on key activity and developments in relation to the Counter Fraud Work Plan 2026/27.

The Counter Fraud Annual Report 2025/26 is appended to the Update Report. The Annual Report summarises the performance and counter fraud activity delivered in the Health Board throughout 2025/26.

The Annual Report incorporates the Health Board's self-assessment return regarding compliance with Counter Fraud Standards which requires direct approval of the Committee Chair. Members are asked to review the Annual Report to support the Chair's approval.

IMPACT ASSESSMENT

Not required

Item 5.7

Counter Fraud Update Report

12 May 2026

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1. INTRODUCTION

The purpose of this report is to update the Audit Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists since the last meeting.

2. BACKGROUND

Meetings are held on a regular basis with the Director of Finance, where progress against the annual work plan and with the LCFS case workload is discussed and monitored.

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below.

Strategic Area	Resource Allocated For FY 2025/26	Resource Used as of July 2025
Strategic Governance	45	12
Inform and Involve	60	2
Prevent and Deter	103	5
Hold to Account	100	35
TOTAL	308	54

4. STRATEGIC GOVERNANCE

The Counter Fraud Annual Report 2025/26 (Appendix 1) is appended to this report for review. The Annual Report incorporates the Health Board's submission of compliance with NHS Counter Fraud Standards to NHS Counter Fraud Authority. The Committee's Chair has a direct sign off responsibility for this submission therefore the Annual Report presentation at this meeting allows for Committee Members to feed into that Chair approval.

5. INFORM AND INVOLVE

The Counter Fraud Team are continuing to drive participation in both online and face-to-face fraud awareness training. The Team are utilising the use of the Employee Engagement Platform – Viva Engage to build a fraud awareness culture within the Health Board. In addition, the Teams are developing the use of AI to produce updated

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counter fraud literature, which include court case updates and scam awareness articles for release to staff and members of the public.

6. PREVENT AND DETER

Following an identified risk of unknown third parties attending in place of registered agency workers, an All Wales risk assessment has been undertaken in relation to the recently revised All Wales Agency Contract Framework agreement. This work is being undertaken with Counter Fraud Liaison Group and is led by an LCFS from the Swansea Bay UHB Counter Fraud Team.

Work on the Health Board's matched data sets released by the National Fraud Initiative is about to commence. The initial emphasis will be on issues which identify dual employment between the Health Board and other public sector organisations. This has been highlighted previously due to the continuous agile working opportunities. This is an area of fraud risk, which continues to be emphasised following the Covid-19 pandemic.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised below. A summary of basic investigation KPI data is presented at outset of the appendix.

The case data is presented with the information, which is currently available and accessible. This data displays those cases which are open and active; contained in the Open Cases table.

Reference	Date Commenced	Title	Type
INV/24/00525	04/03/2024	Working Elsewhere Whilst Sick	Staff
INV/24/03253	17/12/2024	Working Elsewhere	Employee
INV/25/00156	21/01/2025	Prescription Fraud	Patient
INV/25/00902	24/03/2025	Diversion of Practice Funds / Abuse of Position	Contractor
INV/25/01130	01/04/2025	False representation – Volunteer Public member Validation	Non-NHS Staff
INV/25/01519	02/06/2025	Abuse of Position	Employee

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INV/25/01520	02/06/2025	Working Whilst on Sick	Employee
INV/25/01522	20/05/2025	Working Whilst on Sick	Employee
INV/25/01838	30/06/2025	Abuse of Position	Employee
INV/25/02728	16/09/2025	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Employee
INV/25/03024	14/10/2025	Claiming overtime when no evidence of work completed.	Employee
INV/25/03210	30/10/2025	Consultant working elsewhere during contracted hours	Employee
INV/25/03391	13/11/2025	Over claimed Travel Expenses	Employee
INV/25/03419	18/11/2025	Working whilst sick	Employee
INV/26/00528	16/02/2026	Forged Prescription	Patient
INV/26/00768	02/03/2026	Fraudulently prescribing medication	Employee

There is no Closed Case data being presented.

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Counter Fraud Annual Report 2025/26

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12 May 2026

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1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2025/26 was approved by the Audit Committee in March 2025 and identified a total resource of 308 days for the year. The Counter Fraud Team delivered 54 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £13,953.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud work plan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2025/26 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high-risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions,

refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. NHS Wales have adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority’s (NHS CFA) ‘NHS Counter Fraud Standards (Wales)’. At the conclusion of 2025/26 the Health Board Standards are assessed as 7 **Green** rated, 4 **Amber** rated and 2 **Red** rated. This year’s overall rating is classed as **Amber**.

The 2026/27 Counter Fraud Work Plan seeks to re-secure a solid **Green** rating. An action plan has been set for each of the assessed **Amber** and **Red** rating Standards. There are challenges to this, based on current staff resource issues.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2026

The annual report must contain the declaration listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Provider Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2025/26 has been self-reviewed against the Functional Standard Requirements relating fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

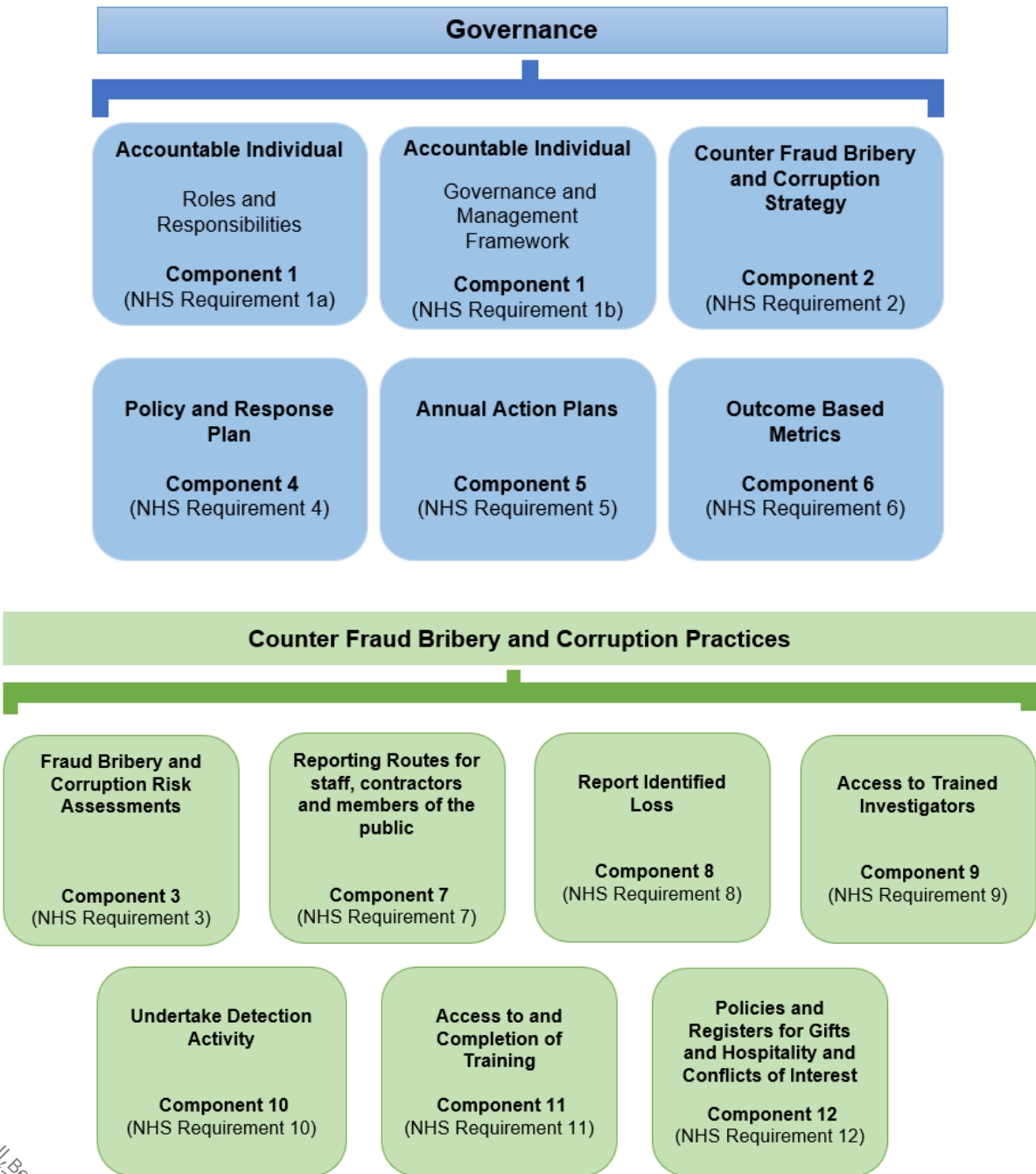
Organisation	Powys Teaching Health Board
Accountable Board Member Signature	Pete Hopgood
Date	

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4. Work carried out against the Functional Standard Requirements

In completing the annual report on the counter fraud, bribery and corruption work undertaken, the organisation should refer to the [Functional Standard Requirements](#) and the expected work needed to be compliant with each component.

The report should detail the work completed against each of the components relating to governance activities and counter fraud, bribery and corruption practices undertaken during the year, as set out below.



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Governance

This section of the annual report should outline how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
Component 1 Accountable individual	NHS Requirement 1A	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in gaining assurance	GREEN	GREEN	NHSCFA proactive exercise reports have been presented to the Health Board's Audit Committee. A

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
		and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.			concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Director of Corporate Governance is nominated as the Organisation's Fraud Champion.
Component 2 Counter fraud bribery and corruption strategy Powell Bethan 12/05/2026 15:11:29	NHS Requirement 2	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFP&RP and work plan are agreed by Director of Finance

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 Policy and response plan	NHS Requirement 4	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy.
Component 5 Annual Action Plan	NHS Requirement 5	This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.

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Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
Component 6 Outcome based metrics	NHS Requirement 6	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	AMBER	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism. This is reduced to Amber due to current Clue3 recoding issues. This is going to be addressed through the retrospective securing and update of Clue3 records for each live investigation.

Counter Fraud Bribery and Corruption Practices

This section of the annual report should outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
Component 3 Fraud bribery and corruption risk assessment	NHS Requirement 3	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	GREEN	AMBER	Work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments. The Action plan to lift rating to Green from previous reporting period was completed with work undertaken to review existing risk assessments with risk owners and to utilise results of previous work to effectively demonstrate monitoring of risk with measurable outcomes which is reflected in

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Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					the 2025/26 Counter Fraud Work Plan. To address this reduced rating, the Fraud Risk LCFS will be tasked to assess and evaluate this area, with a view to reinstating the Green rating during the forthcoming year.
Component 7 Reporting routes for staff, contractors and members of the public Powell Bethan 12/05/2026 15:11:29	NHS Requirement 7	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	AMBER	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting routes to Director of Finance and

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					whistleblowing charity Protect-Public Concern at Work. This is reduced to Amber due to current Clue3 recoding issues. This is going to be addressed through the retrospective securing and update of Clue3 records for each live investigation.
Component 8 Report identified loss Powell Bethan 12/05/2026 15:11:29	NHS Requirement 8	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	RED	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigation materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis. This is reduced to Red due to current Clue3 recoding issues. This is going to be addressed through the retrospective securing

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
					and update of Clue3 records for each live investigation.
Component 9 Access to trained investigators	NHS Requirement 9	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.	GREEN	RED	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS, who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2025/26 was 1.2 FTE. To address this reduced rating, the Fraud Risk LCFS will be tasked to assess and evaluate this area, with a view to reinstating the Green rating.

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Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
Component 10 Undertake detection activity	NHS Requirement 10	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	AMBER	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary. To address this reduced rating, the Fraud Risk LCFS will be tasked to assess and evaluate this area, with a view to reinstating the Green rating.
Component 11 Access to and completion of training	NHS Requirement 11	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations, inclusion on Corporate learning days for inductees and

Function Standard Component	NHS Requirement		2025 Rating	2026 Rating	Current Position
		awareness programme is measured.			managers as well as e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts.
Component 12 Policies and registers for gifts and hospitality and Conflicts of Interest	NHS Requirement 12	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations.

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5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report details the total counter fraud resources used by the organisation.

Area of activity	Days used
Proactive work	19
Reactive work	35
Total days used	54

Appendix 2 – Counter Fraud Costs

This section of the annual report details the total costs of the counter fraud resources used by the organisation.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£4,909
Reactive costs	£9,043
Total costs	£13,952

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Appendix 3 – Nominations Overview

Role	Name of Nominated Person
Accountable Board Member	Pete Hopgood
Audit Committee Chair	Stephen Elliot
Counter Fraud Champion	Helen Bushell
Lead LCFS	Robert Neil Jones
Supporting LCFS	Louisa Steele

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Appendix 4 –Case Information Overview

This section of the annual report details case investigation activity recorded on the Clue case management system.

Case Information	Number
Cases carried forward from previous years	6
Cases Opened during the period	16
Cases Closed during period	9
Cases Ongoing	15

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Appendix 5 – CLUE Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

CLUE Information	Number
Investigations opened during the most recent financial year	2
Investigations closed during the most recent financial year	0
Investigations open as at 31/03/2026	15

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Appendix 6 – Fraud Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	8
Number of new FRAs recorded in line with the organisations risk management policy	0

Local Proactive Exercises	Number
Number of LPEs conducted during the year	0
Number of LPEs recorded on the NHS CFA Case management system as per component 8	0
Number of LPEs concluded during the year	0

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

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Appendix 7 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary applied and recorded during this financial year	0
Civil applied and recorded during this financial year	1
Criminal applied and recorded during this financial year	0
Total Sanctions	1

Redress Imposed	Total Amount £
Fraud identified	£0
Fraud Loss Identified	£0
Fraud Prevented	£0
Fraud Recovered	£2,034.00
Non-Fraud Loss	£7,373.45
Non-Fraud Recovery	£7,373.45

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Agenda item: 5.5

Audit, Risk and Assurance Committee		12 May 2026
Subject:	Information Governance Toolkit Out-Turn Report 2025/2026 and Improvement Plan 2026/27	
Approved and presented by:	Kate Wright, Medical Director and Caldicott Guardian	
Prepared by:	Head of Information Governance, Records and Data Protection Officer and Information Governance Manager	
Other Committees and meetings considered at:	Executive Committee – 29.04.2026 who endorsed the report to the Committee and supported the Improvement Plan.	
PURPOSE:		
The purpose of this paper is to inform the Committee of the Health Board’s performance against the NHS Wales Information Governance (IG) Toolkit for Health Boards and Trusts 2025-2026 submission for assurance purposes. Note: Figures provided include Health and Care Research Wales as a hosted organisation. An Improvement Plan has been developed highlighting areas of work required to improve the current compliance in readiness for the 2026-2027 submission. The detailed plan is not suitable for public publication however; information is provided within the Executive Summary of this paper.		
RECOMMENDATION(S):		
The Committee is asked to: Take ASSURANCE from the Health Board’s 2025-26 IG toolkit submission and performance against data protection legislation and regulator recommendations.		
Approve/Take Assurance	Discuss	Note
Y	Y	Y
ALIGNMENT WITH THE HEALTH BOARD’S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	IG Toolkit ensures that the health board handles information safely, legally, and efficiently building trust among partners, stakeholders, and the public.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	It supports regulatory compliance, digital transformation and collaborative service redesign, and provides
5. Develop Workforce Futures	N	

6. Promote Innovative Environments	N	assurance to commissioned providers and cross border organisations.
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Committee is asked to **NOTE** that compliance within the NHS Wales IG Toolkit is presented in this report as individual scores across each category: Accountability, Freedom of Information, Business Continuity and Information Security. For the 2025-26 submission an additional category covering Video Surveillance has been introduced.

The Committee is further asked to **NOTE** that concerns have previously been raised with the national IG team regarding certain requirements within the Toolkit that are unlikely to be met by many Health Boards and Trusts. These requirements nevertheless remain within the current question set. By way of example, the Toolkit includes a requirement for a system to monitor that staff have read and understood policies and procedures; without additional investment to procure such a system, the Health Board is currently unable to fully meet this requirement.

The detailed results of the 2025–26 submission are provided at **Appendix 1**, alongside comparative trend data from the previous two annual submissions. A detailed Improvement Plan has been developed to address the areas for development identified through the Toolkit; due to the operational detail it contains, the full plan is not suitable for public publication. An assurance-level summary of the key themes, governance and intended outcomes is provided below.

The Health Board is currently assessed as **“Minimum Expectations Not Met.”** Nevertheless, significant progress has been made, with this year’s submission showing continued improvement and the majority of legal requirements now met. The principal residual gap relates to a small number of requirements within one category; delivery of the Improvement Plan is intended to close this gap and support movement to **“Minimum Expectations Met”** in the next submission.

- **Priority focus:** closing the remaining Minimum Expectations gap through (i) strengthening policy governance and approval, (ii) improving mandatory training compliance and local accountability, and (iii) formalising how information-asset risks are recorded, monitored and escalated.
- **Oversight and reporting:** actions have identified Responsible Managers and Executive Directors, with progress reported through existing governance routes (Executive Committee quarterly and Audit, Risk and Assurance Committee bi-annually).
- **Delivery timescales:** work is underway across 2026–27, prioritised to ensure evidence is in place for the next Toolkit submission, with progress reviewed at regular intervals.
- **How success will be measured:** improved Toolkit compliance supported by completed evidence (e.g., approved documentation and embedded processes), sustained training compliance improvements (working towards ≥85%), and stronger assurance over information-risk monitoring and escalation.

- **Key constraints:** a small number of “Expectations Exceeded” requirements remain dependent on investment and/or national alignment; these are being progressed through local governance and raised via national forums where appropriate.

DETAILED BACKGROUND AND ASSESSMENT:

Alongside other NHS Wales organisations, the health board completes an annual self-assessment to demonstrate its maturity in managing information risk and compliance with data protection and Caldicott principles through the NHS Wales Information Governance (IG) Toolkit.

The purpose of the Toolkit is to provide assurance that the Health Board can be trusted to maintain the confidentiality and security of personal and business information in line with legislative requirements. Information is published on the public facing website to demonstrate openness and transparency.

While the toolkit primarily assesses IG and records management compliance, elements of information security assurance are also independently assessed through the biannual Welsh Cyber Assurance Process (WCAP). Findings help identify areas requiring further development and inform the IG Toolkit Improvement Plan.

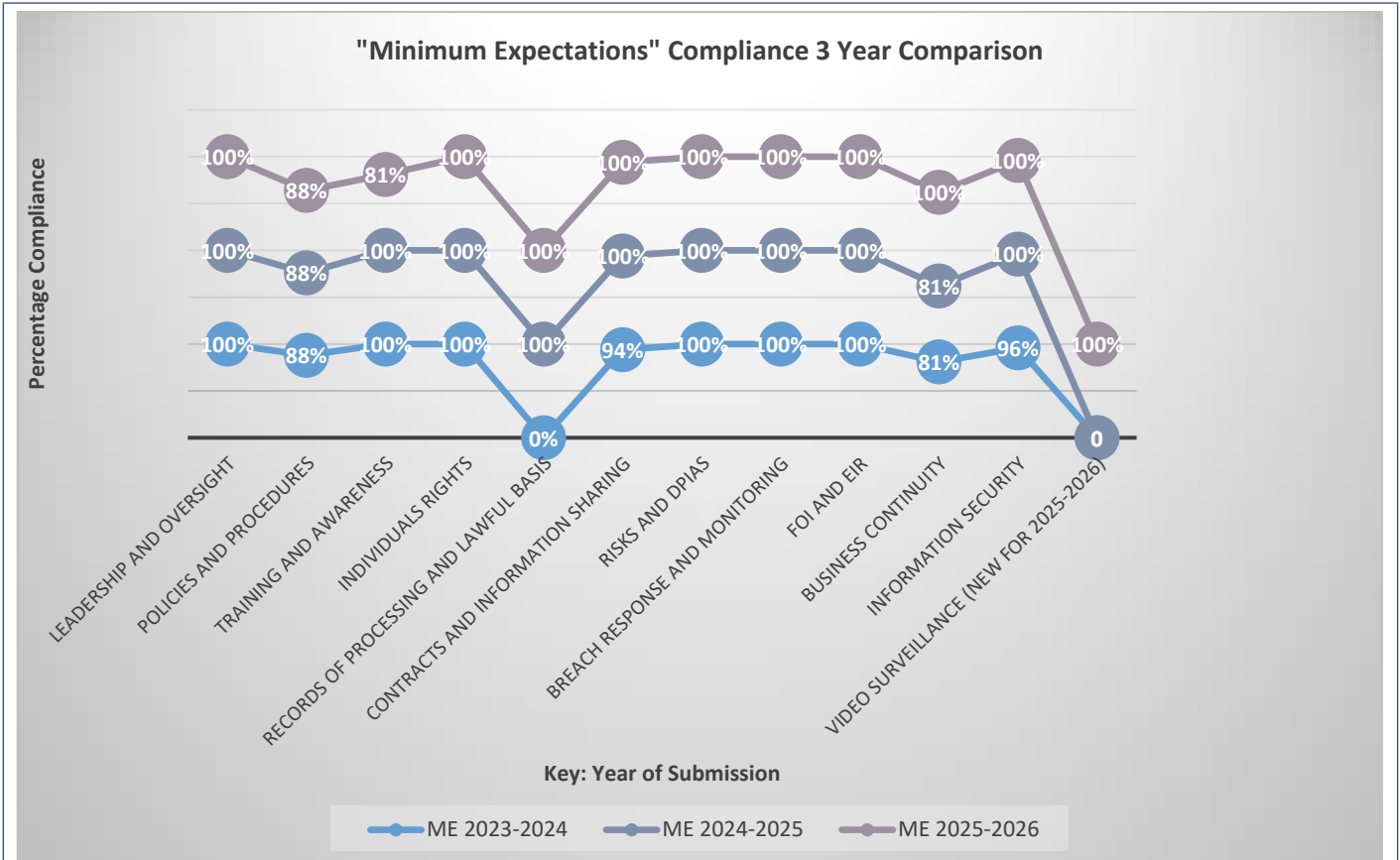
Measuring Compliance: Compliance is measured through responses to assessment questions within each Toolkit category. Organisations are required to provide supporting evidence or narrative explanations to demonstrate the maturity and effectiveness of controls in place.

Each category contains a variable number of questions depending on the subject area, all of which must be satisfactorily completed to achieve full compliance. Following completion and submission of the toolkit, results are reviewed locally and by DHCW, and an improvement plan is generated for local review and approval.

Assurance and Ongoing Improvement: Where full compliance (100%) is achieved within a category, work continues to maintain this level of assurance. Ongoing compliance is essential to meeting statutory obligations and providing assurance to key stakeholders, including provider organisations, service users, and the Information Commissioner’s Office (ICO).

Results

The Toolkit assesses two levels of compliance: “Minimum Expectations” (190 questions) and “Expectations Exceeded” (57 questions). “Minimum Expectations” (ME) represents the minimum requirements for the organisation’s IG compliance and comprises of questions that reflect legal obligations which are set out in the Information Commissioner’s Office (ICO) Accountability Framework. This graph below presents the Health Board’s “Minimum Expectations” performance compared with the previous two annual submissions:

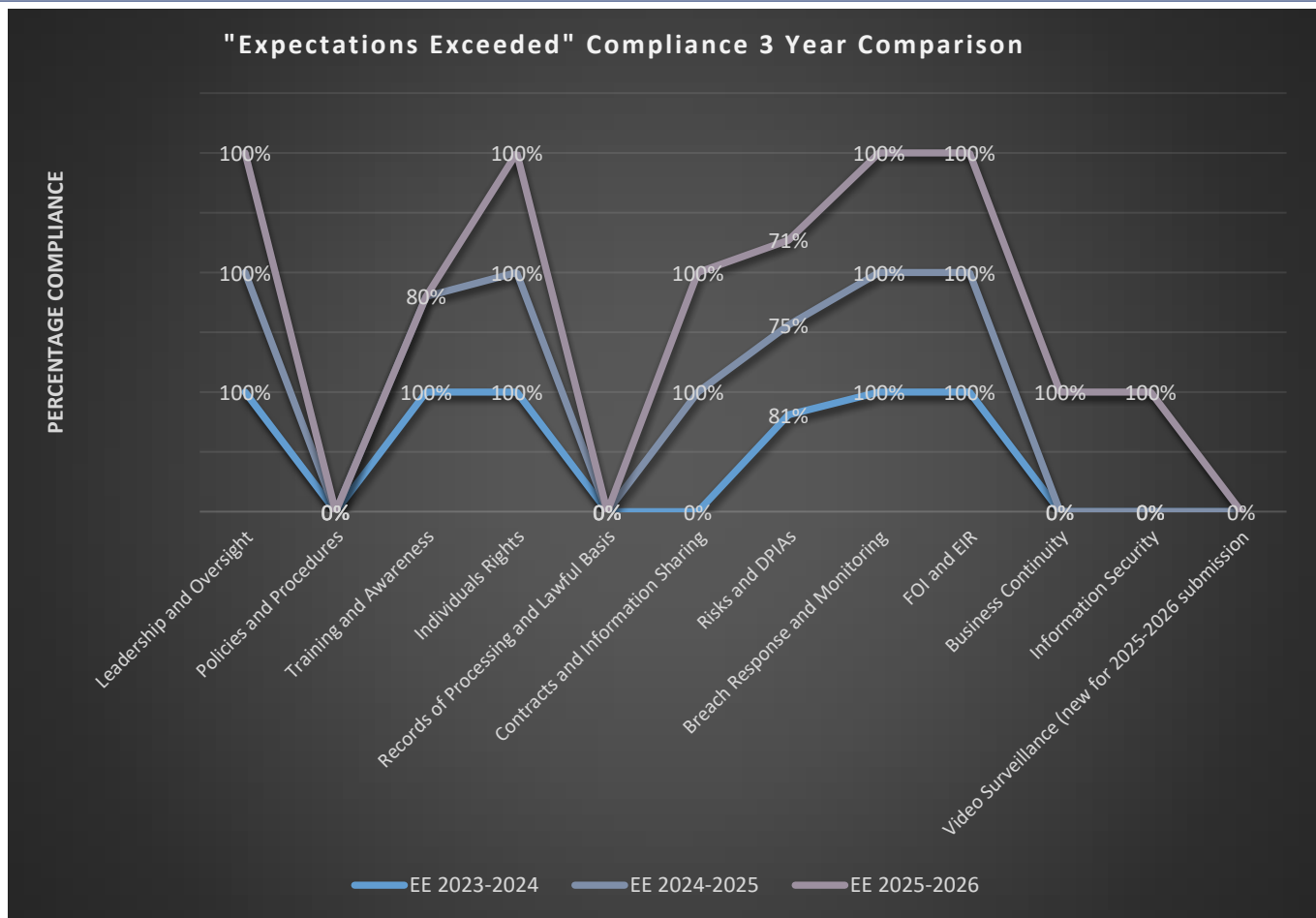


"Expectations Exceeded" (EE) demonstrate that the Health Board is working above the minimum compliance requirements within a given topic area. EE questions only become available once 100% of the Minimum Expectations have been achieved for that category.

As a result, although the Health Board may be able to positively evidence some EE requirements, these responses cannot be included in the overall scoring where the relevant Minimum Expectations have not yet been fully met.

The graph below shows performance against "Expectations Exceeded" compared with the previous two annual submissions.

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Reduction in scores from 2024-25:

Accountability: Training and Awareness

In the 2024-25 Out-turn Report, the Health Board highlighted an additional requirement within the *Training and Awareness* section, whereby organisations must achieve **95% compliance with mandatory IG training** in order to attain an "Expectations Exceeded" rating. A collective response from Health Boards across Wales previously advised that this threshold is unlikely to be achievable unless compliance calculations exclude staff absent for prolonged periods (e.g. parental leave or long-term sickness). This has been raised through the NHS Wales Information Governance Management Advisory Group (IGMAG) and is current sitting with Welsh Government and DHCW.

Notwithstanding this, targeted activity has been undertaken by the IG Team since **Quarter 2 (2025-26)** to improve training compliance beyond **85%**. Current compliance stands at **81%**, as reported through quarterly performance and committee papers. Additional actions undertaken by the IG Team include:

- strengthening the visibility of IG within staff induction programmes
- Targeting non-compliant staff and
- continuing to deliver bespoke and targeted training sessions to services requiring additional support.

Accountability: Risks and Data Protection Impact Assessments

Further work is underway to strengthen the consistency of how information-asset risks are identified, recorded, monitored and escalated, ensuring alignment with the Health Board's corporate risk management arrangements. The IG Team is working with Corporate Governance colleagues to confirm the most proportionate approach and reporting route.

Improvements since last submission (2024-2025):

Business Continuity

There has been a change in the wording for this question set. The Digital, Data and Infrastructure team have continued to develop internal processes to support Business Continuity within PTHB so based on the current question, the Health Board now meets this requirement.

Information Security

Continued work by the Digital, Data and Infrastructure team to undertake internal audits has enabled the health board to achieve "Expectations Exceeded" within this category. This includes regular vulnerability scanning, and monthly reviews against the Cyber Assurance Framework (CAF), as required by NHS Wales Cyber Resilience Unit (CRU).

Future Developments

Digital Health and Care Wales (DHCW): The next iteration of the toolkit is expected to be released in mid-2026. Changes to a number of question sets are anticipated reflecting updated regulatory guidance and legislative developments, including the Data Use and Access Act (DUAA) 2025.

DSPT Completion

Following a formal request from NHS Digital, Powys Teaching Health Board is required to complete the NHS England Data Security and Protection Toolkit (DSPT). This submission is intended to provide consistent and recognised assurance in relation to information governance and data security in the context of cross-border working.

The IG Team is working closely with the Digital Data and Infrastructure team to progress completion of the DSPT, making best use of existing NHS Wales IG Toolkit assurance wherever possible. In parallel, work is underway to undertake a gap analysis to assess areas of duplication and identify any additional assurance requirements.

Given the potential for duplication of effort for NHS Wales organisations that already complete the NHS Wales IG Toolkit and operate under data sharing agreements with NHS England, this matter is currently being escalated through the Information Governance Management Advisory Group (IGMAG). The intention is for the Digital Health and Care Wales (DHCW) representative to raise this issue at the IG Toolkit Senior Management Board (SMB) to support a nationally aligned approach.

NEXT STEPS:

- 1) Engage with Responsible Managers to progress outstanding actions and, agree timelines to improve compliance for next year's submission
- 2) Commence work on completion of the 2026/27 submission by 31 March 2027.
- 3) Provide on-going progress updates to the Executive Committee quarterly and the Audit, Risk and Assurance Committee bi-annually.
- 4) Continue internal work to complete the NHS England Data Security and Protection Toolkit (DSPT), led jointly by the IG Team and the Digital Data and Infrastructure team.
- 5) Finalise a gap analysis comparing DSPT requirements against existing NHS Wales IG Toolkit to identify areas of duplication and any additional assurance gaps.
- 6) Use the findings of the gap analysis to support ongoing escalation via IGMAG, with the DHCW representative raising the issue at the IG Toolkit Senior Management Board (SMB) to seek a nationally aligned approach.
- 7) Review any feedback or decisions from IG Toolkit SMB and determine the most proportionate approach to future DSPT submissions and NHS Wales IG Toolkit submissions, ensuring alignment with NHS Wales and NHS England assurance arrangements.

IMPACT ASSESSMENT – NOT REQUIRED

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Appendix 1

Submission Results

Table below highlights the performance by category for this current submission, with a comparison of trends provided for the 2023-24 and 2024-25 submissions.

Compliance Key
Maintained
Reduced
Improved

	Current Submission 2025-2026		Previous Submission 2024-2025		Previous Submission 2023-2024	
Category	Minimum Expectations % compliance	Expectations Exceeded % compliance	Minimum Expectations % compliance	Expectations Exceeded % compliance	Minimum Expectations % compliance	Expectations Exceeded % compliance
Accountability: Leadership and Oversight	100% (26/26)	100% (4/4)	100% (26/26)	100% (4/4)	100% (26/26)	100% (4/4)
Accountability: Policies and Procedures	88% (15/17)	0% (0/6)	88% (15/17)	0% (0/6)	88 % (15/17)	0% (6/6)
Accountability: Training and Awareness	91% (22/24)	30% (3/10)	100% (24/24)	80% (8/10)	100% (24/24)	100% (10/10)
Accountability: Individuals Rights	100% (17/17)	100% (7/7)	100% (17/17)	100% (7/7)	100% (16/16)	100% (8/8)
Accountability: Records of Processing and Lawful Basis	100% (6/6)	0% (0/1)	100% (6/6)	0% (0/1)	0% (0/2)	0% (0/4)

Accountability: Contracts and Information Sharing	100% (18/18)	100% (7/7)	100% (18/18)	100% (7/7)	94% (17/18)	0% (0/7)
Accountability: Risks and Data Protection Impact Assessments	100% (16/16)	71% (5/7)	100% (16/16)	75% (6/8)	100% (14/14)	81% (9/11)
Accountability: Breach Response and Monitoring	100% (4/4)	100% (4/4)	100% (4/4)	100% (4/4)	100% (4/4)	100% (4/4)
Freedom of Information and Environmental Information	100% (7/7)	100% (5/5)	100% (7/7)	100% (5/5)	100% (6/6)	100% (6/6)
Business Continuity	100% (11/11)	100% (4/4)	81% (9/11)	0% (0/4)	81% (9/11)	0% (0/4)
Information Security	100% (30/30)	100% (2/2)	100% (30/30)	0% (0/2)	96% (29/30)	0% (0/2)
Video Surveillance (new for 2025- 2026 submission)	100% (14/14)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

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Financial Grip & Control

Powys Teaching Health Board
Non-Workforce Controls, Monitoring & Governance Arrangements



April 2026

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Subject:	Non-Workforce Controls, Monitoring & Governance Arrangements (The NHS Wales Financial Grip & Control Assessment Tool)
Approved and Presented by:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Author/s:	Deputy Director of Finance Assistant Director of Finance Head of Operational Procurement & National Sourcing, NWSSP Deputy Board Secretary
Purpose:	This presentation provides an overview of the Health Board’s financial grip and control assessment against the non-workforce elements of the Financial Grip and Control Tool developed by NHS Wales Performance and Improvement.
Recommendations:	The Committee is asked to: • RECEIVE the report taking ASSURANCE that controls are in place across non-workforce cost areas, with clear governance, active oversight and targeted grip in higher-risk areas
Executive Summary:	Overall, assurance can be provided that controls are in place across non-workforce cost areas, with clear governance, active oversight and targeted grip in higher-risk areas. The overall position reflects managed operational pressure and maturity differences, not gaps in governance or control. Actions in progress are expected to strengthen assurance further over the coming period.

The NHS Wales **Financial Grip & Control Assessment Tool**, developed by NHS Wales Performance & Improvement, sets out a consistent approach for Health Boards to assess whether financial and workforce controls are in place, operating effectively and providing assurance.

Scope

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on **core financial, workforce and procurement processes** and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as **commissioning, CHC and prescribing** systems and processes.



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This assessment focusses on the Financial Grip & Control assessment of non-workforce cost areas specifically:

Framework and Guidance	Procurement	Other Items
• Clear and Up to Date Standing Financial Instructions and guidance • Clear procedures & process notes • Budget holders and all financial administrators have received up to date training on their roles & responsibilities • Clear governance process for new investment. • Delegation letters issued & signed • Internal Escalation process	• Monitor use of Single Tender Waivers. • Consolidate a list of supplier discounts. • Robust contract management processes in place. • Enforce 'No PO No Pay' policy. • Review and reduce those able to requisition and order. • Targeted approach for clinical preference variation (identified by V&S procurement group).	• Review and ensure all eligible VAT is being reclaimed. • Income management policies to minimise bad debt costs. • Stock management policies to minimise wastage. • Review all credit balances on the Balance sheet for potential over accrual. • Journals are based on latest relevant data and assumptions

This approach enables the Committee to understand: Where controls are strong and embedded and where further grip action may strengthen assurance.

1. Framework and Guidance

Area	Key Controls	Monitoring/Evidence	RAG
Clear and Up to Date Standing Financial Instructions and guidance	SFIs up to date, regularly reviewed and readily accessible to all relevant officers. Alongside Scheme of Delegation.	Available on internet and intranet <i>Opportunity to highlight to staff as part of communications on policy areas.</i>	G
Clear procedures & process notes	A full set of Financial Control Procedures (FCPs) exist. FCPs are widely available to all relevant team members and available on intranet. Training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures.	Some FCPs need to be revisited as outside 'review by date'. Plan in place to do this by the autumn. Operational process notes available for key financial transactional processes. <i>Opportunity to improve in this area. A vacancy has been carried for a number of months but has in Q4 been appointed to. It is expected to improve work in this area during 2026/27.</i>	A
Budget holders and all financial administrators have received up to date training on their roles & responsibilities	Roles and responsibilities of budget holders clearly defined and clearly communicated. All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process. Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated	Clearly set out in SFIs and FCPs. Detailed scheme of delegation included in Standing Orders/SFIs pack Expected that all budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process Formal Budget holder training provided as part of formal management course. <i>Opportunity to refresh for all budget holders.</i> Budget holders meet regularly with FBP teams and receive support with understanding and action.	G

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1. Framework and Guidance

Area	Key Controls	Monitoring/Evidence	RAG
Clear governance process for new investment	Clear Business Case review procedures for reviewing and approving any new projects across the organisation. The above includes a relevant committee structure where robust review and challenge takes place. Post implementation benefit realisation reviews process in place.	Well established Investment and Benefits Group, which scrutinises business cases before submission to Executive Committee for a decision. Captures most investments. Some go direct to Executive Committee. <i>Opportunity to strengthen report from Chair into Executive Committee and feedback from Executive Committee re resulting decision.</i> Process for evaluation of benefit realisation post implementation. Could be more systematic.	A
Delegation letters issued & signed	Delegation letters have been issued and have been signed	Accountability letters are sent to Executive Directors, signed and returned	G
Internal Escalation process	Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied	Escalation process exists and targeted groups in operation for assessed high risk/spend areas e.g. variable pay group. Mental Health service group currently in escalation process	G

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1. Framework and Guidance

Control Assurance Assessment:

A framework of Standing Financial Instructions and guidance with clear procedures & process notes is in place. Budget holders are supported by the Finance business partner teams on their roles & responsibilities. The Investment and Benefits group is established.

Grip Improvement Actions:

There are opportunities to strengthen further, by highlighting the existence and relevance of SFIs to staff as part of communications on policy areas; ensure all FCPs are reviewed on timely basis; take the opportunity to refresh training for all budget holders; and formalise the reporting from Chair of IBG into Executive Committee and feedback from Executive Committee re resulting decisions on investments.

RAG Rating:
Green

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2. Procurement

Area	Key Controls	Monitoring/Evidence	RAG
Clarity of Roles	Clear documentation and communication of roles between local managers, the procurement function and Shared Services	The THB has a section on intranet, which includes the All Wales procure to pay e manual which outlines role. NWSSP Procurement Services operates in accordance with both UK Procurement Legislation and its internal Document Management System which provides standard operating procedures for all procurement activities that are carried out on behalf of NHS Wales. NWSSP's adherence with procurement policies and procedures is regularly audited by both NWSSP's Business Quality Team and colleagues from Audit & Assurance Services.	G
Tender process	Approval limits are periodically and regularly reviewed where appropriate. All new contracts awarded in compliance with Statutory Regulations and SFIs and procured via appropriate tendering procedures to ensure best value for money is attained. Single Tender Waivers controlled to minimise use Whole Life Costings are applied to evaluate tenders. Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management. Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements.	Financial approval limits are operated in line with Standing Financial Instructions and the Scheme of Delegation. Tenders are carried out by NWSSP Procurement Services in accordance with both UK Procurement legislation and NWSSP's internal Document Management System. The use of Single Tender Waivers is discouraged in favour of following competitive procurement exercises. All Breaches are reported to the Audit Committee.	G

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2. Procurement

Area	Key Controls	Monitoring/Evidence	RAG
Call Off	Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove duplicate items on catalogue (e.g. pens) to ensure value for money.	Contract pricing is reviewed regularly by NWSSP Procurement Services and is benchmarked against other Health organisations across the UK. Product catalogues are updated in line with contract renewal dates.	G
Contract Management	Robust contract management processes are in place, including a complete and up to date contract register. Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over and explore options for efficiencies/price reduction. Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care	Contract management is the responsibility of the relevant HB department. Periodic Internal Audit reviews provide independent assessment. Contract reviews are done on proportionate basis across all healthcare contracts. PtHB does not have any PFI contracts. NWSSP Procurement Services maintains an online e-Contract Management System of the contracts for which it has responsibility for managing, which flags any contracts which are due for renewal/expiry well in advance. Regular Contract Review meeting dates are also recorded against each relevant contract on the e-Contract Management System. Contracts are let in accordance with NHS Standard T&Cs and are proportionate to the subject matter of the contract. All contracts/specifications are reviewed and refined in advance of tendering activity by a Working Group consisting of both HB staff and members of the Procurement Team.	G

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2. Procurement

Area	Key Controls	Monitoring/Evidence	RAG
Purchase to Pay	Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs , in collaboration with Accounts Payable, to help control expenditure. Invoices that fail three way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. Payments are only processed following sign off from the appropriate level. Sample audit batches for any possible out of policy expenditure. Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed.	In place and well established. Requisitioners and approvers are segregated and there are strict approval limits in operation with one named individual by cost centre by financial limit Undertaken as standard Confirmed Work has been undertaken in this area during 25/26 and will continue into 26/27. A manual review of items is undertaken each month before accrual posted.	G
Other	Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses procurement processes. Targeted approach for clinical preference variation (as identified by V&S procurement group)	The Procurement Team proactively monitors HB spend to identify potential savings opportunities, disaggregation of spend and areas for further online automation. Any savings related opportunities are shared with HB Finance colleagues on a monthly basis via the monthly Savings Reports. Only one purchase card is in operation Savings opportunities which have been flagged via the V&S Non & Procurement Sub Group are shared with colleagues. Some elements picked up through GIRFT work on assisting PthB to improve its productivity.	G



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2. Procurement

Control Assurance Assessment:

A comprehensive and embedded control framework is in place for procurement, aligned to All-Wales model SFI and policy requirements. The Health Board works closely with NWSSP Procurement Services. Controls are operating effectively in practice, however, assurance depends on consistent managerial application.

Grip Improvement Actions:

Maintain procurement training for staff across the Health Board.

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RAG Rating:
Green

3. Other Items

Area	Key Controls	Monitoring/Evidence	RAG
VAT recovery management	Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed	Third party organisation undertakes VAT review.	G
Income and Debt management	A NHS visitor and migrant cost recovery programme in place. Bad debt cost management process in place	Limited overseas activity and all in emergency setting (MIU) and excluded from charging takes place no dedicated postholder but finance and commissioning department advise as required. Well established bad debt cost management processes in place. IA review in 2025 with Reasonable judgement.	G
Stock Management	Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf life items or use consignment. Review stock level minimum and maximum thresholds in line with current usage to minimise wastage. Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day). Review controls on consignment stock.	Stock levels and value in PtHB is extremely low. The main areas are Theatres and OPD. Scan4Safety is fully implemented in Theatres, currently under implementation in OPDs. It is focused on end-to-end scanning of barcodes, contributing significantly to inventory management by improving supply chain visibility and enhancing patient safety through accurate point-of-care scanning and streamlining data entry processes and documentation. Scan4Safety supports cost savings through better inventory control, reduction in errors, and more efficient resource allocation.	G

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3. Other Items

Area	Key Controls	Monitoring/Evidence	RAG
Estates	Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT). Ensure appropriate maintenance schedules in place to ensure asset kept in good working order. Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered. Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval.	Benchmarking data and internal performance information, including estates footprint and utilisation data, are being reviewed to identify cost and performance outliers across the estate. This includes analysis of energy consumption, maintenance costs and space utilisation. A comprehensive Planned Preventative Maintenance (PPM) programme is embedded across the estate. Performance against PPM delivery is routinely monitored, supported by compliance sub-groups and audit assurance, reducing unplanned failures and helping to manage risk within the constraints of an ageing estate. The service-led long-term direction for the estate is being developed through the Better Together transformation. In the interim, estates planning is aligned with the PTHB Annual Plan 2026–2027. A prioritised programme of capital, compliance and maintenance schemes is developed through the Capital Control Group. It is presented through the appropriate governance routes for Executive and Board approval.	G
Journal Approvals	Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up to date assumptions. Controls over journals are appropriate including posting authorisation levels, review and sign off process.	All journals input into ledger are subject to approval by a senior finance team member prior to posting recent internal audit found this worked well Established approval process in place and no recommendations made by internal audit in latest review. IA review of general ledger in 2025 gave substantive assurance.	G

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3. Other Items

Area	Key Controls	Monitoring/Evidence	RAG
Fixed Assets and Capital	Fixed asset register is in place and regularly updated including a fixed asset verification exercise. Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate. Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption	Fixed asset register maintained within Finance, which is updated annually. A physical verification exercise has been undertaken in recent years with some small areas remaining to be covered in 26/27. As part of accounts process operational areas are asked to verify assets are still in use at balance sheet date and responses are good to this exercise A fixed asset verification exercise is undertaken annually as part of accounts process where operational areas are asked to verify assets are still in use at balance sheet date and responses are good to this exercise Revenue consequences of capital business cases go to IBG for scrutiny ahead of Executive Committee for a decision. Many capital schemes are must do based on risk or statutory compliance requirements. Reviewed as part of year end processes. However, most are prescribed by WG via the annual manual for accounts.	G
Balance Sheet Review	Ensure all balance sheets are reconciled at appropriate intervals and action is taken to address historical balances. Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end. Review all credit balances on the Balance sheet for potential over accrual.	The balance sheet is reviewed monthly as part of closedown process. Meeting chaired by the Deputy Director of Finance and involves Assistant Directors and Finance Business Partners.	G

3. Other Items

Control Assurance Assessment:

Appropriate controls operate over income and stock and technical areas, such as journal approvals and balance sheet management.
Estates, fixed assets and capital have effective processes in place.

Grip Improvement Actions:

Actions are proportionate to the level of proportionality/usage across the organisation.

RAG Rating:
Green

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Summary of Assessment

Overall, assurance can be provided that controls are in place across non-workforce cost areas, with clear governance, active oversight and targeted grip in higher-risk areas. The overall position reflects managed operational pressure and maturity differences, not gaps in governance or control. Actions in progress are expected to strengthen assurance further over the coming period.

- **Framework and Guidance:** Framework of SFIs and guidance with clear procedures & process notes is in place. Budget holders are supported by the Finance business partner teams on their roles & responsibilities. The Investment and Benefits group is established. There are opportunities to strengthen further, by highlighting the existence and relevance of SFIs to staff as part of communications on policy areas; ensure all FCPs are reviewed on timely basis; take the opportunity to refresh training for all budget holders; and formalise the reporting from Chair of IBG into Executive Committee and feedback re resulting decisions on investments.
- **Procurement:** The Health Board works closely with NWSSP Procurement Services to ensure that comprehensive arrangements are in place, aligned to the All-Wales model SFI and policy requirements. Controls are operating effectively in practice, however, assurance depends on consistent managerial application. Maintaining procurement training for staff across the Health Board will strengthen skills and knowledge.
- **Other Item:** Appropriate and proportionate controls are in place and operating over income, stock and technical areas, such as journal approvals and balance sheet management. Estates, fixed assets and capital have effective processes in place.

RAG Rating:
Green



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Recommendations

These actions focus on improving training and communication, rather than addressing gaps in basic control design. Clear senior ownership supports delivery and ongoing assurance, with actions expected to strengthen grip and confidence over time.

Area	Opportunity to strengthen	Lead
Standing Financial Instructions	Highlight the existence and relevance of SFIs to staff as part of communications on policy areas.	Director of Governance
Financial Control Procedures	Ensure all FCPs are reviewed on timely basis.	EDFCSS
Budget holders	Develop a programme of refresh training for all budget holders.	EDFCSS
Governance process for new investment	Formalise the reporting from Chair of IBG into Executive Committee and feedback from the Executive Committee re resulting decisions on investments.	Director of Governance
Procurement	Maintain procurement training for staff across the Health Board.	EDFCSS

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Health & Care Research Wales

Powys Teaching Health Board Audit Risk & Assurance Committee

12 May 2026

Item 5.7

Helen Grindell, Head of Support and Delivery Centre
Cath Quarrell, Corporate Services Manager



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Subject:	Hosted Body Annual Assurance Report (Health & Care Research Wales)
Approved and Presented by:	Debra Wood-Lawson, Executive Director People & Culture
Prepared by:	Helen Grindell, Head of Research Support & Operations (HCRW) Cath Quarrell, Corporate Services Manager (HCRW)
Purpose:	The Health Board hosts the Health & Care Research Wales (HCRW) Support and Delivery Centre (S&DC). This paper is provided annually to offer assurance that both the Health Board as host and the hosted body (HCRW) are both fulfilling the requirements of the hosting agreement.
Recommendations :	The Committee is asked to: • RECEIVE the hosted body annual assurance report for Health & Care Research Wales (HCRW) • Take ASSURANCE that the hosting agreement is being managed appropriately by both host and hosted body.

Overarching Goal of Health and Care Research Wales

8 To ensure that today's research makes a difference to tomorrow's care

Health and Care Research Wales - Remit

The services we provide are:

- **All Wales Research Delivery** – coordination of an all-Wales approach across NHS, social care and community settings
- **Researcher Development Services** – supports the development of research careers across health and social care through personal award schemes, mentoring, training, leadership development and tailored career support.
- **Research Support Services: including Information** – delivers Wales-wide digital systems services to support research delivery, research management and UK-wide research transformation programmes
- **Regulatory Approvals** - delivers the Wales contribution to the UK-wide approvals service providing governance and ethical approval for research and supporting the 7 Research Ethics Committees in Wales.
- **Communications, Engagement and Involvement** – provides a national service to promote health and care research in Wales, including strategic communications, public engagement and involvement, media and social media activity, and specialist communications advice to support research delivery and impact.
- **National Projects and Programmes** – leads and supports strategic programmes, service development and continuous improvement projects across the remit of Health and Care Research Wales, aligned with Welsh Government and UK-wide priorities.

New or Expanded Areas within current Remit

- **Non-NHS, social care and community settings** – The service remit now explicitly encompasses social care, care homes and wider community settings, reflecting a move towards a whole-system research support & delivery model beyond the NHS.
- **Equality, diversity and inclusion as embedded service activity**- now embedded as a cross-cutting core function through the HCRW Inclusivity Plan and reflected in S&DC workplans
- **Industry engagement and commercial research delivery** – Commercial research delivery is strengthened and positioned as a national strategic function with a clear focus on sustainability, partnerships and UK-wide leadership.

Governance

Hosting Agreement

- Moved to a two-year agreement, signed in April 2026
- Outlines the obligations of the Support and Delivery Centre in complying with PTHB Standing Orders, Standing Financial Instructions and all relevant PTHB policies and procedures
- Outlines the obligations of PTHB in undertaking roles and responsibilities to host the Support and Delivery Centre

Roles and Responsibilities

- PTHB shall provide services and facilities for hosting the Support and Delivery Centre
- Responsible Officer is the Director of Support and Delivery and reports to Director of Workforce & OD at PTHB.
- Accountable Officer is the Chief Executive of PTHB.
- Director of Support and Delivery (reporting directly to the contract manager within WG) is responsible for setting the direction, workplans, performance, ensuring compliance with PTHB policies and management of risk
- Support and Delivery Centre is contract managed by Welsh Government for both financial management and performance (quarterly)
- WG will underwrite the financial liabilities of HCRW Support and Delivery Centre

Governance

Monitoring & Review

- Quarterly Review meetings: the leads for the Support and Delivery Centre and PTHB meets quarterly to discuss hosting arrangements and any areas of concern.
- Annual presentation: the Support and Delivery Centre Leadership Team updates the PTHB Board via the Audit Committee annually re: all activity, identifying and highlighting any areas of risk
- Regular formal meeting: the leads for the Support and Delivery Centre, PTHB and the Science Research & Evidence Division within WG, will meet on a two-yearly basis to discuss issues, governance and any hosting arrangements.
- Health and Care Research Wales are currently complying with the governance arrangements as highlighted within the Hosting Agreement.

Health and Safety

- **Risk Assessment and Management**

- Individual Teams within the Support and Delivery Centre manage their own service level risk registers. Risks scoring over 12 escalated to the Leadership Team – during this time period no escalation has been required.

- **Datix Reporting**

- 4 incidents were reported in 2025/ 2026, a summary is included below:

Month	Classification	Subcategory	Severity	Description
September 2025	Information Governance	Staff Base amended in error	Low	A staff member's base was amended in error following a bulk ESR update associated with the OCP base move.
October 2025	Manual Handling	Staff member injured moving equipment	Low	A staff member sustained an injury while moving equipment; manual handling procedures were not followed at the time of the incident.
December 2025	Health & Safety / Environmental / Estates	Suspected Gas Leak in Cathays Park office	Low	WG Facilities Team investigation confirmed that the incident was not related to a gas leak.
January 2026	Health & Safety / Environmental / Estates	Staff member had asthma attack triggered by Air Freshener in toilet	Low	Staff member required 2 days' absence following the incident. Air freshener has been removed from the toilet. Line manager notified.

Freedom of Information Requests

During this reporting period, there were six Freedom of Information request submitted to Health and Care Research Wales. Five of the six were responded to within the legislative time frame.

Month of Request	FOI Reference	Request	Requestor Type	Outcome
May 2025	FOI.314.25	Employment of Mammographers	Individual	Response drafted by PTHB within key timescales.
July 2025	FOI.423.25	Voluntary scheme for branded medicines pricing	Individual	Advised to contact Science Research and Evidence division in Welsh Government
October 2025	FOI.525.25	Full funding amount / costs provided to The Centre for Research Equity (CfRE) at the University of Oxford	Individual	Response drafted by PTHB within key timescales.
October 2025	FOI.052.26	Pest Control Services	Individual	This response is issued in February 2026 following confirmation that the original email was not received by the PTHB FOI team. The team has advised that technical difficulties during this period affected the receipt of some emails.
November 2025	FOI.566.25	Less Survivable Cancers Taskforce	Individual	Advised to contact Science Research and Evidence division in Welsh Government
December 2025	FOI.611.25	VPAG Funding Allocation Query	Individual	Response drafted within key timescales.

Subject Access Requests

During this reporting period, there was one Subject Access Request submitted to Health and Care Research Wales.

Month of Request	SAR Reference	Request	Requestor Type	Outcome
March 2025	SAR26.235	A complete copy of all personal data Health and Care Research Wales holds about them from January 2023 to present, including all meeting records, correspondence, and any phone call transcripts referencing them	Individual	Consent / Identification documents received 30.04.2026

Finance

- Overall budget: core budget, additional budget and funding for programmes and expansion of scope.
- Financial position is reported quarterly to WG as part of contract management

Description	Additional Budget	Cumulative Total
Core Budget 2025/2026 (with Public and Patient Involvement, Faculty Admin Team, and Faculty non-pay inc.)		£3,611,000
Core Budget 2025/2026 with additional post & Public & Patient Involvement additional funding) Health and Care Research Wales Secretariat post (£47,339)	£47,339	
		£3,658,339
Core Budget 2025/2026 with additional posts and additional Faculty budget. (Faculty Director MB (£31,274), Personal Award Holder BG (£21,150), RDA's 1.2wte (£118,702), RDA non-pay (£6,000) and GMS (£0))	£177,126	
		£3,835,465
Other additional items. (Primary Care Specialty Lead (£19,148), LPMS (£120,288), YouGov Survey (£5,000), R&D Framework (£81,815), ENRICH Cymru (£149,165) & VPAG (£766,755), SSCs (£59,117) & ETCs (£62,349)	£1,263,637	
		£5,099,102

Workforce – Compliance as of 31st March 2026

(data less than 5 is identified as 'xx')

PADR Compliance

- 94.05% (April 2025 – 84.42%). Service areas needing improvement have been identified and support provided.

Mandatory and Statutory Training

- 92.49% (April 2026 – 91.53%) Provision of face-to-face courses have been planned May 2026 in line with Manual Handling Trainer availability.

Staff Absence

- 1.99% (April 2025 - 3.25%) Colds, Coughs Flus and Stress / Anxiety remain the top reasons for absences with many staff being absent for 1 – 3 days.
- xx staff member on long-term sick leave
- xx staff on Maternity leave

Return to Work Conversations

- 87.65% (April 2025 – 98.77%).

Staff Turnover

- Staff turnover remains consistent and recruitment remains steady.

Workforce – Other Metrics

(data less than 5 is identified as 'xx')

- **Respect and Resolution** – There have been no R&R cases raised in the last 12 months.
- **Disciplinary** – xx disciplinary investigation/s and appeal/s process has concluded in line with the All-Wales Disciplinary Policy (Jan 2026), with outcome of dismissal.
- **Capability** – There have been no capability reviews raised in the last 12 months.
- **Occupational Health Referrals** – No outstanding referrals or requirements for escalation.
- **Counter Fraud** – xx issue/s being managed (ongoing from 2025/2026)



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Agenda Item: 5.8

Audit, Risk and Assurance Committee		12 May 2026
Subject:	Internal Audit Progress Report	
Approved and presented by:	Director of Corporate Governance / Board Secretary Head of Internal Audit	
Prepared by:	Head of Internal Audit	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.		
RECOMMENDATION(S):		
The Audit, Risk & Assurance Committee are requested to:		
• Note the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.		
Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
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	

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EXECUTIVE SUMMARY:

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

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

- North Powys Integrated Wellbeing Hub (Reasonable Assurance)
- Risk Management & Assurance (Reasonable Assurance)
- Asbestos Management (Reasonable Assurance)
- Mattresses Follow-up (Assurance Not Applicable)

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

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
May 2026

NWSSP Audit and Assurance Services



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Appendix A	Assignment Status Schedule
Appendix B	Report Response Times
Appendix C	Key Performance Indicators
Appendix D	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
Mortality Reviews	Work in Progress		Management request to pause fieldwork due to absence of lead contact.
Budget Setting	Work in Progress		Delay in receiving initial information.
Vaccine Storage	Work in Progress		Delay in completion of fieldwork.

3. Outcomes from Completed Audit Reviews

Four 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.

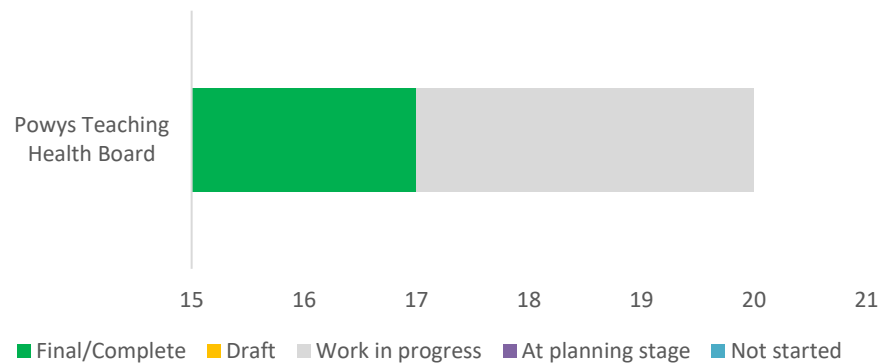
The full versions of the reports are included in the committee’s papers as a separate agenda item.

FINALISED AUDIT REPORTS		ASSURANCE RATING	
North Powys Integrated Wellbeing Hub	Reasonable		
Risk Management & Assurance			
Asbestos Management			
Mattresses Follow-up	N/A		

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4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 20 reviews included within the 2025/26 Internal Audit Plan and overall progress is summarised below.



The illustration above shows that seventeen audits from the 2025/26 plan have been finalised so far this year.

The remaining three audits are currently work in progress.

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).

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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								
Learning Disabilities Eligibility Assessment & Care Co-ordination Processes	Review of the eligibility assessment and care co-ordination processes operating within the Learning Disabilities service.		Primary, Community Care and Mental Health	3		Work in Progress		June
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
Core Financials	Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management	04	Finance, Capital & Support Services	3		Final Report	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
	/ Accounts Receivable / Capital Asset Management.							
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	±	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
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		Final Report	N/A	May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
North Powys Integrated Wellbeing Hub	To evaluate the processes and procedures put in place by to support the management and control arrangements applied to deliver the project through to the Submission of the FBC.	07	Finance, Capital & Support Services / People, Culture & Transformation	3		Final Report	Reasonable	May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance / Board Secretary	4		Final Report	Reasonable	May
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		Final Report	Reasonable	June
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		June
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		June
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		Work in Progress		June
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 nature of commissioning, linked to affordability for Powys.	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
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. 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. 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. 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
Mattresses Follow-up	N/A	Final	24/04/26	18/05/26	24/04/26	24/04/26	G
North Powys Integrated Wellbeing Hub	Reasonable	Final	14/04/26	05/03/26	26/04/26	27/04/26	G
Risk Management & Assurance	Reasonable	Final	23/04/26	15/05/26	29/04/26	29/04/26	G
Asbestos Management	Reasonable	Final	23/02/26	16/03/26	01/05/26	04/05/26	R

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	70% 14 from 20	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 17 from 17	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	83% 14 from 17	85%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 17 from 17	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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North Powys Integrated Wellbeing Hub

Final Internal Audit Report

2025/26

Powys Teaching Health Boards



Reasonable Assurance

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Review Reference

PTH-SSU-2526-07

Fieldwork

November 2025-January 2026

Executive Sign Off

26th April 2026

Audit Committee

12th May 2026

Executive Lead

Lucie Cornish, Director of Improvement & Transformation

Audit Team

Huw Richards, Deputy Director (SSU)
Melanie Goodman, Audit Manager

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Executive Summary

Purpose

The overall objective of this audit was to evaluate the progression and delivery of the North Powys Wellbeing Programme and to assess the adequacy of the systems and controls in place to support the successful delivery of Phase 1 (development of an Integrated Wellbeing Hub). The audit considered the period during which the combined Strategic Outline Case (SOC) / Outline Business Case (OBC) was being developed, i.e. from April to December 2025.

This audit has been delivered as part of the 2025/26 internal audit plan. An Integrated Audit Plan has been provided to the THB for inclusion within the SOC/OBC, outlining a proposed audit plan for the remainder of Phase 1.

Overview

The North Powys Health and Wellbeing Campus Programme is being jointly delivered in partnership with Powys County Council (PCC), with a vision to bring together partner organisations to transform the way health, care, wellbeing and education services are delivered in North Powys. The campus will include a new primary school, Rural Regional Centre and an Integrated Health, Care and Wellbeing Hub. The Programme Business Case was endorsed by Welsh Government in 2022, with the Integrated Wellbeing Hub currently being progressed as a stand-alone project. The Hub will provide a 'front door' to existing and future health, care and wellbeing services.

We have concluded **reasonable assurance** at this review.

Whilst progress against the original timeline set out in the Programme Business Case had been delayed, the SOC/OBC development stage was progressed at pace, meeting its milestone targets and was delivered within the allocated fee budget. The SOC/OBC was approved by Welsh Government on 11th March 2026. Recognising the current stage of the project's development, it is acknowledged that an element of cost uncertainty remains. This will need to be carefully monitored and escalated in a timely manner, in line with Welsh Government's funding criteria.

The matters requiring management attention include:

- Review and refresh of the governance arrangements in readiness for the next stage;
- Consideration of the application of NEC Professional Services Contracts at any future adviser appointments;
- Escalation (internally and to WG) of any increase to capital costs or the targeted revenue position during FBC development.

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

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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	Project Performance: Consideration of delivery performance against the key project objectives e.g., time, cost, quality, etc.).			Reasonable
2	Governance: To obtain assurance that adequate governance arrangements are defined and applied at the programme, including e.g. appropriate programme start-up and initiation processes, formulation and application of defined project protocols, assignment and delivery of key roles and responsibilities, the adequacy of reporting and approval arrangements, supporting workstreams etc., and interface with collaborating third parties / delivery partners e.g. via the Regional Partnership Board.		1,2	Reasonable
3	Stakeholder Engagement: Assurance that appropriate stakeholder and user engagement is operated, including stakeholder identification, a communications plan, user feedback, stakeholder support and third party and/ partnership agreements.		-	Substantial
4	Contractual arrangements: Assurance that appropriate tender and appointment processes have been applied and that contractual arrangements have been formalised for the appointed advisors and contractors (as appropriate) together with appropriate monitoring of contractual performance and payments.		3	Reasonable
5	Project Management: Assurance that the investment proposal and associated risk is being appropriately budgeted, planned, monitored and progressed within allocated funding and target time scales etc.		-	Substantial
6	Design Development: Assurance that a robust design has been developed e.g. based on appropriate surveys and user input.		4,5	Reasonable



Findings & Agreed Action Plan

Overview / Summary of Observations

 Time

Recognising the complexities of planning a multi-partner campus programme, the original timeline for the Health & Care elements of the programme has understandably slipped. Impacts have included Welsh Government affordability concerns, the Covid pandemic, the NHS Wales capital re-prioritisation exercise and introduction of a phased approach at Welsh Government’s request. The timeline as set out in the SOC/OBC compares to the Programme Business Case aspirations as follows:

Key Milestone	PBC Date	Draft SOC/OBC Date <i>(as at December 2025)</i>
SOC submission	June 2021	December 2025
OBC submission	June 2022	
FBC submission	March 2023	Q3 2026/27
Construction start	August 2023	Q1 2027/28
Construction complete	December 2025	Q3 2028/29

Delivery of the current phase (SOC/OBC development) has been completed to a tight timeline set by Welsh Government, with key internal governance and approval milestones achieved at the time of review. Submission of the business case to Welsh Government was achieved in December 2025, with approval granted in March 2026.

 Cost

The programme was in receipt of two sources of funding for 2025/26: £660k Regional Integration Fund (RIF) revenue funding to support programme resourcing, and £970k Integration & Rebalancing Capital Fund (IRCF) funding for technical fees to develop the SOC/OBC. Both funds were reported to be within budget at the time of the audit.

In terms of overall project affordability, the capital cost presented within the SOC/OBC sits outside the original cost envelope, at £35.65m compared with the original estimated project cost of £30m (19% variance). We also note that the original estimate of £30m included £2m for the purchase of an adjacent site, which has not been taken forward in the business case costings. This increases the variance in the cost envelope to 27%. Purchase of the adjacent site remains an ambition of the project, and should the opportunity arise in the future, this would further increase the total project cost.

Recognising however that the Welsh Government has now approved the SOC/OBC, we acknowledge there are no current risks in relation to the Welsh Government's acceptance of the baseline cost envelope or affordability of the current outturn forecast. We further recognise that the THB has identified a number of cost reduction opportunities to be explored further during FBC development, which aim to bring the total capital cost down to circa £33m.

It is acknowledged that a degree of cost uncertainty remains, recognising the absence of an agreed procurement and contract strategy, or involvement of a supply chain partner in design development and costings to date, which would typically be in place at OBC stage. We also note that revenue costs had not yet been determined, however the ambition to achieve a revenue neutral or better position is recognised.



Quality

The performance of the multi-disciplinary advisory team was being monitored by quarterly Key Performance Indicators (KPIs), based on the Building for Wales KPI framework. KPIs completed to date indicate that performance has been generally satisfactory, but with some concerns noted including around timeliness of inputs.

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Overview / Summary of Observations

Programme governance arrangements had been well defined, and our review determined that arrangements were generally operating as intended throughout the period of review (SOC/OBC development period, April-December 2025). The arrangements benefited from:

- Clearly defined arrangements set out in the Project Execution Plan (PEP);
- Clear leadership from the Project Sponsor (CEO) and Senior Responsible Officer at Programme Board;
- A strong Programme Board including representation from relevant partner organisations. Whilst there have been some challenges in attendance during the period, only one meeting was non-quorate, and poor attendance had been recognised by the Programme Board with action taken to strengthen arrangements;
- Robust control and reporting of workstream activity through the workstream Workbooks and the Programme Highlight Report;
- Design and construction technical matters managed through the Innovative Environment workstream and Project Board, reporting to the Programme Board, with leadership from the Capital Project Director and support from external advisers;
- A clear route (critical path) to SOC/OBC approval, routinely monitored at Programme Board.

We have highlighted some opportunities for improvements to the governance arrangements at the above forums in the Key Findings, and these should be considered for implementation in readiness for the next stage (FBC development). We recognise that these issues have not posed any significant risk to date.

The THB should also clarify with Welsh Government the expectations for demonstrating compliance with the funding conditions associated with the SOC/OBC capital funding, which has not to date been reported to any internal forums or to Welsh Government via the established route (bi-monthly Project Progress Reporting).

Key Findings		Risk & Impact	Agreed Management Action
1	Governance Arrangements During the audit, a number of opportunities for improved governance arrangements were identified. Whilst none individually posed any significant risk to programme/ project delivery, the next phase of the project (or future projects) may benefit from review and implementation of improved controls in the following areas: • The defined delegated authorities set out in the PEP and terms of reference could have more usefully identified key decision-making points aligned to the accelerated approach, e.g. those matters normally approved at SOC stage before progressing to OBC;	The programme / project may not be subject to sufficient oversight and control.	Agreed Action: We will review the audit findings and determine which actions can be taken to improve the governance arrangements at this project for the new phase.

	- The Programme Board quoracy requirement should include representation from both PTHB and PCC; - The Programme Highlight Report should be fully populated to provide a summary of risks, issues and milestones as intended by the template; - Noting poor attendance from some parties, particularly PCC, Innovative Environment Project Board and Workstream attendance should be reviewed and commitment reinforced; - Advisers should be included in terms of reference as attendees not members, noting they should not have any decision-making authority; - The PEP should be updated to reflect Project Board arrangements; - Expenditure against capital budgets should be routinely reported to the Project Board.		Expected Evidence of Implementation: Updated terms of reference. Updated PEP. Updated Programme Highlight Reports. Improved attendance at Project Board and IE Workstream meetings. Routine reporting of capital expenditure to an appropriate forum.
	Theme: Governance	Medium Priority	Officer: Project Director Target Implementation Date: 31 May 2026
2	Capital Funding Conditions The Welsh Government IRCF funding letter of 27th March 2025 stated the following: <i>"As part of the Scrutiny Panel on 19 February 2025, the following details were highlighted and are required to be further evidenced as a condition of the funding:-</i> <i>PTHB need to look into the opportunity to work with RSL's to consolidate and repurpose existing buildings within the public estate.</i> <i>As there is no capital contribution from the Local Authority, discussions should be progressed to consider using the land as a contribution to the scheme.</i> <i>There needs to be a clear funding envelope for the scheme which differentiates the shared infrastructure for the various phases and the staged developments".</i> Whilst management have demonstrated to us the ongoing actions in each of these areas, we have not evidenced the reporting of progress against these conditions to a relevant forum, e.g. Innovative Environment Project Board or	Non-compliance with funding conditions may result in withdrawal of funding. Failure to achieve the benefits targeted from the allocated funding. Non-compliance with Welsh Government procedural requirements.	Agreed Action: This has been resolved via Welsh Government approval of the SOC / OBC. The approval letter has not defined any further funding conditions.

Programme Board, and also note that the relevant section of the bi-monthly IRCF Project Progress Reports (submitted to Welsh Government) has not been completed. Recognising the requirements of the funding letter that <i>"You must...provide us with such documents, information and reports which we may reasonably require from time to time in order for us to monitor your compliance with the Conditions"</i> and <i>"you must notify us immediately if a Notification Event has occurred,"</i> (with a 'Notification Event' including failure to comply with the funding conditions), the THB should seek clarity from Welsh Government as to the required deadline and process for demonstrating compliance. It may be that compliance should be demonstrated through the SOC/OBC submission or can be developed further during the FBC stage. Whilst we have rated this issue as a Medium Priority to resolve from a procedural perspective, we recognise that the THB has demonstrated during the audit the actions taken in relation to the conditions, and the more significant risk of funding withdrawal (for non-compliance with funding conditions) may be low. The THB should confirm the position with Welsh Government.	Medium Priority	Expected Evidence of Implementation: N/A
Theme: Approvals	Control Operation	Officer: N/A Target Implementation Date: Actioned since fieldwork

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Overview / Summary of Observations

The programme had appropriately identified its key stakeholders and their corresponding needs. A Communication Plan was in place for the SOC/OBC stage, with engagement matters jointly managed at Regional Partnership Board level.

Engagement and communication workstream activity has been reported routinely to Programme Board via the Programme Highlight Report, with the Communication Plan also reported and approved at this forum.

A Memorandum of Understanding was in place between PTHB and Powys County Council, with arrangements to be developed as the delivery model is firmed up at FBC stage.

We note there has been uncertainty around the inclusion of a GP practice and Pharmacy in the Wellbeing Hub. The risks of the current uncertainty (e.g. in terms of implications on the current design and costs) had been assessed and reported. The position is to be progressed during FBC development.

Inclusion of key stakeholders in the design development process was evidenced, as discussed at *Objective 6*. We have noted that during the design development process (see *Objective 6*), some late design changes were requested from the GP and Pharmacy that, whilst managed within the overall budget allocation, did incur additional costs. As an enhancement point, engagement with key partners should be reviewed and reinforced for the next stage.

Whilst Heads of Terms / leases with building occupiers are to be developed at a later point, the draft building operating model had been defined and was included within the SOC/OBC appendices. The business case confirms that this will be managed by a cross-partner Building Management Group.

Recognising that the uncertainties around GP and Pharmacy inclusion within the Hub have been outside the control of the THB, and the situation has been appropriately monitored and reported, assurance has not been reduced in this area.

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Overview / Summary of Observations

At the current stage (SOC/OBC development), only the multi-disciplinary advisory team (providing Project Management, Cost Advisory, and design services) had been appointed.

The appointment was made via an appropriate framework, following a mini-competition process, with the award in the sum of £872,930.

The appointment was made via Service Level Agreement (SLA). We note that for an appointment of this size and complexity, application of the NEC Professional Services Contract would provide improved control.

Payments have been managed by the Capital team, assessing delivery against the activity schedule. Three variations had been agreed to date, totalling £67,702, in relation to re-design requirements and prolongation of Project Management and Cost Advisory services. These have been discussed further in *Objective 5* in relation to change control.

Performance of the advisers has been monitored via quarterly Key Performance Indicators (KPIs), and whilst performance has generally been assessed as satisfactory, some concerns were noted at the October assessment, particularly with the Project Management and Cost Advisory service. The KPI record notes that a senior meeting has been held with the Consultant to address the issues.

The procurement and contract strategy for the construction stage had not yet been determined, although we recognise that technical advice had been prepared by the advisers and options set out in the SOC/OBC. Noting that, at Building for Wales projects, a Construction partner would typically be appointed during OBC development to feed into the design and cost position, this reduces the cost certainty of the position presented in the SOC/OBC. The THB should ensure any impact to the current project costs once a Construction partner comes on board are escalated in a timely manner.

Key Findings		Risk & Impact	Agreed Management Action
3	Advisor Contractual Arrangements The appointment of the multi-disciplinary advisory team was via framework Service Level Agreement (SLA). For appointments of this value and complexity, best practice would be to use the NEC Professional Services Contract. Application of the same should be considered at any relevant future appointments. The benefits of using the NEC PSC include: • Allows for execution as a deed with 12 years liability; • Provides consistency and alignment across the NEC suite with e.g. the Engineering & Construction Contract (ECC).	Reduced contractual control over key appointments.	Agreed Action: We will review the potential benefits, against costs, of applying NEC Professional Services Contracts at future appropriate projects. We will seek professional advice on this matter where appropriate.

	• Acts as a stimulus to strong project management control, including in areas such as early warning/risk, programme and compensation events; • Helps the client monitor adviser performance against agreed deliverables, and structure payments accordingly; • Provides a structured way for dealing with additional costs or time.		Expected Evidence of Implementation: Documentation of decision making for future Consultant contract versus framework appointment
	Theme: Contractual	Medium Priority Control Design	Officer: Project Director Target Implementation Date: For future application, should the situation arise

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Overview / Summary of Observations

We reviewed the controls in place to manage project finances, the programme, risk and change control.

Responsibilities and processes for project management activity were clearly defined within the Project Execution Plan (PEP).

Each workstream operated a Workbook, providing a comprehensive and consistent record of workstream project management activity. The Workbooks captured information including RAG ratings, highlight report, action logs, risk and issues registers, change register and finances. The Workbooks were utilised at programme level to inform the Programme Highlight Report.

We found milestones and risks to be clearly documented to inform accurate reporting up through the governance structure.

Technical/design/construction risks were also captured, and costed, in the construction risk register, which informs the risk contingency at SOC/OBC.

In terms of financial monitoring, the revenue position was documented in the Workbook and reported to and approved at Programme Board. Whilst the capital budget was monitored by the external cost adviser and reported to the Innovative Environment workstream members, we did not evidence the budget position to be recorded in the workstream Workbook or in the workstream reporting arrangements (see *Governance* objective, *Key Finding 1*).

Whilst variations to the adviser contract had been appropriately approved, we note that increased design fees may have been avoidable had late user changes not been requested/permitted (see *Objective 3*), but recognise this was controlled within budget.

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Overview / Summary of Observations

The design had been developed to an appropriate level of detail (1:200 scale and RIBA Stage 2) for the SOC/OBC.

We evidenced robust processes for developing the design via user groups, with feedback from each round clearly recorded, and overall sign off confirmed. Progress against defined milestones was routinely monitored at workstream and programme board level to ensure alignment with the SOC/OBC delivery timeline.

The project team had also visited completed wellbeing hubs in other health boards to inform the design.

Design development was robustly scrutinised at Programme Board, including matters such as the determination of space requirements, building footprint (including net to gross ratio), and affordability.

Clear sign-off points were established and outputs were approved at Programme Board, including the Concept Design, Operating Model, Schedule of Accommodation and RIBA Stage 2 report. *Objective 2, Key Finding 1* considers the clarity of delegated remits noting some of these sign off-points would typically take place via a Board-approved SOC.

Whilst noting the robust processes set out above, the pace of SOC/OBC development to achieve the Welsh Government deadline, and the accelerated nature of progression through two business case stages at once, has contributed to a reduced certainty in some key areas (compared to that typically seen at OBC stage). This includes an absence of revenue costs, and lack of construction partner engagement which may impact design and costs at the next stage. GP/Pharmacy involvement had also not yet been confirmed.

Noting the total project cost of £35.65m is currently 19% above the Welsh Government cost envelope of £30m, and the Board have been presented with an ambition to achieve a revenue neutral position or better, any adverse impacts to capital and revenue costs during FBC development will need to be escalated in a timely manner to an appropriate forum, and to Welsh Government should capital costs increase by more than 10% above the approved SOC/OBC level (in accordance with WG policy and funding requirements).

Key Findings		Risk & Impact	Agreed Management Action
4	Capital Affordability Whilst recognising that Welsh Government approval has been obtained for the SOC/OBC, with funding secured to progress to FBC development, we note a number of areas of cost uncertainty / risk going forward. These include: Whilst the original cost envelope of £30m was intended to include purchase of an adjacent site (at £2m), this has not been taken forward in the SOC/OBC. The SOC/OBC cost of £35.65m therefore represents a potential maximum 28% variance to the like-for-like cost envelope. We note the potential for future opportunity to	The project may be unaffordable. Appropriate scrutiny and control may not be applied in a timely manner to increasing costs.	Agreed Action: We will engage with Welsh Government in line with the specific requirements set out in the March 2026 funding letter (Schedule 1), including the submission of technical and commercial progress reports on the FBC development process, and of appropriate milestone information to satisfy Welsh Government that the programme scope and cost envelope remain within the award.

	purchase the site, which would add further costs to the agreed budget; - The intended procurement and contract strategies had not yet been determined; - As such, and noting the combined nature of the SOC/OBC, a Construction partner had not yet been appointed. At Building for Wales schemes, for example, the Supply Chain Partner would be appointed during the OBC stage, with the design and costs developed in partnership with the client and SCP; - Global impacts further impact construction cost certainty; - Some uncertainties remained in relation to the design, e.g. inclusion of GP and Pharmacy space (see <i>Objective 3</i>). We recognise the THB has set out a series of cost reduction opportunities to be explored during FBC development, which aim to bring the total capital cost down to circa £33m. Going forward, the THB should engage with Welsh Government in line with the specific requirements set out in the March 2026 funding letter (Schedule 1), including the submission of technical and commercial progress reports on the FBC development process, and of appropriate milestone information to satisfy Welsh Government that the programme scope and cost envelope remain within the award.		
			Expected Evidence of Implementation: Regular reporting to Welsh Government in line with the requirements of the approval letter.
	Theme: Finance Management & Control	Medium Priority Control Operation	Officer: Project Director Target Implementation Date: Immediate and ongoing
5	Revenue Costs Whilst recognising that revenue costs for building operation had been robustly determined, including benchmarking to other projects, service revenue costs had not yet been determined, with the SOC/OBC stating <i>"In respect of predicted revenue costs, the design at OBC stage does not include sufficient detail for the anticipated cost profile to be assessed"</i>. The business case does state the intent to deliver, as a minimum, a revenue neutral position for the Hub and its operation.	The project may be unaffordable. Appropriate scrutiny is not applied to increasing costs.	Agreed Action: We will report any negative deviation from the revenue neutral target in a timely manner to appropriate forums within the THB.

The absence of revenue costs at this stage reduces the certainty of information available to the Board and Welsh Government when scrutinising the business case. It also does not benchmark well with the position typically confirmed in an OBC, where a revenue budget would have been included. We recognise the tight timeline for submission of the business case may have impacted this position. The emerging revenue position should be reported in a clear and timely manner, to relevant forums (which may include the Board), including any risk to the achievement of the revenue neutral target.		
		Expected Evidence of Implementation: Timely reporting of the emerging revenue position, should this exceed the revenue neutral target, to appropriate forums.
	High Priority	Officer: SRO Target Implementation Date: For future application, should the situation arise
Theme: Finance Management & Control	Control Design	

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Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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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.



Risk Management & Assurance

Final Internal Audit Report

2025/26

Powys Teaching Health Board



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Appendix A 10

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTHB-2526-01

March - April 2026

29 April 2026

May 2026

Helen Bushell, Director of Corporate Governance

Ian Virgil, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit

Powell Bethan
12/05/2026 15:11:29



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CYMRU
NHS
WALES**

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risks and to also review the risk management arrangements in the areas of Primary Care and Public Health.

Overview

The Health Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board’s governance and system of internal controls. The Board is committed to having a risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements, meeting objectives and promoting its values.

Over the course of the last year there has been significant progress in risk management arrangements following the approval of the revised Risk Management Framework in March 2025. This has included the development of the Strategic Risk Register (SRR), which is owned by the Board, and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk which is owned by the Executive Committee. Both reports are to be updated and reported three times annually as a minimum. Risks within the ORR are linked to a strategic risk in the SRR and all risks in the latter document have been allocated to a Board sub-committee and feature on that Committee’s agenda as a standing item. The Board also approved revised Risk Appetite Statements in July 2025.

The implementation of Datix Risk Management software is currently on hold due to an issue whereby existing controls could not be added to the system. For the interim, the Health Board has reverted to the use of Excel spreadsheets, which were still being used as the Health Board was operating a system of dual running. It is hoped that the problem with the Datix software will be resolved shortly and that the implementation can therefore recommence. This has however meant that the planned further updates to risk management documentation, and the associated provision of training, has been delayed.

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

- The need to update guidance and deliver training as mentioned above.
- The full implementation of Datix across the Health Board once the software issue is resolved; and
- Review of risk registers for Primary Care and Public Health identified some issues including some misunderstandings of how risks should be scored, particularly with regards to the impact of a risk.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	There is appropriate guidance in place which is up to date and accessible to all staff.		1	Reasonable
2	There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.		-	Reasonable
3	There are appropriate processes in place for reviewing, monitoring and reporting of risks. Risks are escalated when appropriate.		2,3	Reasonable
4	There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.		-	Substantial
5	The audit will identify the progress of implementing the internal audit recommendations raised in the 2024/25 audit of Risk Management (PHTB-2425-01).		1	Reasonable

Management Actions

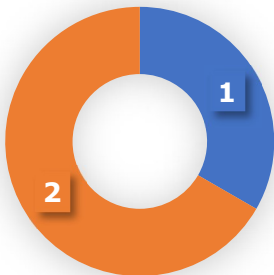


High Priority



Medium Priority

Themes



- Policies & Procedures
- Risk Management

Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance
- Choose an item.
- Choose an item.

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Findings & Agreed Action Plan

Objective 1: There is appropriate guidance in place which is up to date and accessible to all staff.

Reasonable

Overview / Summary of Observations

The implementation of Datix has been put on hold due to a technical error that has resulted in controls not being able to be added to the system. Directorates were consequently adding controls to inappropriate fields within Datix, so the decision was taken to halt the implementation and revert back to Excel for the interim. Datix are working on correcting this issue and it is hoped that an upgraded system will be available to the Health Board within the next month. This has however meant that the planned delivery of training, and the updating of guidance, has been put on hold as it needs to be relevant to the operation of the Datix system.

Key Findings		Risk & Impact	Agreed Management Action
1	Guidance and Training Documented guidance has not been updated due to the delay in implementing Datix. Existing documentation is largely still relevant although it refers to the role of the Risk and Assurance Group which is no longer in existence. Testing of procedures within Primary Care and Public Health identified some misunderstandings in how to score risks and therefore the provision of training to support the roll-out of Datix would be beneficial in reinforcing consistent and good practice.	Inconsistent and ineffective management of risk across the Health Board.	<i>Suggested Action:</i> In 2026/27 the Health Board will review its approach to the recording and analysing of risks across the organisation to ensure an appropriate system for the reporting and recording of risk is available to staff. In conjunction with this the Risk Management Toolkit will be revised, and appropriate training will be made available to relevant staff. Due to timescales beyond the control of the organisation with regards to the Datix system the allocation of a target implementation date is difficult at this stage, hence a suggestion of March 2027.
			Expected Evidence of Implementation: Updated guidance and training material.
		Medium Priority Control Operation	Officer: Deputy Board Secretary Target Implementation Date: March 2027
Theme: Policies & Procedures			

Objective 2: There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.

Reasonable

Overview / Summary of Observations

There is an appropriate risk management structure in place which is centrally resourced via the Corporate Governance team, albeit that it has been affected by significant long-term absence at Band 6 level which is still continuing. This has restricted the opportunity for the Assistant Director of Corporate Governance to provide on-going support to operational staff as she has had to undertake responsibility for many of the detailed administrative procedures that should have been undertaken by the Band 6 role. The Assistant Director of Corporate Governance is also due to go on maternity leave imminently until the autumn of 2026, although cover had been arranged for her role.

The former Risk and Assurance Group has been stood down and its responsibilities taken over by the Operational Leadership Group (OLG), who's remit is wider than just risk. There are some aspects of risk management, particularly at an operational level, which are not picked up by the OLG and there is therefore a proposal to establish a Risk Champions network across the Health Board. Due to the imminent absence of the Assistant Director of Corporate Governance, this is not planned until the start of the 2027/28 financial year.

As there is currently some limitation on resource at both a central and devolved level, we have assigned a rating of reasonable assurance to this objective. However, we have not raised a separate finding as measures are already in place, or are planned, to address the issues noted.

Powell, Bethan
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Overview / Summary of Observations

An Organisational Risk Register has been produced that is being reviewed by the Operational Leadership Group, before submission to the Executive Committee and then presentation to the Board. This cycle of reporting will be undertaken as a minimum three times a year. Risks within the ORR are linked to a strategic risk in the SRR and all risks in the latter document have been allocated to a Board sub-committee and feature on that Committee's agenda as a standing item. In addition, all directorates are reviewed twice-yearly by the Chief Executive of the Health Board, and the standard review pack includes a slide on key directorate risks. However, the delay noted earlier in this report and the subsequent requirement to revert to excel in the interim, result in the ability to have an effective oversight of all Health Board risks being restricted.

Processes are in place to review risks at a directorate and departmental level, and assessment of both the Public Health and Primary Care risk registers and arrangements largely demonstrated a consistent and regular focus on risks. However, there were a number of anomalies noted in both areas as follows:

For Public Health:

- The required information for a number of risks was incomplete, despite some risks having been on the register for at least two years:
- A large number of risks had a target risk score that was the same as the current risk score despite there being significant further action identified to mitigate the risks.
- Of three risks relating to Immunisation, two, relating to respiratory infections and teenage vaccination rates, had a current impact score of 1 which is considered negligible, and one, relating to the risk of a measles outbreak, had a current impact score of 2, which is considered minor. These scores do not seem to reflect the consequences if these risks were to crystallise.
- Some risks had not apparently been reviewed since October 2024, or no date was given for their last review.

For Primary Care, where we attended the monthly Risk Management meeting, there was evidence of appropriate scrutiny and updating of risks. However, there were a large number of instances where the target impact score had been reduced to 1 (negligible). In some cases, this may have been a case of the likelihood and impact scores being the wrong way round, but as a general point, mitigations reduce the likelihood of a risk occurring but rarely affect the impact. This issue was highlighted in the meeting, and we understand that the Risk Register is being updated accordingly.

Powell, Bethan
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Key Findings		Risk & Impact	Agreed Management Action
2	Implementation of Datix The delay in implementing Datix due to an issue with the software restricts the ability of the Corporate Governance Team to have effective oversight of all risks across the Health Board.	Inconsistent and ineffective management of risk across the Health Board.	Suggested Action: In 2026/27 the Health Board will review its approach to the recording and analysing of risks across the organisation to ensure an appropriate risk system is available to staff and provides sufficient value for money.
	Theme: Risk Management	Medium Priority Control Design	Expected Evidence of Implementation: Adoption of an appropriate risk system across the Health Board. Officer: Deputy Board Secretary Target Implementation Date: January 2027
3	Completion of Operational Risk Registers The issues noted in review of both the Primary Care and Public Health Risk Registers highlight a potential lack of understanding in scoring the impact of risks, and for Public Health specifically there were a number of risks that were either incomplete or bore no evidence of recent review.	Inconsistent and ineffective management of risk across the Health Board.	Suggested Action: Whilst the training to be delivered as part of the implementation of a system for risk will help to ensure that such issues are addressed across the whole Health Board, the Corporate Governance Team will ensure that both Public Health and Primary Care resolve the issues noted in the audit.
	Theme: Risk Management	Medium Priority Control Operation	Expected Evidence of Implementation: Updated guidance and training material. Updated Risk Registers for Primary Care and Public Health Officer: Deputy Board Secretary Target Implementation Date: July 2026

Powell Bethan
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Objective 4: There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.

Substantial

Overview / Summary of Observations

A Board Assurance Framework (BAF) Dashboard has been developed in support of the Health Board’s Strategic Risk Register (SRR). The dashboard supports the Board to seek/receive assurance that the actions deployed by the Board to manage/mitigate its key risks are adequate and effective. The dashboard also helps facilitate opportunity to undertake further action where gaps or weaknesses are identified. The Audit Risk and Assurance Committee received and provided scrutiny of the proposed BAF Dashboard templates at its meeting in July 2025 prior to the presentation of the fully developed BAF Dashboard, alongside the SRR to the Board on 30 July 2025.

The SRR is reported to the Board at least three times a year and specific risks have been allocated to Board sub-committees with evidence to show that they are a standing item on the agenda of each Committee. The reporting cycle prior to March 2026 took some time to get off the ground resulting in some Committees reviewing the same information more than once but going forward the review process should become more routine and regular.

Objective 5: The audit will identify the progress of implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (PHTB-2324-01).

Reasonable

Overview / Summary of Observations

Detail on the position with each of the prior recommendations is provided in Appendix A. Of the four outstanding recommendations, two have been completed but the remaining two are dependent on the upgrading and subsequent full implementation of Datix as noted above and reported under Finding 1 of this report.

Powell, Bethan
12/05/2026 15:11:29

Appendix A – Progress with Prior Audit Recommendations

Ref	Recommendation	Management Response	Audit Update (March 2025)	Audit Update (March 2026)
1	The Risk Management Framework and Risk Management Toolkit should be reviewed in accordance with their stated version control requirements to ensure that their content is current, and in alignment with organisational strategic objectives.	The Risk Management Framework and Risk Management Toolkit will be revised as recommended. Deputy Board Secretary 30 September 2024	The Risk Management Framework has been updated and was signed off by the Board in March 2025. The Risk Management Toolkit will be updated in the coming months. On-going	Updating of risk management guidance has been delayed due to the problems noted with the implementation of Datix which is currently on hold. Action on-going
2	Promotion of risk management should be undertaken to ensure that all Health Board staff are aware of their roles and responsibilities, and a rolling programme of risk management training introduced to maximise their understanding and application of the contents of the Risk Management Toolkit.	A programme of risk management training and awareness will be developed and roll out will commence by 30 October 2024. Deputy Board Secretary 31 October 2024	Training has been provided in-year but it is recognised that an effective programme of training and support will be essential for the effective implementation of the revised framework. Implementation will be supported by a suite of training, guidance and support which is currently under development by the Corporate Governance Team. This will include a revised Risk Management Toolkit, which will return to the Audit, Risk and Assurance Committee on 8 July 2025 for approval. On-going	The delivery of further training has also been impacted by the problems with the Datix implementation. Action on-going.
5	All Directorate/departmental risk management leads should be reminded that key risks that are scored 12 and above should be submitted to the RAG for discussion, with a further view for potential escalation onto the Corporate risk register.	Requests for directorate risks have been issued and incorporated onto the Risk and Assurance Group agenda for the scheduled meeting on the 18 July 2024 and will be a standing item thereafter. Director of Corporate Governance 30 June 2024	Review of the Risk & Assurance Group meeting notes suggest that this has been occurring but not on a consistent basis. However, the change in risk management arrangements, with the implementation of an Organisational Risk Register, is likely to make it easier for Directorate risks to be considered for escalation as appropriate and this is reinforced by the updated Risk Management Framework. On-going	The role previously undertaken by the Risk & Assurance Group has now been passed to the Operational Leadership Group. The Organisational Risk Register has been documented and presented to both the OLG and the Executive Committee. Review of procedures in both Primary Care and Public Health supported the view that staff were aware of how and when risks should be escalated. Complete

Appendix A – Progress with Prior Audit Recommendations

Ref	Recommendation	Management Response	Audit Update (March 2025)	Audit Update (March 2026)
6	Ongoing action should be taken to ensure that the BAF is populated as detailed within the covering paper presented to the May 2024 Board meeting. Furthermore, the BAF should then be subject to ongoing progress reporting to the Audit Risk & Assurance Committee and the Board.	The development of the BAF forms part of the scheduled work programme and forms part of the Board work programme for the Boards meeting on the 25 September 2024. Director of Corporate Governance 30 September 2024	Although work has been taken forward on the design of the BAF and how it will work in practice, it is still to be actually populated. The plan is for the Strategic Risk Register to be presented to the May Board meeting with the BAF then going to the July meeting. Ongoing	The Strategic Risk Register is now regularly being presented to the Board, along with the BAF dashboard. Complete

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Appendix B

Assurance Opinion

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

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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Asbestos Management

Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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Review Reference

Fieldwork
Executive Sign Off
Audit Risk and Assurance Committee
Executive Lead

Head of Internal Audit

PTH-SSU-2526-05

October - November 2025

May 2026

May 2026

Pete Hopgood, Director of Finance,
Capital & Support Services

Huw Richards, Deputy Director
(SSu)

David Butler, Audit Manager



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Executive Summary

Purpose

Asbestos-containing materials were used for a wide range of construction purposes in new and refurbished buildings until 1999, when almost all use of asbestos was banned. Buildings constructed after year 2000 can normally be regarded as being asbestos-free.

The review was undertaken to determine the adequacy of, and operational compliance with the Teaching Health Board's systems and procedures for the management and control of Asbestos, taking account of NHS and other supporting regulatory and procedural requirements (notably the Control of Asbestos Regulations 2012). The audit was included as part of the internal audit plan for 2025/26 agreed by the Audit Committee.

The overall objective was to ensure that the Health Board's overarching asbestos management procedures (as implemented) are robust and sufficiently comprehensive to manage asbestos based risks.

The Control of Asbestos Regulations 2012 (CAR 2012) place specific responsibilities on duty holders to assess the presence of asbestos, notably prior to any refurbishment or work likely to disturb building materials, and to ensure that appropriate information, instruction, and training are provided to staff.

Overview

The audit found procedures in place to provide practical guidance on the implementation of the Control of Asbestos Regulations 2012 in the Health Board context. This included the specific roles of their Estates staff relating to the identification, management, and safe handling of asbestos.

Controls included risk assessment, re-inspections, monitoring and reporting arrangements, and action for high risk or deteriorating materials. Asbestos issues were found to be appropriately identified and addressed at sample testing.

We have concluded **reasonable assurance** on this area. Matters requiring management attention included to the need to improve procedures or improve alignment of procedures with operational practices. There was also the need for enhanced record keeping procedures to ensure that on-going regulatory compliance can be demonstrated. Key matters for management attention included:

- the need to ensure appropriate frequency of management surveys and re-inspections;
- clarified requirements for record keeping within procedures including any exemptions for minor works;
- a clear risk rating at the Annual Asbestos Report;
- monitoring risk action dates;
- monitoring asbestos training for the various categories of staff as required; and
- enhanced waste procedures to provide assurance of legal disposal.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Highlight reporting could usefully be extended to include proposed, approved and expended sums to facilitate communication, budget monitoring and approvals (including authority to proceed).

Full details of these are provided at **Appendix A**

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Governance - Assurance that an approved Asbestos Management Plan / Policy was in place, verify that there was appropriate and demonstrable executive ownership, that day-to-day management of asbestos has been assigned to a suitably qualified and competent individual and further that monitoring and audit arrangements were operating effectively.		Substantial
2 Identification- Appropriate surveys had been undertaken to identify the presence of asbestos and the potential exposure risk to staff/ public.	1	Reasonable
3 Records – To ensure that the Health Board held a fully comprehensive asbestos register to identify the locations of Asbestos Containing Materials on all sites.	2	Reasonable
4 Risk Management – To confirm all high-risk Asbestos Containing Materials had been identified and escalated to the Health Board’s corporate risk register – including proposed action.	3, 4	Reasonable
5 Action Plans - The Health Board had an Asbestos Risk Register that identifies all asbestos across the estate, and an Asbestos Management Plan that determines how the Asbestos Containing Materials are managed in each premises.	5	Reasonable
6 Operational Delivery - That Compliance with Control of Asbestos Regulations 2012 was demonstrated through operational activities including - Plans of Work, Information, Instruction and Training, Use and Maintenance of Control Measures etc.	6, 7	Reasonable

Management Actions



High Priority



Medium Priority

Themes



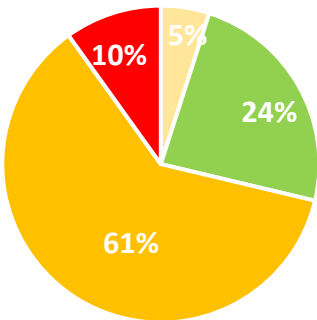
Risk Types

Quality or Safety Issues
Legal & Regulatory Non-Compliance

Asbestos Management – At a Glance

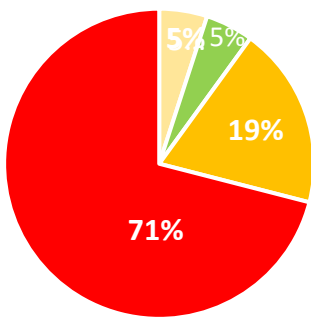
Re- inspection performance (% premises)

As at August 2025



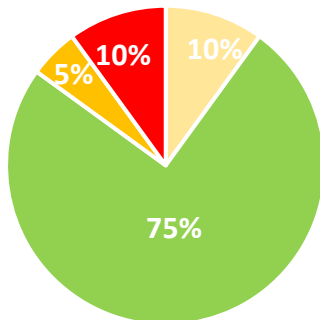
Not required Re-inspected
Due within 3 months Overdue

As at November 2025



Not required Re-inspected
Due within 3 months Overdue

As at March 2026



Not required Re-inspected
Due within 3 months Overdue

By November 2025, 71% of planned re-inspections were reported as over-due, with a further 19% reported as due within the next 3 months. These figures were significantly reduced by March 2026 (the majority of re-inspections being undertaken during December 2025).

The reported 10% of overdue inspections (as at August 2025 through to March 2026) have been attributed to anomalies in data provided by an external party i.e. relating to sites that are no longer in the ownership/maintenance responsibility of the Health Board. Audit testing was able to affirm the same.

Findings & Agreed Action Plan

Objective 1: Governance Arrangements

Substantial

Overview / Summary of Observations

Defined governance and reporting arrangements are not a requirement of asbestos regulations. However, effective communication and oversight arrangements can facilitate compliance. Accordingly, governance and reporting arrangements were defined within the Asbestos Management Policy and Procedure and terms of reference of relevant groups and committees in accordance with best practice.

An in-date Asbestos Management Policy was in place as approved by both the Asbestos Safety Group and the Innovative Environments Group. The Policy was supported by in-date Asbestos Management Procedures approved by the Asbestos Safety Group detailing operational controls. Together these provided a practical framework applicable to the Health Board to ensure compliance with requirements of the Control of Asbestos Regulations 2012.

The Asbestos Safety Group was chaired by the Associate Director of Capital, Estates and Facilities (as the Responsible Person), the Asbestos Manager (Capital Manager), Deputy Asbestos Manager (Head of Estates), Senior Health and Safety Officer, Support Services (Facilities) Manager, ICT Manager, and Head of Technical Services (Property). These arrangements provide both direct linkage to the Executive, and operational linkage to those likely to encounter asbestos (e.g. IT cabling). The Group met quarterly and was supported by a bi-monthly Asbestos sub-group informed by a Highlight report of operational issues (showing risk and priced assessed issues).

The Asbestos Safety Group reported to the Estates Compliance Group (also chaired by the Associate Director of Capital Estates and Facilities – the Responsible Person), with escalation to the Innovative Environments Group demonstrating appropriate oversight and escalation arrangements. The Innovative Environments Group was attended by both the Associate Director of Capital, Estates and Property, and Head of Facilities ensuring effective communication of any issues.

Noting the above, substantial assurance has been determined in relation to governance arrangements applied to asbestos management.

Powell, Bethan
12/05/2026 15:11:29

Overview / Summary of Observations

The Health Board undertook a Management (general) Survey of the entire estate between 2012 – 2013 (as evidenced by sample testing). This was supplemented by an annual re-inspection regime (or more frequent, as guided by scored risk appraisals). Procedures also require the need for a refurbishment / demolition survey before any works are undertaken (in accordance with Health & Safety Guidance HSG 264). Reliance was therefore placed on comprehensive coverage of the Management Survey, with inspection on an exception basis thereafter.

These surveys were conducted by UKAS (United Kingdom Accreditation Service) accredited surveyors as required by regulations.

Management acknowledged the need to refresh the management survey on a rolling basis. Monitoring reports showed that 16% of buildings were not included within the original Management Survey and 10% of properties were over-due re-inspections. However, management demonstrated that these issues related to data anomalies at the database monitoring provided by an external consultant. Whilst these items were acknowledged by the Health Board, the anomalies had not been rectified at the time of the report.

Asbestos work is categorised by risk level, dictating whether it requires an HSE-licensed contractor (high risk) or not. The Health Board uses licenced asbestos contractors for all asbestos works (excepting minor works not requiring notification to the HSE undertaken by the works department).

For purposes of sampling, the audit reviewed eight works completed from January 2024 comprising:

Table 1

Date	Job description	External contractor / works dept	Value
Oct 24	Brecon Duct	Licenced contractor	£30k
Oct 24	Brecon Admin Roof	Licenced contractor	£30k
Mar 25	Bronllys Critical Asbestos Removal	Licenced contractor	£135k
Mar 25	Llanidloes Critical Asbestos Removal	Licenced contractor	£106k
Jan 24	Tawe Ward	Works dept.	n/a
Sept 24	Brecon War Memorial Hospital Boiler Room	Works dept.	n/a
Jan 25	Mortuary Fridge	Works dept.	n/a
Mar 25	Fire Alarms	Works dept.	n/a

Sampling found asbestos issues to be appropriately identified and works to be appropriately directed by surveys. However, there was a need to define circumstances in which exemptions from refurbishment / demolition surveys may be applied (as was the case for the minor works – see **Records – Administrative procedures**).

Noting a risk-based approach and satisfactory assurances obtained from sampling, **reasonable** assurance has been determined in relation to asbestos identification.

Power, Bethan
11/05/2026 15:11:29

Key Findings		Risk & Impact	Agreed Management Action
1	Survey frequency <i>Management Surveys</i> Health & Safety guidance requires a “suitable and sufficient” management survey of the estate to be undertaken to assess asbestos risks. Such management surveys are intended to act as the basis to direct more thorough / invasive re-inspection surveys. A full survey was last undertaken in 2012 – 2013. Monitoring reports showed that 16% of buildings were not included within the original Management Survey. Management were subsequently able to demonstrate that this related to data anomalies of the external consultant which were being managed / addressed (e.g. 6 x-ray facilities reported as separate sites, disposed of premises etc). However, the asbestos issues identified within the (sampled) Brecon Roof works were not identified at the original Management Survey. The October 2024 Asbestos Highlight report, noting the elapsed time since the prior survey, commented that it was: <i>“good practice to revisit surveys and possible rolling programme for individual sites in order to update.”</i> <i>Re-inspections</i> The Asbestos Management Policy requires re-inspections to be undertaken of all premises on an annual basis as directed by risk assessments (e.g. as informed by the management survey and subsequent information). While subject to monitoring and discussion, compliance data and graphs were not included within reports. The effectiveness of reporting the associated risks has been considered at the Risk Management objective.	Failure to evidence compliance with the Control of Asbestos Regulations 2012, risking legal liabilities.	Proposed Management Action: (a) A decision has been made to introduce a rolling programme of Management Surveys starting with Llanidloes from 2026 alongside the continued programme of re-inspections. (b) In order to increase the resilience of the maximum annual cycle for asbestos re-inspections (which are currently commissioned every year and entailing potential procurement delays) a 5-year contract will be secured.
			Expected Evidence of Implementation: (a) Progressive survey of the estate (b) 5-year contracts for both re-inspections and management surveys completed between the Health Board and appointed provider.
		Medium Priority	Officer: Associate Director of Capital, Estates and Property Date: (a) from July 2026 (b) December 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Overview / Summary of Observations

The Asbestos Manager was able to evidence a range of key documents to demonstrate compliance with the Control of Asbestos Regulations 2012 (CAR 2012), Health & Safety Guidance HSG 264, and both the Health Board Asbestos Management Policy and Asbestos management Procedure.

Asbestos Management Plans were in place for each of the sites sampled. Similarly Plans of Work including associated surveys (refurbishment survey) and risk assessments were filed for all works sampled.

However, while no non-compliance was noted at works undertaken, there was a need to better define documentation and record retention requirements to evidence compliance e.g. required insurances, and records of those discovering / disturbing asbestos and associated medical records.

While a listing was available for "Permit" jobs this was not routinely published to the Asbestos Sub-Group to facilitate review and control of minor works. There was also a need for clarity as to procedures for closure of these works (see **Overview** bullet listings).

While recognising these issues, noting records in the key aspects of works risk assessment and plans of work, reasonable assurance is determined in relation to asbestos records.

Key Findings		Risk & Impact	Agreed Management Action
2	Administrative procedures While the audit did not find non-compliance with the CAR 2012 regulations, procedures did not always fully specify expected administrative and record maintenance requirements, and in one instance did not fully record compliance (In the case of Bronllys, evidence of site induction relied upon the contractor's site diary, and only referenced induction the day prior to works completion). In the event of challenge that due process had been followed, procedures should therefore also include expectations as to administrative processes to evidence compliance e.g. - waste management (see finding 5); and - records of those discovering / disturbing asbestos and associated medical records (noting 40-year retention requirements and that at the time of the audit the asbestos officer(s) indicated that they did not have access to historical records of exposure to asbestos). Management advised that they were not aware of any such incidents.	Failure to evidence compliance with the Control of Asbestos Regulations 2012 risking legal liabilities.	Proposed Management Action: The Asbestos Management Procedures will be reviewed and updated including to: (a) Recognise a process where the Asbestos / Deputy Asbestos Manager can authorise work without the need for samples where the knowledge of the material involved is well-established from similar appropriate prior sampling. (b) Reflect the process to capture the documentation on the closure of Permits.

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Minor works exemptions

Surveys

In review of minor works it was also found that refurbishment / demolition surveys had not been undertaken in these instances.

In the case of Fire Alarms, works were required as part of a larger capital project (being embedded in an Artex roof of similar age to another with known asbestos).

Workers were not exposed to undue risk due to the presumption of asbestos presence with associate precautions and practices.

However, the Asbestos Management Procedures did not specify exemption from such survey by way of emergency or other exception. It is also possible that without such survey undue asbestos precautions may be undertaken.

There was therefore a need to define the nature of works where such exceptions would be applied and the applicable exceptions.

Reporting and closure

Reporting of approvals, costs, issues and completion of minor / emergency Permit jobs is presently as discussed at sub-group meetings.

While a listing was available for "Permit" jobs (**Table 1**), this was not routinely utilised to inform monitoring by the Asbestos Sub-Group of minor works e.g. the February 2024 Asbestos Sub-Group meeting referred to 16 such jobs "*mainly in Ystradgynlais and Bronllys*" with no further detail.

Formal closure was not identified for these jobs. However, there was no exception to standard handover and closure within *procedures for minor works*.

A systematic report could perhaps be of benefit to ensure comprehensive coverage e.g. including authorisation, costing, survey exemptions and closure certification etc.

Theme: Policies & Procedures

Expected Evidence of Implementation:

Amended Asbestos Management Procedures

Medium Priority

Control Design

Officer: Associate Director of Capital, Estates and Property

Date: July 2026

Overview / Summary of Observations

Asbestos risks were assessed and scored in detail at the Asbestos Risk Register in addition to confirmation at re-inspections and Plans of Work.

The 2024 Asbestos Annual Report (to the November 2024 Integrated Assurance Group) included the review of current estate risks. At the time of audit, the 2025 report (provided in draft) had yet to be published. While management confirmed that an overall assessment and derivation of estate risk was reported at the Annual Report, the report did not make this clear.

A risk-based approach was in place in the monitoring and reporting of issues relating to asbestos works (as confirmed by audit sampling – see **Asbestos Identification** Objective). The October 2025 Highlight Report recognised re-inspections being due between November and December 2025. The **At a Glance** section, detailed movement in the over-due re-inspection requirements. Management confirmed that all re-inspections were completed by 17th December 2025 mitigating the reported risks. While other risks were of a more minor nature, full monitoring of risk action dates was not identified.

While noting these matters, reasonable assurance is determined in relation to risk management.

Key Findings		Risk & Impact	Agreed Management Action
3	Risk score	Risks are not sufficiently reported to appropriately inform the decisions of the Responsible Officer.	Proposed Management Action: We will clarify the derivation of the overall asbestos risk score e.g. being based on both works and wider factors such as training compliance, up to date procedures, and current surveys.
	While the November 2024 Asbestos Annual Report reported an asbestos risk of 10, this was linked to one current removal job rated at 10. Wider derivation of this score was not apparent. There was therefore scope for greater clarity as to the reporting and derivation of the overall asbestos risk within the Health Board estate. At the draft 2025 report (compiled during the audit) linkage to risk scoring of individual works had been removed.		Expected Evidence of Implementation: Clear derivation of the risk score at the annual asbestos report.
	Theme: Risk Management	Medium Priority	Officer: Associate Director of Capital, Estates and Property Date: March 2027
		Control Operation	
4	Risk Actions	Appropriate plans are not in place to mitigate asbestos risks.	Proposed Management Action: An action tracker will be developed for the re-inspection survey recommendations (which will provide a pan-Powys tracking tool).
	Action dates for all the full number of identified risks (several hundred) were not completed. While all site risks were monitored via Asbestos Management Plans for each site, these did not include monitoring against set risk action dates. There was therefore a need for management to confirm appropriate monitoring and reporting of identified risks.		Expected Evidence of Implementation: An operational action tracker for re-inspection survey recommendations.

		Medium Priority	Officer: Associate Director of Capital, Estates and Property
	Theme: Risk Management	Control Operation	Date: September 2026

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Overview / Summary of Observations

Asbestos Containing Materials were managed in accordance with the Health Board’s Asbestos Management Policy and Procedure. These in turn aligned with the Control of Asbestos Regulations 2012.

The Asbestos Risk register, supported by Asbestos Management Plans and a Works Tracker, acted as the key documents informing actions plans.

The 2024 Asbestos Annual Report stated that site specific Asbestos Management Plans were to be re-issued in November 2024 (with on-going actions recorded at Highlight Reporting). The June 2025 Highlight Report subsequently noted these to have been completed for all hospital and owned clinic sites. However, the October 2025 Highlight Report also noted that action was still required to ensure Asbestos Management Plans for Primary Care and premises leased from third parties. At the time of audit, there remained a need to ensure that Asbestos Management Plans were up to date based on full surveys and re-inspections of the entire estate (see **finding 3**).

Management measures included isolation, encapsulation or enclosure of Asbestos Containing Materials to prevent deterioration or accidental disturbance; and clear labelling of higher-risk materials. A graded response (of isolation, encapsulation or removal), based on risk, deterioration, and re-inspection was clearly specified at the Procedures, supported by awareness training.

A “low” rated matter is also observed, that while Highlight reporting included indicative costs, reporting could usefully be extended to include proposed, approved and expended sums to facilitate communication, budget monitoring and approvals (including authority to proceed).

While recognising the need to fully update action plans following completion of surveys & re-inspections, noting identification of key issues at monitoring including this requirement reasonable assurance is determined in relation to action plans.

Key Findings		Risk & Impact	Agreed Management Action
5	Leased premises The September 2025 Asbestos Group meeting noted with regards to buildings leased from third parties that there was a need that: <i>“documentation from the landlord on the leased building is required for asbestos” with an agreed action “to arrange a meeting to progress, looking at the sites, getting the information off the lease holders, the quality of the report and how to respond to the lease holders”.</i> The October 2025 Highlight Report further noted the need for: <i>“Asbestos Management Plans to be set up for Primary care and leased buildings as well as sites where there are no asbestos containing materials present to provide a historical check” with the need to “gather information from Freeholder / landlord or survey site” and for “documents to be completed in conjunction with project team and use of Powys County Council database for</i>	Appropriate plans are not in place to mitigate asbestos risks.	Proposed Management Action: A review will be undertaken of the effectiveness of the Duty of Care process related to the monitoring of asbestos management by Landlords of leased premises.

<i>asbestos</i>", with a working group to be set up to progress. Accordingly, there was a corresponding need to ensure appropriately informed asbestos mitigations and Asbestos Management Plans were in place for Primary Care and leased premises.		Expected Evidence of Implementation:
		Duty of Care review of monitoring of asbestos management by Landlords of leased premises.
	Medium Priority	Officer: Associate Director of Capital, Estates and Property
Theme: Risk Management	Control Operation	Date: December 2026

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Overview / Summary of Observations

The Health Board’s Asbestos Management Policy and Procedure, in combination provide a practical framework for governance and regulatory compliance in the context of the Health Board estate. These clearly set out clearly defined procedures to be followed in the event of an accidental or suspected disturbance of Asbestos Containing Materials. Work requiring licenced asbestos contractors and also that requiring notification to the Health & Safety Executive were clearly described in both the Policies and Procedures (in accordance with the Control of Asbestos Regulations 2012).

Procedures detailed requirements for both Risk Assessments and method statements e.g. as required for HSE notifications and within the proposed Plans of Work (as found to accord with practice in sample testing).

Planned work was appropriately notified to the Health & Safety Executive and undertaken using licenced contractors where required. However, the waste carriers should be detailed at the Plan of Works to facilitate appropriate checks. There was also a need to describe the bagging and storage procedures used operationally.

As previously noted, issues and actions were communicated, monitored and prioritised via Action Logs and Highlight Reports with assigned officers for action. It was evident from the Action Logs, Highlight Reporting and sample testing that risk assessed issues were being appropriately addressed.

Effective operational delivery also relies on effective training. While various tiers of training were detailed as in place at the Annual Report, this should explicitly confirm levels of compliance, notably by the Responsible Officer and key delegates.

Accordingly, noting these matters, reasonable assurance is determined in relation to operational delivery.

Key Findings		Risk & Impact	Agreed Management Action
6	Waste procedures <u>Waste Carriers</u> In accordance with legislation, the Asbestos Management Procedure states that Hazardous Waste: "must only be removed from site by a registered Waste Carrier and transferred to a suitably licensed Hazardous Waste facility with Hazardous Waste Consignment Note to be provided by the Waste Carrier". This was re-iterated at Plans of Work, including the waste carrier licence of the contractor (to permit advance vetting), procedures did not state these additional expectations. Management confirmed that operationally, asbestos waste is stored in red asbestos waste bins, held securely and collected periodically. However, similarly, these processes / requirements were not described within procedures. This also means that staff cannot reasonably be held to account for non-compliance.	Appropriate declarations and checks are not made for a current Waste Carrier Licence resulting in regulatory breach, potential legal action, fines, and adverse publicity.	Proposed Management Action: The Asbestos Management Procedure will be updated to fully reflect required waste procedures.
			Expected Evidence of Implementation: Updated asbestos waste procedure.
	Theme: Policies & Procedures	Medium Priority Control Design	Officer: Associate Director of Capital, Estates and Property Date: July 2026

7	Asbestos awareness training Detailed monitoring of asbestos training was undertaken for the Estates, Works and Capital teams. The Asbestos Management Policy requires the Asbestos Annual Report to report on training status. While this reported various tiers of training in place, from awareness to Duty to Manage, it did not report compliance (notably for the Responsible Person and supporting managers).	Inadequately trained staff may lead to unintentional disturbance of Asbestos Containing Materials with resultant health risks and potential breaches of the Control of Asbestos Regulations 2012.	Proposed Management Action: A narration will be added to the annual report in relation to levels of training compliance.
			Expected Evidence of Implementation: Annually reported training compliance.
		Medium Priority	Officer: Associate Director of Capital, Estates and Property Date: March 2027
Theme: Reporting		Control Design	

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Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of 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 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.



Mattresses Follow-up

Final Internal Audit Report

2025/26

Powys Teaching Health Board

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Review Reference	PTH-2526-27
Fieldwork	April 2026
Executive Sign Off	24 April 2026
Audit Committee	May 2026
Executive Lead	Claire Madsen – Executive Director of Allied Health Professions, Health Sciences and Digital
	Ian Virgill, Head of Internal Audit
Audit Team	Lucy Jugessur, Deputy Head of Internal Audit



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Executive Summary

Purpose

We have completed a follow-up review of 'Mattresses'.

Our original Mattresses audit was reported in July 2025 and identified seven 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 seven 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	5	5	0	0
Medium	2	2	0	0
Total	7	7	0	0

As part of our follow-up review, we met with the Head of Nursing for the Community Services Group 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.

Whilst implementation of the agreed actions has improved the management of Mattresses within the Health Board, ongoing work is required to ensure that the training that has been developed is delivered to all relevant staff, and the oversight and reporting arrangements continue to operate in order to provide effective ongoing assurance.

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	Lack of awareness and specific training on the Health Board’s Mattress Policy. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Linzi Shone, 30/07/25	High Priority	Action Status: Implemented A mattress Inspection Training programme is now in place and a record of attendance at the training by relevant staff is held on ESR. The latest training record confirms that 41 staff have received the training through sessions delivered to 7 individual wards. Work is ongoing to deliver the training to all relevant staff. There are challenges due to the disparate nature of the staff across Powys but ways to overcome this are being developed.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 2	No monthly confirmation of compliance with the Health Board's policy. <u>Finding:</u> There is currently no process in place whereby the ward leads confirm at the end of each month that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. There is also no periodic review undertaken by the CSMs to check completion and follow up on any issues where necessary. <u>Agreed Action:</u> A system will be implemented to record monthly confirmation from the ward leads that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. The records will be reviewed by the Community Services Managers and followed up where necessary. A summary of these declarations will also be incorporated into the reporting arrangements under Finding 7. <u>Original Responsibility & Timescale:</u> Zoe Client / Donna Jones / Paul Sussex, 31/08/25	Medium Priority	Action Status: Implemented Monthly mattress audits are now being consistently undertaken across all wards, and these confirm the cleaning, decontamination and maintenance status of all mattresses. Copies of the completed audits are being retained within a Mattresses Teams Channel. The Community Services Managers (CSM) for each of the 3 localities are undertaking oversight to confirm that the audits have been completed and this is recorded within a central file. Review of the central file confirmed that the oversight has been consistently undertaken and recorded by the CSMs since August 2024.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 3	Monthly mattress audits not completed by all wards. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Linzi Shone, 30/07/25	Medium Priority	Action Status: Implemented The requirement to ensure monthly mattress audits are undertaken across all wards has been communicated to all ward leaders by the Head of Nursing. Copies of completed audit forms are being retained within a central teams file and review of these confirmed that the monthly audits are now being consistently completed across all Powys wards. Review of a sample of completed audits also confirmed that the required templates are being consistently utilised.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 4	Confirmation that actions are taken to address issues identified. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Zoe Client / Donna Jones / Paul Sussex, 30/07/25	High Priority	Action Status: Implemented A mattress Asset register is now in place which includes comprehensive details of all mattresses across all Powys wards. Issues identified for the mattresses are not included within the register, but they are recorded on the monthly mattress audit forms completed by each ward. The details of the issues identified, actions taken and new items ordered are then recoded by the CSMs within the central file referenced under Finding 2 above. This provides an appropriate record of issues identified and how they have been addressed.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 5	Retention of completed mattress audits. <u>Finding:</u> Completed mattress audits are generally retained on the individual wards. They are not held centrally and are not therefore available for review or oversight. We were informed that a mattress audit Teams channel had been set-up but has not been fully implemented and is not therefore fully operational. <u>Agreed Action:</u> All mattress audits will be retained centrally, either on the Teams channel or SharePoint so that they are readily available to all staff who need access to them. <u>Original Responsibility & Timescale:</u> Zoe Client / Donna Jones / Paul Sussex, 31/08/25	Medium Priority	Action Status: Implemented Copies of completed audit forms are being retained within a central Teams channel. Review of the information retained in the Channel confirmed that copies of the monthly audit forms were present for all Powys wards.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 6	Missing mattress audit information. <u>Finding:</u> 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. <u>Agreed Action:</u> Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit. <u>Original Responsibility & Timescale:</u> Zoe Client / Donna Jones / Paul Sussex, 30/08/25	High Priority	Action Status: Implemented Monthly audits are now being undertaken by all wards and copies of the audit forms are retained on a Teams Channel. Review of a sample of completed mattress audit forms confirmed that the required information is now being consistently recorded for all mattresses.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 7	No central monitoring and reporting arrangements are in place. <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Linzi Shone, 30/09/25	High Priority	Action Status: Implemented The CSMs for each of the 3 localities provide a regular update on Inpatient Ward Mattresses as part of the Community Service Group (CSG) Quality, Safety and Patient Experience slides that go to each meeting of the CSG Patient Experience Quality Group. The content of the slides provides effective assurance around the completion and oversight of mattress audits along with information on any issues identified and actions taken. The Head of Nursing for the Community Services Group confirmed that any significant concerns would be escalated as required although there haven't been any to date due to the system that has been implemented, and the resolution work undertaken.

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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.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

Date issued: May 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 May 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

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Accounts audit update

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

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

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

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

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Performance audit update

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:** Final
- **Expected committee date:** May 2026

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:** Final
- **Expected committee date:** May 2026

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:** June 2026

Review of urgent and emergency care

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

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

We have also reviewed progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).

- **Status:** Part 1 – Reporting, Part 2 - Draft report with Health Board for clearance.
- **Expected committee date:** June 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>Additional Learning Needs: Do public bodies know if the system is working? Audit Wales</u>	April 2026
<u>Managing the Regional Integration Fund Audit Wales</u>	March 2026

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

<u>Annual Plan 2026-27</u>	April 2026

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.

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galwadau ffôn yn Gymraeg a Saesneg.



Improving Quality Governance

Powys Teaching Health Board

February 2026

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Audit snapshot

What we looked at

- 1 Our review assessed progress made by Powys Teaching Health Board (the Health Board) in implementing our 2021 quality governance audit recommendations. It also considered progress made by the Health Board to review and implement corporate arrangements to meet the new Duties of Quality and Candour requirements, and related oversight and scrutiny.

Why this is important

- 2 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' before anything else is one of the core values underpinning the NHS in Wales. Poor quality healthcare can be costly in terms of harm, waste, and variation.
- 3 During 2021-22, the Auditor General reviewed quality governance arrangements across all health boards and trusts in Wales. Our 2021 Review of Quality Governance at the Health Board found that it was committed to ensure high quality, safe and effective services and had taken steps to improve its quality governance arrangements. Work remained to embed these arrangements and articulate the quality priorities of the organisation. The Health Board also needed to ensure there were measures in place to show and monitor achievement to drive improvements across the full range of services provided and commissioned.
- 4 We made nine recommendations which focused on:
 - the commissioning assurance framework;
 - the clinical quality framework;
 - alignment of frameworks;
 - complaints on commissioned services;

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- quality and safety performance measures;
- DATIX training;
- statutory and mandatory training; and
- data analytics capacity.

5 In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements. It also placed a Duty of Candour on NHS bodies, requiring them to be open and honest with service users when things go wrong and apply lessons learned.

What we have found

- 6 The Health Board has made some progress against our previous audit recommendations. New frameworks are in place to better articulate the arrangements for commissioning services, supported by improved monitoring of quality and safety measures. The Health Board has also met its statutory and mandatory training compliance target.
- 7 However, the Health Board still needs to set out its expected standards of care for commissioned services, and to ensure it produces regular Commissioned Services Performance Reports. These should include oversight of complaints about commissioned services, which is still a gap. Although the Health Board has made some progress to improve access to data, analytical capacity is also a gap, and the Health Board would still benefit from having a quality dashboard. The Health Board also needs to ensure appropriate corporate staff have received DATIX training.
- 8 The Health Board has made reasonable progress in embedding the duties of quality and candour. There was a clear implementation plan, and the Board receive regular updates on compliance. However, oversight of the uptake of relevant training needs to improve.

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What we recommend

- 9 We have made four recommendations which replace six 2021 recommendations that are not yet complete, updated to reflect the current delivery context. These focus on:
 - performance measures and outcomes for commissioned services
 - oversight of complaints about commissioned services;
 - DATIX training; and
 - data analytics.
- 10 We have also made two new recommendations which focus on:
 - the Commissioned Services Performance Reports; and
 - oversight of duty of quality e-learning.

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Key facts and figures

- Three of the nine previous recommendations are complete. There has been some progress against three recommendations and no action taken for the remaining three.
- 89% compliance with statutory and mandatory training in October 2025, compared with 85% in January 2024 and 82% in January 2023.
- Two 'moderate harm and above'¹ incidents have needed the application of the Duty of Candour procedure during 2024-25, out of a total of 66 incidents.

¹ Moderate harm within the context of the Duty of Candour is defined as a patient safety incident that results in a moderate increase in treatment and significant, but not permanent, harm.

Our findings

Implementation of previous recommendations

The Health Board has aligned frameworks, exceeded training targets, and progressed data analytics, but has taken no action on complaints about commissioned services or corporate DATIX training

Commissioning Assurance Framework

- 11 Our 2021 review recommended that the Health Board reviews its Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes. This recommendation is in progress.
- 12 Since our review, the Health Board has replaced the Commissioning Assurance Framework with its Strategic Commissioning Framework (SCF). The Board approved this in September 2025. The SCF details the Health Board's approach to commissioning services for the population of Powys². The scope of the SCF relates to services the Health Board provides and commissions from neighbouring NHS bodies.
- 13 The SCF is supported by the monitoring arrangements set out in the Integrated Quality and Performance Framework (IQPF) approved by the Board in May 2025. The IQPF sets out how the Health Board monitors, assures, and escalates the quality and performance of provider and commissioned services. The two frameworks work together as a single governance system.

² The SCF does not cover Primary Care, Continuing Health Care and out of area Mental Health placements, which have separate governance arrangements.

- 14 Despite a consistent and integrated focus on quality across both the IQPF and SCF and a clear framework of how the Health Board will monitor standards of care and patient outcomes, it has not yet developed expected measures and outcomes for each of its commissioned providers.
- 15 The Health Board has recently recruited a people's experience coordinator, which it hopes will drive the identification and development of appropriate outcomes and measures.

Oversight of Clinical Quality Governance

- 16 Our 2021 review recommended that the Health Board develop a governance map for the organisation. This should clearly show the range of activities in place at the strategic and operational level to ensure there is a clear line of sight on quality and safety from service to Board and identify any overlaps or gaps between groups. This recommendation is complete.
- 17 The Health Board has introduced new oversight arrangements for clinical quality for both its provider and commissioned services. The Integrated Quality and Performance Report (IQPR) provides routine assurance on performance to the Finance and Performance Committee and Board. An Integrated Quality Report (IQR) is presented to the Patient Experience, Quality and Safety Committee every quarter with a specific focus on quality. This committee provides robust scrutiny on quality issues.
- 18 For commissioned services, lines of accountability are clear but mechanisms to provide strategic and operational oversight are not fully operational. Since our original review, the Health Board has:
 - established a Commissioning Oversight and Assurance Group (COAG), chaired by the Executive Director for Planning, Performance and Commissioning with representation from across the organisation including finance, nursing, and quality;
 - updated and strengthened its Contract Quality and Performance Review Meeting (CQPRM) process (change of frequency of meetings and reporting /escalation to COAG);

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- recognised the effective alignment/interdependency of the IQPF and the Strategic Commissioning Framework (SCF); and
- committed to develop a monthly Commissioned Services Performance Report.

19 However, the Health Board needs to fully embed these arrangements. The COAG should report relevant information on commissioned services into the Executive Committee and onto the Finance and Performance Committee via the Commissioned Services Performance Report. Despite the Health Board setting up the COAG in summer 2025 and this group meeting regularly, the Commissioned Services Performance Report has not been presented to any committee. As a result, there is little assurance on the quality of commissioned services reported into relevant committees. Considering the Health Board updated the IQPF in May 2025, it should do this at pace to ensure there is sufficient oversight and scrutiny of clinical quality governance as intended.

20 The CQPRMs are taking place but frequency of meetings is decided by a range of factors including circumstances, performance, and any relevant contract risks. The Health Board may want to consider whether it needs a minimum meeting requirement each year to ensure oversight of each contract. At the time of our audit, updates from CQPRMs were verbal with no information on how often these meetings will be held and the level of data they will include.

Alignment of frameworks

21 Our 2021 review recommended that the Health Board review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework. We have found that the Health Board has completed this recommendation.

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- 22 The Health Board's IQPF replaced its Clinical Quality Framework and Commissioning Assurance Framework in 2024. The IQPF applies to all services the Health Board provides and those commissioned from neighbouring NHS bodies. It provides the monitoring arrangements for the Health Board's new Strategic Commissioning Framework. As a result, the Health Board's previously separate frameworks now work in a more aligned and coherent way.

Concerns and Complaints

- 23 In our 2021 review we found there needed to be greater oversight of complaints from Powys residents on commissioned services at committee level. There also needed to be clarity on the responsibility for monitoring and reporting complaints. We have found that there has been no progress in this area.
- 24 Whilst the Health Board has good oversight of complaints about the services it directly provides, challenges remain recording, analysing, and understanding complaints about commissioned services.
- 25 The Health Board told us it will monitor complaints about commissioned services as part of the Strategic Commissioning Framework (SCF). However, the SCF does not mention complaints. We were told oversight of complaints would be provided by the COAG, using intelligence from the CQPRMs, before escalating any relevant complaint reports to the appropriate committee. However, this process is not yet in place.
- 26 The current SCF does not include a requirement to ask for and/or explore any complaints made to the commissioned service by Powys patients. The SCF also does not include how the COAG will gather complaints about commissioned providers or how these complaints will be reported and escalated. The SCF is not specific enough in setting out the complaints process. As a result, there is still a lack of clarity about complaints about commissioned services.

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- 27 This is a missed opportunity to hold commissioned services to account and use data to show trends. As found in our previous audit, current arrangements do not provide a formal process for identifying, managing, and reporting complaints about commissioned services to the Patient Experience, Quality and Safety Committee.

Quality and Patient Safety Performance Measures

- 28 In our 2021 review we recommended that the Health Board develop a quality dashboard which articulated the Health Board's quality and patient safety and performance measures. There has been some progress in this area.
- 29 The IQPF includes a range of both national and local performance measures including statutory and local key performance indicators. The IQPF also includes an escalation framework which includes performance triggers, expected actions and monitoring and support arrangements.
- 30 The IQPR clearly sets out each performance measure, its target, trend, and escalation status allowing clear oversight. Where performance from commissioned services is available, the report presents provider and commissioned services performance separately to avoid confusion.
- 31 The Health Board presents more detailed quality and patient safety performance measures in the IQR to the Patient Experience, Quality and Safety Committee quarterly. The IQR holds useful information, including:
- Concerns and Complaints (Putting Things Right PTR);
 - Duty of Candour cases;
 - Incident Reporting;
 - Nationally Reportable Incidents; and
 - Infection Prevention and Control.

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- 32 However, we noted in our 2025 Structured Assessment that the IQR is very narrative and although interspersed with some useful data and graphs, the report needs to be clearer in how it identifies areas of concern. We have recommended a review of the structure of the IQR in our 2025 Structured Assessment.
- 33 The Health Board would still benefit from a dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board. This would more easily allow readers to measure success and see improvements.

DATIX training

- 34 In our 2021 review we found that not all corporate staff have received training and support on how to use the DATIX system³ to report concerns and near misses. We have found there has been no action in this area.
- 35 All staff across the Health Board can access DATIX training via the Health Board intranet and the Health Board intends to pre-record training for ease of access. However, we have no evidence the relevant corporate staff have completed this training.

Statutory and mandatory training

- 36 Our 2021 review found that the Health Board was not achieving its statutory and mandatory training compliance target. This training is important for ensuring staff and patient safety, as well as wellbeing. We have found that the Health Board has completed this recommendation.
- 37 In October 2025 mandatory and statutory training compliance was 89%, exceeding the Health Board's target of 85%. This is an increase on 2023 and 2024 performance, and benchmarks positively against other health boards in Wales.

³ Datix specifically the Once for Wales Concerns Management System - Datix Cymru is the standard, secure, cloud-based system used by NHS Wales to report, manage, and analyse patient safety incidents, risks, and concerns, including those triggering Duty of Candour

Data Analytics

- 38 Our 2021 review recommended the Health Board build data analytics capacity within their operational teams to support them to better understand and evaluate their performance. We have found the Health Board has made some progress in this area.
- 39 The Health Board has digital dashboards which underpin performance reports held and managed by the operational digital team. The digital team maintain the dashboards, gathering data from the data owners and the performance team have overall oversight. These underpin a range of reports including performance reports to the People and Culture Committee. The dashboards include sickness absence rates, sickness rates by staff groups and reasons for absence. The IQPR to the Finance and Performance Committee also draw on the dashboards for triangulation.
- 40 Whilst digital dashboards underpin the performance reports, they are not interactive Power BI dashboards which staff can easily interrogate for scrutiny purposes. The Health Board would like to develop this going forward, and intends to set up an interactive, real time performance data dashboard with dedicated data analysts. However, this is not currently possible due to capacity.
- 41 The Health Board set up an Operational Leadership Group in 2025. One of the functions is the scrutiny and oversight of operational governance including quality, improvement, performance, and delivery. The group also recognises the need to build capacity in operational teams to analyse and evaluate performance.

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Responding to the Duties of Quality and Candour

The Health Board has arrangements in place to embed the duties of quality and candour, but uptake of training has limited oversight

- 42 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. In advance of its introduction, the Health Board assessed its preparedness for following the Act against the Welsh Government baseline position.
- 43 The Executive Director of Nursing, Quality, Women and Family Health leads on both duties supported by the Assistant Director of Quality. The Health Board's Duty of Quality webpage includes the Health and Care Standards and links to relevant websites such as Healthcare Inspectorate Wales and the Public Service Ombudsman for Wales.
- 44 The Health Board articulated a clear approach to the implementation of both statutory duties. The Health Board set up an internal Implementation Board chaired by the Director of Therapies and Health Sciences with input from all Directorates. The Board met monthly to oversee the progress of implementation of the duties and report back to the National Team.
- 45 The Health Board delivered Board Development sessions on the Duty of Quality in 2023, and Independent Members attended a national training session. The Health Board undertook a training needs analysis for the Duty of Candour and made available training and a video to all staff.
- 46 In April 2024, the Patient Experience, Quality and Safety Committee received a Quality and Engagement Act Implementation Plan for the Duties of Quality and Candour. A dedicated Implementation Board and relevant directors oversaw delivery of this plan.

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- 47 Following the introduction of the Duty of Quality, the Health Board updated its IQPF to include a quality and performance escalation process in March 2024. The Health Board reviews the escalation status for operational directorates and corporate departments monthly. The status considers quality and safety matters and patient experience.
- 48 The Annual Duty of Quality Report 2024-25 includes information on the Duty of Candour, including the number of times the duty was triggered in 2024-25 and the process the Health Board follows when this happens. This involves following the NHS Wales Putting Things Right procedure and steps are listed in the report for clarity.
- 49 At an operational level, the Health Board holds internal Integrated Quality and Performance Group (IQPG) meetings. IQPGs are the Health Board's key process for reviewing, challenging, and supporting directorates on quality, performance, finance, workforce, and delivery. They sit below the Executive Committee but above directorate/team-level meetings. These are a tool to oversee, challenge and review quality and performance across all domains but include a specific focus on quality and safety and patient experience. IQPGs can escalate issues to the Executive Committee and to relevant committees and the Board when necessary.
- 50 Routine performance is monitored through the IQR. As previously noted, the IQR is reported to the Executive Committee and the Patient Experience, Quality and Safety Committee to provide an update on the quality and safety agenda across the Health Board.
- 51 A Duty of Quality training package is available via the Electronic Staff Record (ESR). However, we were unable to assess how many staff need to undertake this training or how many have completed it. The Health Board needs to strengthen its arrangements for monitoring training compliance, to provide assurance that staff are being supported to understand and respond to the new duties.

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Recommendations

- 52 We have made four recommendations which replace six 2021 recommendations that are not yet complete, updated to reflect the current delivery context. We have also made two new recommendations.
- 53 The status of the 2021 recommendations is set out in **Appendix 2**.

New recommendations replacing 2021 recommendations not yet complete

Commissioned provider performance measures

R1 The Health Board should develop performance and quality measures for each commissioned provider which it can monitor and measure in line with the Strategic Commissioning Framework. This will provide oversight and assurance on commissioned services and patient care (**paragraph 14**).

Complaints about commissioned services

R2 The Health Board should set out a mechanism in the Strategic Commissioning Framework about how it will provide assurance on complaints about commissioned services. This should include the mechanism for recording complaints and reporting them to the Patient Experience, Quality and Safety Committee (**paragraph 26**).

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DATIX training

R3

The Health Board should ensure, record and report that all relevant corporate staff have received training and support on how to use the DATIX system to report concerns and near misses (**paragraph 35**).

Data analytics and dashboards

R4

The Health Board should explore opportunities within existing capacity to develop interactive digital dashboards to present performance indicators and help the reader to understand and evaluate success and challenges (**paragraphs 33 and 40**).

New recommendations

Commissioned Services Performance Report

R5

The Health Board should develop and present the monthly Commissioned Services Performance Report as outlined in the Integrated Quality and Performance Framework. This will develop oversight and scrutiny of the quality and safety of commissioned services as intended (**paragraph 19**).

Duty of Quality e-learning oversight

R6

The Health Board should strengthen its arrangements for duty of quality e-learning training by routinely monitoring and reporting on staff completion rates (**paragraph 51**).

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Appendices

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1 About our work

Scope of the audit

We have assessed whether:

- the Health Board has implemented previous audit recommendations arising from our 2021 review of its quality governance arrangements and is realising the intended outcomes and benefits of those recommendations; and
- there is a sound corporate approach to oversee and scrutinise the quality and safety of services in line with the Duty of Quality and Duty of Candour requirements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Health Board reviewed its commissioning assurance framework?
- Has the Health Board clearly set out the mechanisms in place to provide strategic and operational oversight of clinical quality governance?
- Had the Health Board aligned the Clinical Quality Framework and the Commissioning Assurance Framework?
- Does the Health Board have greater oversight of complaints from Powys residents on commissioned services?
- Are the Health Board's quality and patient safety measures clear?
- Has the Health Board completed training for relevant staff on the All-Wales concerns management system?
- Are all staff receiving the necessary statutory and mandatory training?

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- Does the Health Board collect relevant quality and safety data to understand and evaluate performance?
- Has the Trust taken steps to implement arrangements to deliver both the Duty of Quality and Duty of Candour?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it:

- had made the expected progress in implementing our 2021 audit recommendations (set out in **Appendix 2**) to address the issues and concerns found in the original audit; and
- was implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) in respect of the duties of quality and candour.

Methods

We undertook our audit work between July and September 2025.

We reviewed the following key documents:

- Integrated Quality and Performance Framework
- Strategic Commissioning Framework,
- People Experience Framework
- Health Board's Annual Plan
- Duty of Quality Annual Reports
- Committee reports, including Quality Assurance and Performance reports.

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We interviewed the following:

- Executive Director of Nursing and Midwifery,
- Director of Corporate Governance/Board Secretary,
- Executive Director of Planning, Performance & Commissioning,
- Independent Member/Vice Chair/ Chair of Patient Experience, Quality and Safety Committee

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2021 recommendations. The Health Board submitted a completed self-assessment on 8 July 2025.

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2 Previous recommendations

We made the following recommendations in 2021 following our review of the Health Board’s quality governance arrangements. We have highlighted the status of these recommendations based on our follow up review and replaced outstanding recommendations where necessary.

Commissioning Assurance Framework
R1 Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes **(Some progress – replaced by R1 2026)**

Clinical Quality Framework
R2 Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps or gaps between groups **(Complete)**.

Alignment of Frameworks
R3 Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework **(Complete)**.

Concerns and Complaints
R4a Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee **(No action – replaced by R2 2026)**.
R4b Update the Commissioning Assurance Framework to ensure clarity on responsibility for monitoring and reporting of complaints **(No action – replaced by R2 2026)**.

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Performance Measures

- R5 Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board, to measure success and demonstrate improvements (**Some progress – replaced by R4 2026**).

DATIX

- R6 Ensure that all corporate staff receive training appropriate to their role (**No action – replaced by R3 2026**).

Training

- R7 Ensure that all statutory and mandatory training compliance meets the required target (**Complete**).

Data Analytics

- R8 Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance (**Some progress – replaced by R4 2026**).

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3 Key terms in this report

Term	Description
Duty of Candour	The Duty of Candour is a legal requirement for Welsh NHS organisations to be open and honest with service users when harm occurs during their care. This includes communicating with the patient, investigating the incident, and learning from it to prevent future occurrences.
Duty of Quality	The Duty of Quality is a legal obligation on Welsh NHS organisations to continually improve the quality of healthcare services and outcomes for the people of Wales. The Duty requires a focus on quality in all strategic decisions and ongoing monitoring of progress in quality improvement
Power BI	Computer software used to analyse and view data to help support understanding of data.
Putting Things Right	The formal process for raising concerns and complaints about the NHS in Wales and its services.
Quality governance	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.

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Term	Description
Strategic Commissioning Framework	Sets out the Health Board’s approach to commissioning services for the Powys population.

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Management response form

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	Commissioned provider performance measures The Health Board should develop performance and quality measures for each commissioned provider which it can monitor and measure in line with the Strategic Commissioning Framework. This will provide oversight and assurance on commissioned services and patient care (paragraph 14).	Accepted and completed. The Health Board has established baseline performance metrics for commissioned providers through NHS Wales and NHS England standard contract arrangements. In addition, work is underway to develop a comprehensive suite of quality and patient safety metrics for commissioned services. These measures will be embedded within the Integrated Quality and Performance Framework (IQPF) and	March 2026	Executive Director Planning, Performance and Commissioning / DoNQFH

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		aligned to the Strategic Commissioning Framework (SCF) to strengthen oversight, assurance, and early identification of quality or performance concerns in commissioned services. Detailed Commissioning Intentions have been issued to the three main NHS England providers and to NHS Wales providers to support timely data submission and strengthen contractual oversight arrangements.		
R2	Complaints about commissioned services	Partially accepted and completed.	Complete	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	The Health Board should set out a mechanism in the Strategic Commissioning Framework about how it will provide assurance on complaints about commissioned services. This should include the mechanism for recording complaints and reporting them to the Patient Experience, Quality and Safety Committee (paragraph 26).	The operational mechanisms for the recording, management, and reporting of concerns and complaints relating to commissioned services sit within the Integrated Quality and Performance Framework (IQPF) and wider Quality Management System (QMS) arrangements. The Strategic Commissioning Framework references the PTHB QMS in providing a focus on quality domains and enabling actions as per the PTHB QMS; references requirement as per Duty of Quality to actively monitoring progress in quality improvement efforts;		Executive Director Nursing, Quality and Family Health

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		and cross references to the IQPF through which PTHB discharges its duty to scrutinise and assure the performance of PTHB and the delivery and commissioning of quality, patient centred services. The Executive Director of Nursing, Quality and Family Health and Deputy Director teams have reviewed current processes to strengthen mechanisms through Datix. Concerns and complaints relating to commissioned services are reported through established Integrated Quality Framework reporting		

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		arrangements to the Patient Experience, Quality and Safety Committee.		
R3	DATIX training The Health Board should ensure, record and report that all relevant corporate staff have received training and support on how to use the DATIX system to report concerns and near misses (paragraph 35).	Accepted. The Health Board is currently reviewing DATIX training provision to improve content, accessibility, and uptake across relevant corporate staff groups.. The updated programme will be rolled out within the next four weeks. Completion rates will be monitored and recorded, with compliance and uptake reported through established governance	30 June 2026	Executive Director Nursing, Quality and Family Health

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		structures. This work aims to improve reporting culture, enhance the quality of incident reporting, and strengthen organisational learning from concerns and near misses.		

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R4	Data analytics and dashboards The Health Board should explore opportunities within existing capacity to develop interactive digital dashboards to present performance indicators and help the reader to understand and evaluate success and challenges (paragraphs 33 and 40).	Accepted. There is ongoing work through the Digital and performance teams to continue to develop interactive dashboards. Grant Thornton and Partners are supporting the development of a Commissioning Dashboard by end Q1 as the priority area.	30 July 2026	Executive Director Planning, Performance and Commissioning / Director of Digital and Therapies

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	Commissioned Services Performance Report The Health Board should develop and present the monthly Commissioned Services Performance Report as outlined in the Integrated Quality and Performance Framework. This will develop oversight and scrutiny of the quality and safety of commissioned services as intended (paragraph 19).	Partially accepted. The Health Board is developing a Commissioned Services Performance Report as part of its broader commissioned services oversight model. The report will incorporate quality, patient safety, and performance indicators arising from Recommendation 1 and will form part of the Integrated Quality and Performance Framework (IQPF). Reporting will be provided on a regular basis, aligned to data availability and	30 Sept 2026	Executive Director Planning, Performance and Commissioning

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		provider reporting timelines, to ensure meaningful oversight and scrutiny of commissioned services. The report will be presented through relevant governance and committee structures. Development of the Commissioning Dashboard referenced in Recommendation 4 will further support the maturity and presentation of commissioned services reporting. The ability to regularly produce the report is contingent on the development of the Commissioning Dashboard referenced in R4.		

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	Duty of Quality e-learning oversight The Health Board should strengthen its arrangements for duty of quality e-learning training by routinely monitoring and reporting on staff completion rates (paragraph 51).	Accepted. Our improvement approach includes a joint strategic responsibility between the Executive Director of Nursing, Quality and Family Health, and the Executive Director for People, Culture and Transformation. The Executive Director of Nursing, Quality and Family Health is responsible for promoting and building compliance and the Executive Director of People, Culture and Transformation will ensure that regular monitoring reports are provided, highlighting areas of concern in compliance rates.	30 September 2026	Executive Director People, Culture and Transformation/ Executive Director Nursing, Quality and Family Health

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Improvements in training compliance will be done through the consideration of adding the E-Learning course to the all-staff Statutory and Mandatory Training list and adding performance reporting to the Workforce Performance Report, which is monitored through People and Culture Committee, Patient, Experience and Quality Committee as well as Executive Committee. This report will also be included as part of the Directorate Performance Review approach for both People and Culture, and Nursing.	31 December 2026	

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)

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Digital Transformation

Powys Teaching Health Board

May 2026

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About us

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Audit snapshot

What we looked at

- 1 We looked at how Powys Teaching Health Board's approach to digital transformation is supporting service improvement. This included the approach to digital strategy, leadership and skills development. We also considered how the organisation manages risks around digital infrastructure, cyber resilience and Artificial Intelligence (AI).

Why this is important

- 2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.
- 3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another and organisations must manage ever-growing risks around cyber resilience.
- 4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

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What we have found

- 5 The Health Board has a clear Digital Strategic Framework that is aligned to national priorities and supports long-term service improvement. The Health Board has strengthened its governance arrangements for digital transformation, and a structured programme of digital projects is in place. However, weaknesses in financial planning, benefits realisation, and assurance reporting limit the Board's ability to fully understand progress, risks, and impact. While digital infrastructure and cyber controls have improved, assurance over long-term resilience remains limited, particularly in relation to capital planning, legacy systems, and disaster recovery.
- 6 Although the Health Board recognises the potential of AI, governance arrangements remain underdeveloped. The Digital Strategic Framework sets out high-level ambitions but lacks clarity on implementation, resourcing, risk management, and oversight. At the same time, the organisation does not yet have a comprehensive understanding of its digital skills and workforce capacity, with low uptake of self-assessment tools, no co-ordinated training plan, and reliance on small numbers of specialists creating resilience risks.
- 7 Engagement with staff and service users has supported some positive digital developments, but approaches are inconsistent and lack formal structure, including the absence of a Board-approved digital engagement or inclusion plan. Overall, the Health Board is progressing a range of digital initiatives and shows commitment to transformation. However, gaps in strategic risk management, workforce planning, benefits evaluation, and long-term investment planning weaken assurance that digital investment will consistently deliver sustained improvements in service quality, efficiency, and accessibility.

What we recommend

- 8 We have made 7 recommendations to the Health Board:

strengthen the Digital Roadmap so progress, ownership, and outcomes can be clearly tracked;

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- clearly identify digital transformation risks on the Strategic Risk Register to support informed Board oversight;
- produce an annual plan to comply with the NIS 2018 Cyber Assessment Framework;
- strengthen its planning, risk management, and governance for the safe use of AI;
- take a more structured approach to assessing and developing digital skills across the workforce and digital teams;
- assign clear leadership for digital inclusion and embed it consistently across all digital projects; and
- introduce consistent post-implementation reviews to confirm digital projects deliver their intended benefits.

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Key facts and figures

Of the Health Board's workforce of approximately 2,150 employees, only 67 have completed the Health Education and Improvement Wales (HEIW) interactive self-evaluation digital capability tool as part of the Digital Capability Framework.

Since March 2025, the Health Board has had no reportable cyber incidents per the Network and Information Systems Regulations 2018.

In 2023, the Health Board was assessed at Stage 1 of the HIMSS EMRAM model meaning core digital systems are in place, but overall digital maturity is still at an early stage. Its Digital Strategic Framework sets an ambition to reach stage 5 by 2027.

Overall compliance against Cyber Assurance Framework was reported as 'Not Achieved' in July 2024.

From 2021-22 to 2024-25, the Health Board invested approximately £13.9 million in digital revenue and £5.2 million in digital capital.

Between 2025-26 and 2028-29, the Health Board is forecasting total expenditure of circa £17.8m on digital revenue and £3.1m on digital capital.

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Our findings

Strategy, planning and leadership

The Health Board has a clear digital strategy, but progress reporting to Board needs to provide clearer assurance on delivery and impact.

Digital strategy and plans

- 9 Following effective engagement with stakeholders and Board members, the Health Board developed its Digital Strategic Framework 2023-27 (the 'DSF'), which the Board approved in July 2023. It sets a clear vision for using digital tools to improve health and care, focussing on five main themes¹. However, as 2027 approaches, it is unclear whether the Health Board plans to review and renew its DSF.
- 10 The DSF is well aligned with the Health Board's Integrated Plan for 2024-29 and is recognised and a key enabler to deliver its strategic priorities. The DSF is also strategically aligned to national priorities, including Healthier Wales, and Welsh Government's Digital and Data Strategy.

¹ The five themes are: Citizen-centred Care and Support; Leadership, Partnership and Alliances; Infrastructure and Security; Enabling Efficiency and Effectiveness; and Big Data and Artificial Intelligence.

- 11 The DSF sets out digital transformation as a key enabler for improving service sustainability, quality, and access to care. It explains how digital will support new ways of working, including real-time access to shared patient records, improved interoperability across services, and greater use of data to inform planning and decision-making. It also highlights how digital tools such as virtual consultations, patient portals, and self-management technologies, will enhance patient experience, support care closer to home, and help manage rising demand.
- 12 The DSF is based on the Health Board's digital maturity, assessed in 2023 at Stage 1 of the HIMSS EMRAM, meaning that core digital systems are in place². Furthermore, as part of developing its five-year Integrated Plan, the Health Board carried out a PESTLE³ and SWOT⁴ analysis which were also used to support the assessment of the organisation's digital maturity.
- 13 The Health Board has created a Digital Roadmap which translates the DSF into practical action by setting out what it plans to do in the short-, medium-, and long-term. This includes things like offering more virtual consultations, moving systems to the cloud, and building better ways to use data. However, the roadmap lacks detail on responsibilities, targets, and detailed timelines. This makes it harder to assess progress and to know whether the roadmap is delivering its intended outcomes.

² Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM) Stage 1 signifies that the Trust has installed core ancillary systems for lab, pharmacy, and radiology.

³ A PESTLE analysis examines the main external factors (Political, Economic, Social, Technological, Legal, and Environmental) that may influence an organisation.

⁴ A SWOT analysis is conducted to identify an organisation's strengths, weaknesses, opportunities, and threats.

- 14 The Health Board has also put a Benefits Framework in place to help ensure that digital and service-transformation projects are linked to strategic objectives. However, an Internal Audit review of Digital Systems Uptake in October 2025 found that the framework is not yet applied consistently across all digital projects. Despite this, we did find examples of benefits being delivered and reported, such as cost savings from virtual consultations and efficiency improvements from modernising data systems. However, further work is needed to embed benefits tracking across all digital programmes and projects and clearly demonstrate value for money.

Board ownership of digital transformation

- 15 The Board shows a reasonable understanding of, and support for the DSF. To strengthen awareness of digital risks, Board Development Sessions were held in December 2025 focussing on cyber security, digital services, and digital infrastructure. However, more digital education and awareness-raising would help Board members provide stronger challenge, scrutiny, and strategic leadership as the Health Board continues its digital transformation journey.
- 16 Due to delays in the recruitment process beyond its control, the Health Board currently does not have an Independent Member for Digital. This potentially reduces the profile of digital matters at Board level. However, the Executive Director of Allied Health Professions, Health Science and Digital attends relevant Board and committee meetings. Furthermore, the Chief Digital Officer also attends these meetings, as required.
- 17 The Health Board is no longer represented on the All-Wales IM Digital Network, a role undertaken by the previous Independent Member for Digital. This reduces opportunities to share learning, exchange good practice, and contribute to national digital discussions that could support the Health Board's own digital transformation.

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Roles, responsibilities and accountability

- 18 There is clear accountability within the Health Board for delivering digital transformation, supported by well-defined senior roles. Executive responsibility sits with the Executive Director of Allied Health Professions, Health Science and Digital. The Chief Digital Officer oversees operational delivery of the Health Board's digital, data and technology functions.
- 19 Progress against the DSF is regularly reported to the Executive Committee, the Digital Governance Board, and the Delivery and Performance Sub-Committee. The ARAC provides Board-level oversight of DFS delivery and escalates issues to the Board where required. While quarterly reports to ARAC provide a clear overview of progress, milestones and risks, they often lack detail on benefit realisation and how risks will be managed.

Identifying and managing risks

The Health Board has arrangements to manage digital risks, but these are inconsistent and incomplete and there is clear scope to strengthen them in key areas.

Strategic digital risks

- 20 The Health Board's Strategic Risk Register has one specific digital risk, with a high score of 15 – failure of digital and electrical infrastructure posing a risk to delivery of care. The risk is considered in detail by ARAC in private due to its sensitive and confidential nature. While the Strategic Risk Register appropriately identifies key digital issues, they mainly focus on the network, electrical, and cyber components of the risk.

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- 21 The Strategic Risk Register includes a specific risk relating to transformation. However, it is quite broad and does not set out any specific issues or risks associated with digital transformation. This means the Health Board may not fully understand or plan for the problems that could affect the delivery of its DSF, such as delays to key projects or resources challenges. This can make it harder for the Board to make informed decisions, to target resources properly, and to show it is managing all strategic digital risks in a clear and transparent way.

Digital infrastructure risks

- 23 The DSF identifies “Infrastructure and Security” as a core strategic theme, showing how important it is to modernise systems and keep them strong and reliable. However, it does not set out clear timelines, milestones, or costed plans for doing so.
- 24 The Health Board has introduced new policies and tools to improve how digital assets are managed, including a Digital Asset Management Policy, and the Halo IT Service Management tool. These help reduce risks such as data loss. However, the Health Board told us that not all staff follow the policies consistently, so more work is needed to make sure they are used properly across the organisation.
- 25 The Health Board is making progress in updating devices, improving Wi-Fi, upgrading cabling, and modernising phone systems. These upgrades are being done in stages, starting with the most important areas like cyber security by replacing old equipment. This shows the Health Board is committed to fixing outdated technology and building the right foundations for digital transformation.
- 26 ARAC receives quarterly updates on replacement of old hardware and software, which are escalated to the Board when necessary. We also observed a Board briefing session focused on digital matters, which clearly articulated the challenges and opportunities associated with the Health Board’s digital infrastructure. The session demonstrated effective Board engagement through constructive challenge and discussion.

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- 27 Financial planning for longer-term infrastructure upgrades is another area of concern. Although short-term projects are being delivered (see **paragraph 25**), the absence of a long-term capital plan makes it difficult to ensure sustainable investment and prioritisation of future needs. This creates uncertainty around the ability to maintain modern infrastructure beyond the current planning cycle.

Cyber resilience

- 28 While cyber resilience is a core component of the DSF, the Health Board's lacks a separate Cyber Security Delivery Plan. Having a separate delivery plan for cyber security would strengthen the Health Board's ability to plan appropriately and use resource more effectively.
- 29 ARAC oversees cyber security risks, which are included in the corporate and strategic risk registers. Controls are in place to improve cyber resilience, such as making the network more reliable, removing old software, and regular audits. Most of the Health Board's controls are providing reasonable or substantial assurance.
- 30 The Health Board maintains an effective working relationship with the Cyber Resilience Unit and Digital Health and Care Wales (DHCW), utilising their guidance and expertise to support cyber resilience. In 2024, the Cyber Resilience Unit gave a 'Not Achieved' assurance rating for the Health Board's compliance with the Cyber Assessment Framework. This reflected delays in developing a Digital Cyber Disaster Recovery Response. The CRU also recommended more advanced and ongoing cyber training for senior leaders, in addition to mandatory training, to strengthen resilience. There have been no reportable cyber incidents at the Health Board in the past 12 months.

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Artificial intelligence

- 31 The Health Board's DSF recognises the potential for artificial intelligence (AI) to support its digital ambitions, but it does not clearly set out which services are expected to benefit from AI, when AI solutions might be implemented, or what outcomes are expected from the use of AI. As a result, AI remains a high-level aspiration rather than a clearly defined programme with measurable benefits.
- 32 The framework also lacks clarity on the resources required to develop and use AI. It does not specify the funding, workforce capacity, skills, or technical tools needed, nor does it clearly explain how AI-related risks will be identified and managed. While the DSF refers to enabling foundations, such as secure data platforms and improved interoperability, this does not provide sufficient assurance to the Board that AI risks are being adequately planned for and addressed.
- 33 The Health Board's governance arrangements for AI are underdeveloped. Although the Digital Governance Board has a role in approving AI tools, there is no clear framework setting out accountability, decision-making, or escalation arrangements. The Health Board has begun developing policies to manage AI risks, but these are not yet complete and are not specific to AI. This creates gaps in oversight, especially as staff already have access to generative AI tools through Microsoft 365, which introduces potential data security and information governance risks.

Digital skills

The Health Board lacks a comprehensive understanding of digital skills and faces significant workforce capacity and resilience challenges, limiting its ability to plan, oversee, and develop a fully digitally capable organisation.

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Assessing digital skills

- 34 The Health Board does not yet have a full understanding of digital skills across its workforce. As of October 2025, only 76 employees had completed HEIW's Digital Capability Framework self-evaluation tool. Most of those who did take part said they were either confident or still learning.
- 35 Beyond the HEIW Digital Capability Framework, the Health Board has carried out some targeted checks to see if staff are ready for new digital systems. These checks are helpful for individual projects, but they only cover small groups of staff and do not replace the need for a full assessment of digital skills across the whole organisation.

Developing digital skills

- 36 The Health Board has articulated a clear vision for what a digitally enabled workforce looks like within its DSF; however, it lacks a formalised training plan for upskilling, improving digital literacy, and creating a 'Digital First' culture.
- 37 Despite this, the Health Board does offer some support to help staff improve their digital skills and knowledge. These include regular training on cyber security and data protection for all staff and "Digital Days" where staff can get face-to-face help from the Digital Team. The Health Board also wants to bring more clinical experts into digital teams, increase the number of digital champions, and develop a training strategy with key partners. However, these plans are difficult to deliver because the digital teams are small and there are not enough specialists, especially in high-demand areas like cyber security.
- 38 The Health Board's Digital Team is currently operating with limited staffing, with some functions reliant on a single specialist. This exposes the Health Board to resilience risks and limits its ability to undertake proactive work. The reliance on annual funding cycles makes it challenging for the Digital Team to plan over the medium term, leading to short-term contracts, retention challenges, and difficulty building capability.

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- 39 The Health Board is aware of the significant workforce risks linked to digital, such as the inability to recruit and retain specialist staff. However, these risks aren't being tracked or reviewed at Board-level. As a result, the Board does not have a full picture of the scale of the problem and cannot properly challenge or support the organisation to make improvements. This lack of oversight also makes it harder to manage long-term workforce risks effectively.

Collaboration and involvement

The Health Board engages with staff and service users, but its approach is inconsistent and unstructured, and it lacks a clear plan for tackling digital exclusion.

Staff and service user involvement

- 40 The Health Board demonstrates a positive approach to involving staff and service users in digital design and implementation; however, the absence of a documented communication and engagement process limits consistency and impact. Engagement activity is not well co-ordinated across programmes and remains largely ad hoc. Furthermore, the Board does not receive routine assurance that feedback is being captured, acted upon, or used to inform decision-making.
- 41 The Health Board introduced a new Target Operating Model for Digital Services in 2024, after ending its joint ICT arrangement with Powys County Council. This new model puts staff and service users at the centre of how digital services are designed and delivered with a strong focus on engagement and user experience. For example, on-site 'Digital Days' are delivered across the year at every Health Board site to support and engage with services directly. This was an important step for the organisation, as it gives the Health Board full control of its digital strategy, how services are delivered, and how well they perform.

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- 42 User involvement has helped improve digital services and inform decision-making. Improvements in Guest Wi-Fi across all sites following patient feedback has led to a positive impact on patient experience, particularly for mental health inpatients. Despite these efforts, engagement with service users remains predominantly indirect, typically filtered through staff stories rather than direct engagement and consultation. This means the Health Board doesn't always hear people's experiences first-hand, which can limit its understanding how well digital services meet their needs.

Reducing digital exclusion

- 43 The Health Board's DSF recognises the need to prevent digital exclusion and commits to inclusive access by signing the organisation up to the Digital Inclusion Charter⁵. However, the Health Board lacks a formally documented or Board-approved Digital Inclusion Plan that clearly sets out what actions it will take to increase digital uptake and reduce digital exclusion. It also hasn't appointed a dedicated Digital Inclusion Lead.
- 44 Despite this, the Health Board is becoming more aware of the risks of digital exclusion, especially for people in rural areas and older or vulnerable groups. It uses Equality Impact Assessments and similar tools to consider how digital projects affect these groups, but this approach is still developing and not used consistently by every project. The Health Board also works with partners like HEIW, Cwmpas⁶, and voluntary organisations to help to identify possible barriers to digital access.

⁵ The Digital Inclusion Charter exists to support and champion organisations in Wales who are willing to promote basic digital skills and help people get online.

⁶ Cwmpas is a co-operative that supports and promotes digital inclusion across Wales through a number of initiatives.

Using digital developments to support service transformation

The Health Board is progressing local and national digital solutions, but funding uncertainty risks slowing progress, and stronger evaluation is needed to understand whether digital investments are achieving meaningful impact.

Investment in digital transformation

- 45 The DSF does not set out the exact funding needed for each stage of the Health Board's Digital Roadmap. As a result, the Health Board is unable to clearly plan which projects are affordable or prioritise resources effectively. The Health Board reported that this is difficult to address due to the short-term nature of funding cycles.
- 46 **Exhibits 1 and 2** show that the Health Board's overall digital investment is rising, mainly due to rising revenue costs. Capital funding remains low and is much more unpredictable. While rising investment shows commitment to digital modernisation, the imbalance between capital and revenue, along with uncertainty about long-term investment opportunities creates risks for delivery of the Health Board's digital ambitions.

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Exhibit 1: Annual capital and revenue investment in digital (2021-22 to 2024-25), split by core and grant funding

Financial Year	Capital Budget £m	Capital Expenditure £m	Revenue Budget £m	Revenue Expenditure £m
2021-22	£1.9	£1.9	£2.1	£2.7
2022-23	£0.7	£0.7	£3.1	£3.2
2023-24	£1.2	£1.2	£3.3	£3.5
2024-25	£1.4	£1.4	£4.2	£4.4

Source: Health Board supplied data

Exhibit 2: Planned levels of capital and revenue investment in digital (2025-26 to 2027-28)

Financial Year	Capital £m	Revenue £m
2025-26	£0.7	£4.3
2026-27	£0.7	£4.4
2027-28	£0.9	£4.5

Source: Health Board supplied data

Local and regional digital projects

47 The Health Board is progressing a range of local digital programmes that supports its goals to improve access, quality, efficiency, and productivity. These include establishing a digital telephony service, which has improved response times for operational service delivery according to the Health Board. The Health Board has also developed its in-house application development capabilities which has led to 12 new applications being developed to improve efficiency, such as DigiFlow and Silvercloud. To track efficiency improvements, the Health Board has also developed 33 new dashboards in 2025-26 and migrated a further 409 dashboards to the cloud, improving data security and accessibility.

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- 48 The Digital Project Management Team oversees day-to-day delivery, whilst the Change Advisory Board and the Digital Governance Clinical Board use the MoSCoW⁷ method to assess which projects should be prioritised. This helps make sure that essential work, such as cyber security and replacing outdated systems, is balanced with longer-term digital initiatives. Progress updates on the delivery of projects and digital services are reported quarterly to ARAC for assurance.
- 49 The Health Board reported that it works closely with regional partners to deliver its DSF. Its involvement in statutory groups, such as the Public Services Board and Regional Partnership Board, gives even more opportunity to tackle shared challenges, support joint planning, and reduce duplication. However, we failed to find evidence of any regional digital initiatives in the Health Board digital reporting. While these partnerships are seen as a strength, the Health Board reported that there are significant resource constraints, which can limit the scale and impact of joint digital initiatives.

Adopting national digital systems

- 50 The Health Board is actively adopting national digital solutions as part of the 'Once for Wales' approach and works constructively with DHCW and Welsh Government. Senior leaders take part in national digital forums to make sure Powys' needs are heard and that local plans match national developments. The Health Board is involved in major digital projects like WCCIS⁸, Digital Maternity Cymru, Digital Eye Care Programme, the NHS Wales App, the Welsh Nursing Care Record, and diagnostics systems such as RISP⁹ and LIMS¹⁰.

⁷ The MoSCoW method is a technique for prioritising digital projects, where the acronym stands for Must have, Should have, Could have, and Won't have.

⁸ Welsh Community Care Information System

⁹ Radiology Informatics System Procurement

¹⁰ Laboratory information management system

- 51 Quarterly Digital First Monitoring Reports to the ARAC show that delays to national digital programmes remain significant. These delays limit the Health Board's ability to manage digital risks and slows with the pace of its wider digital transformation plans. The reports highlight delays in key national programmes, including ePMA and the Digital Eye Care Programme. Delays to a cross-border project delivered in collaboration with Digital Health and Care Wales have also affected progress, meaning interoperability remains a significant issue. Many delays are outside the Health Board's control and depend on national partners, meaning progress with digital modernisation and wider digital transformation is largely reliant on the delivery of national programmes.

Evaluating digital solutions

- 52 The Health Board does not yet have a strong or consistent approach for reviewing projects after they are completed or checking whether the expected benefits have been delivered. As noted previously, recent Internal Audit work gave only limited assurance in this area. The lack of regular post-implementation reviews makes it harder for the Health Board to learn from experience, measure the real impact of digital projects, and show whether the investment is worthwhile. Without a more structured evaluation process, the Health Board cannot be fully confident that its digital changes are leading to meaningful and long-lasting improvements.

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Recommendations

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

R1	The Health Board should clearly set out responsibilities, milestones, and measures for each project in the Digital Roadmap so progress and outcomes can be properly monitored (see paragraph 14).
R2	The Health Board should strengthen its Strategic Risk Register by clearly identifying and articulating risks associated with digital transformation, including risks related to delivery, capacity and resources (see paragraph 20).
R3	The Health Board should produce an annual Cyber Security Delivery Plan that states how it intends to comply with the Network and Information Systems Regulations 2018 Cyber Assessment Framework (see paragraph 28).
R4	The Health Board should strengthen its arrangements for managing risks relating to Artificial Intelligence by: R4.1 developing a clear organisational plan for the safe and effective use of AI; R4.2 strengthening arrangements for identifying, assessing, and managing AI-related risks; and R4.3 ensuring appropriate governance arrangements are in place so that AI is deployed and used safely, appropriately, and in line with agreed policies (see paragraph 31 - 33).

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R5	The Trust should strengthen its approach to understanding and developing digital skills in the workforce by: R5.1 increasing participation in the HEIW Digital Capability Framework self-assessment; R5.2 creating a clear plan for measuring digital confidence and monitoring progress over time; and R5.3 assessing the technical digital capabilities within the core digital team (see paragraph 34 - 39).
R6	The Health Board should strengthen leadership for digital inclusion and develop a digital inclusion plan (see paragraph 44).
R7	The Health Board should introduce a consistent post-implementation review process to assess whether digital projects deliver their intended benefits (see paragraph 52).

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Appendices

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1 About our work

Scope of the audit

The goal of this audit is to find out if the Health Board is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a well-led and appropriately resourced approach to digital transformation?
- Is the Health Board developing the digital skills, capacity, and capability of its workforce?
- Does the Health Board have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Health Board engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Health Board actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

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Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.
- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked the Health Board to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Digital First Quarterly Monitoring Reports and Digital Annual Reports.
- Key strategies and plans, including Digital First Strategic Framework Strategy, People Strategy, Health Board Integrated and Annual Plan, and their Health and Care 2017 - 2027 Strategy.
- Key risk management documents, including the Board Assurance Framework and Corporate and Strategic Risk Registers.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

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- Chair of the Board
- Chief Executive Officer
- Chief Digital Officer
- Chief Operating Officer
- Executive Director of Allied Health Professions, Health Science and Digital

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

- Delivery and Performance Committee (now Finance and Performance Committee)
- Audit, Risk and Assurance Committee
- Digital Board Briefing

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We welcome correspondence and
telephone calls in Welsh and English.

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galwadau ffôn yn Gymraeg a Saesneg.

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Management response form



Audit Wales use only	
Audited body	Powys Teaching Health Board
Audit name	Digital Transformation
Issue date	30 th March 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R1	The Health Board should clearly set out responsibilities, milestones, and measures for each project in the Digital Roadmap so progress and outcomes can be properly monitored (see paragraph 13).	Accepted: We agree that the Digital Strategic Framework will be reviewed and refreshed ahead of 2027. This intention is reflected in our Integrated Planning cycle and will be made explicit in future digital reporting. A new “Digital Roadmap on a Page” is in development, setting out strategic	August 2026	Chief Digital Data Officer	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		alignment, priority programmes, ownership, milestones, dependencies, risks and expected outcomes.			
R2	The Health Board should strengthen its Strategic Risk Register by clearly identifying and articulating risks associated with digital transformation, including risks related to delivery, capacity and resources (see paragraph 20).	Accepted: We agree that digital risks require clearer articulation at corporate level. These risks have been reviewed with Executive colleagues and submitted into the Corporate Risk Register, with clear ownership, mitigations and	July 2026	Chief Digital Data Officer	

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		reporting through ARAC and the Board alongside operational directorate risks.			
R3	The Health Board should produce an annual Cyber Security Delivery Plan that states how they intend to comply with the Network and Information Systems Regulations 2018 Cyber Assessment Framework (see paragraph 28).	Accepted: The Health Board will develop a proportionate annual Cyber Security Delivery Plan aligned to the Network and Information Systems (NIS) Regulations and Cyber Assessment Framework.	October 2026	AD Digital, Data and Technology and Senior Cyber Security Specialist	

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		The plan will set out priority actions, controls, assurance activity, dependencies and deadlines, recognising the Health Board's scale, risk profile and available specialist capacity.			
R4	The Health Board should strengthen its arrangements for managing risks relating to Artificial Intelligence by: R4.1 developing a clear organisational plan for the safe and effective use of AI;	Accepted: We recognise that AI governance is underdeveloped. In response to: R4.1 , there is a draft AI policy that is ready for submission to approve. Once	March 2027	Assistant Director of Digital & Data Operations	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
	R4.2 strengthening arrangements for identifying, assessing, and managing AI-related risks; and R4.3 ensuring appropriate governance arrangements are in place so that AI is deployed and used safely, appropriately, and in line with agreed policies (see paragraph 31 - 33).	approved this will be supported by a SOP R4.2 there is already a process in place via the Digital Initiatives Group, this can only monitor those that we are aware of. R4.3 This will be supported by a SOP and a communication to all staff to follow the process. A method of auditing proper use of AI in context will be investigated.		Head of Information Governance CNIO & SIRO	

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R5	The Trust should strengthen its approach to understanding and developing digital skills in the workforce by: R5.1 increasing participation in the HEIW Digital Capability Framework self-assessment; R5.2 creating a clear plan for measuring digital confidence and monitoring progress over time; and R5.3 assessing the technical digital capabilities within the core digital team (see paragraph 34 - 39).	Accepted: The Health Board will request HEIW to support with a clear plan to strengthen our approach to understanding and developing the digital skills in the workforce In response to R5.1, We will promote the HEIW Digital Capability Framework self-assessment through staff engagement and staff briefings. In response to R5.2, we will develop an iterative plan for measuring Digital	March 2028	Chief Digital Data Officer, EDWOD	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
		confidence using surveys as part of each digital implementation/evaluation in our IMTP. In response to R5.3, Digital will assess technical capability and capacity risks within the core Digital Team and agree development actions, which will be reported through established governance. This will be proportionate to organisational capacity and financial constraints.			

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R6	The Health Board should strengthen leadership for digital inclusion and develop a digital inclusion plan (see paragraph 44).	Accepted: We accept this recommendation and will look to have support from our Boards Independent members. We do already have Executive oversight with the Exec Director of AHP, Health Science and Digital. A plan will be developed in collaboration with HEIW, Workforce and Organisational Development, the Living Well Service and the Clinical Informatics Team	March 2028	Chief Digital Data Officer, CNIO, Business Manager Powys Living Well Service (PLWS)	

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)	Audit Wales only
R7	The Health Board should introduce a consistent post-implementation review process to assess whether digital projects deliver their intended benefits (see paragraph 52).	Accepted: We accept and recognise the need to apply the Benefits Framework more consistently as projects go live and come to an end. The Benefits Framework will be adapted to include user experience to regularly assess and measure if the digital projects deliver the intended benefits.	March 2027	Chief Digital Data Officer/Head of Digital Programmes	

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Management response form

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
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).	Accepted and Completed. Action logs will be adapted to ensure the purpose of referral and any follow up action/reporting is clearly articulated.	1 April 2026	Director of Corporate Governance / Board Secretary
R2	The Health Board should further refine the management of its strategic and organisational risk registers. The Health Board should review what is a strategic risk and what is an organisational risk. Organisational risks should	Accepted. The Risk Management Framework and Board Assurance Framework will be reviewed and aligned to ensure consistency and clarity.	30 May 2026	Director of Corporate Governance / Board Secretary

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	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)	Accepted and Completed. A revisited report has been presented to Executive Committee and will be presented to our PEQS committee in April 2026. The report is structured to separate three key elements: intelligence, triangulation, and assurance. A dedicated compliance section then provides assurance against key regulatory and national standards. This approach is intended to improve the visibility of learning, support a more	April 2026	Executive Director Nursing, Quality, Women and Family Health

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		integrated understanding of risk, and strengthen the Health Board's ability to drive targeted improvement.		
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)	Partially Accepted and Completed. The Strategic Priorities in the Integrated Plan flow from the Joint Health and Care Strategy, which include the statutory Wellbeing Objectives. The strategic priorities in each successive Annual Plan cycle also flow from the Joint Health and Care Strategy (and thereby the Integrated Plan) however we refresh them in each annual planning cycle in line with best practice in strategy deployment; to ensure we respond to the changing external		Executive Director Planning, Performance and Commissioning

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Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		context and WG's annual Planning Framework. We will keep this under review.		
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).	Accepted The finance report to Board will be modified to contain information on actual savings delivered to date. Appropriate commentary will be included.	30 July 2026	Executive Director Finance, Estates and Support Services
R6	The Health Board should ensure it regularly reports more explicitly on the activity and impact of	Accepted	31 March 2027	Executive Director Finance, Estates and Support Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	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).	The Health Board undertakes a series of Deep Dive reviews into areas of concern. These are presented to the Finance and Performance committee. The Health Board will ensure that all working groups are covered within the schedule.		
R7	The Health Board should arrange for more training on finance for	Accepted	30 June 2026	Executive Director Finance, Estates and Support Services

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	Independent Members to allow them to enhance scrutiny further in line with the developing financial pressures challenges. (paragraph 100)	The Health Board will arrange a specific training session on finance for Independent Members.		

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Agenda item: 5.12a

Audit, Risk and Assurance Committee		Date: 12 May 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:	Executive Committee on 29.04.2026	
PURPOSE:		
To inform the Audit Risk and Assurance Committee that there has been one Single Tender Waiver requests made between 1 March 2026 to 31 March 2026		
RECOMMENDATION(S):		
The Committee is asked to:		
- NOTE there has been three Single Tender Waiver requests made between 1 March 2026 to 31 March 2026 - Take ASSURANCE an appropriate reporting mechanism is in place.		
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	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

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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 March 2026 meeting which covered the period from 1 January 2026 to 28 February 2026.

A summary of the use of Single Tender Action from 1 March 2026 to 31 March 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
2526-091-STA-POW	TENDER	DEFINITIVE PSA LTD TA SECURE 24	SECURE PATIENT TRANSPORT	THERE IS NECESSITY TO RETAIN A PARTICULAR SUPPLIER FOR REAL BUSINESS CONTINUITY	30/03/2026	£33,600	7 months	Prospective	A1
2526-092-STA-POW	TENDER	PEGASUS MEDICAL 1808 LTD	SECURE PATIENT TRANSPORT	THERE IS NECESSITY TO RETAIN A PARTICULAR SUPPLIER FOR REAL BUSINESS CONTINUITY	30/03/2026	£193,200	7 months	Prospective	A2
2526-093-STA-POW	TENDER	PROMETHEUS SAFE & SECURE LTD	SECURE PATIENT TRANSPORT	THERE IS NECESSITY TO RETAIN A PARTICULAR SUPPLIER FOR REAL BUSINESS CONTINUITY	30/03/2026	£42,000	7 months	Prospective	A3

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 formal reference on

the table states it is 093 STW document issued it is confirmed this is the ninth 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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Agenda item: 5.12b

Audit, Risk and Assurance Committee		Date: 12 May 2026
Subject:	SINGLE TENDER WAIVERS 2020/21 to 2025/26	
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services	
Prepared by:	Assistant Director of Finance (Accounts & Services)	
Other Committees and meetings considered at:	Executive Committee - 29.04.2026	
PURPOSE:		
The Audit Risk and Assurance Committee is asked to NOTE the analysis of Single Tender Waiver requests made between 01 April 2020 and 31 March 2026.		
RECOMMENDATION(S):		
The Committee is asked to:		
RECEIVE the report covering the period 2020/21 to 2025/26 taking ASSURANCE that appropriate reporting mechanisms are in place.		
Approve/Take Assurance	Discuss	Note
Y	N	N

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

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EXECUTIVE SUMMARY:

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 (STW) 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. They are only 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.

In the pandemic the number of STWs increased to between 10 and 20 p.a.. They have since reduced to very low numbers.

This area of activity will continue to be monitored and all STWs will be reported to the ARAC committee to ensure transparency.

HEADING:

Periodically the Audit Risk and Assurance Committee receive a summary of STWs over a period of time, to identify trends and themes where there is a greater use of STWs in a particular area.

An analysis of approved Single Tender documents covering the period 1st April 2020 to 31st March 2026 has been undertaken by the Assistant Director of Finance. The findings of this analysis are as follows:

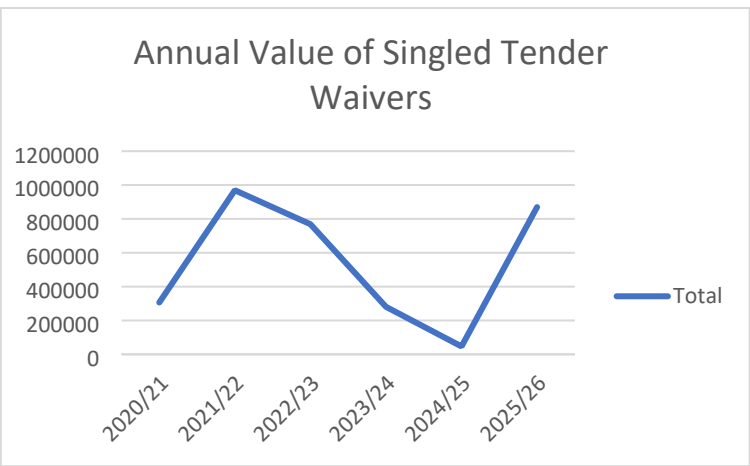
Annual Value and Numbers of STWs

In the pandemic the number of STWs increased to between 10 and 20 p.a.. They have since reduced to very low numbers. In 2025/26, there have been 4 STWs from the hosted body, Health and Care Research Wales.

In terms of the value of the STWs, the graph below shows that there was a peak in 2021/22. This was due to Health Care Provision related STWs, covering longer periods and larger values than previously.

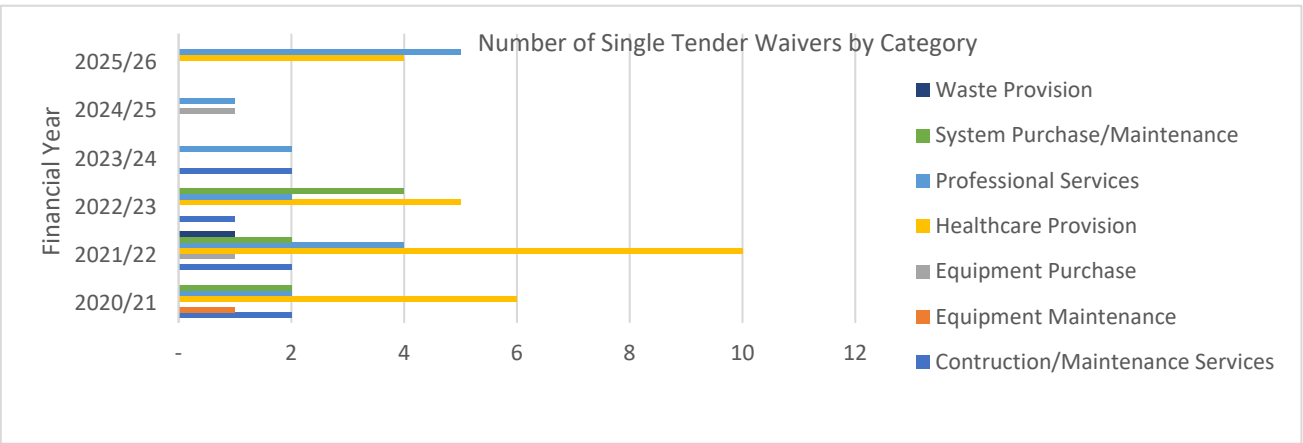
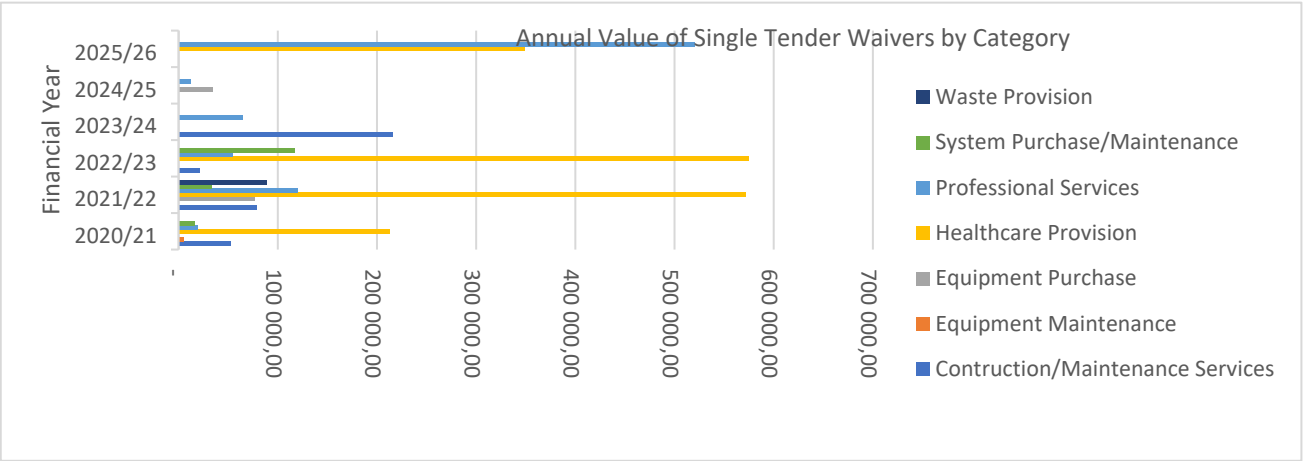
Since this peak the annual value and number of STWs has decreased over the following three years with a sharp rise in 2025/26. The increase in value was due to procuring specialist survey and Research and Development activity by Health Care Research Wales.

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Category of Single Tender Waiver

The following charts show that the majority of Single Tender Waiver usage relates to healthcare provision but this had reduced since the peak period of 2021/22.



An increase has been seen in 2025/26 due to the requirement for safe secure transport for patients. Another main reason for Healthcare Provision usage is due to augment NHS Capacity to undertake necessary services or treatments for the population of Powys.

System purchase/Maintenance is the next highest category. This is mainly due to sole suppliers of systems in use within the Health Board and the resulting requirement for maintenance contracts that only that supplier can carry out. This trend is showing a downward movement.

A peak in professional services use can be seen in 2025/26 and this is mainly as a result of specialist survey and Research and Development activity by the hosted body Health Care Research Wales.

The number of waivers by category chart is showing that on an annual basis the comparison of numbers per category can fluctuate but due to the low level of forms approved on an annual basis it is difficult to see any significant trends.

Numbers of Single Tender Waivers by Directorate

Detail of Usage per Directorate is as follows with the majority being undertaken by the Directorate of Primary and Community Care and Mental Health with other directorates having intermittent use over the years.

Directorate										
	Community Health Councils	Directorate of Medical Services	Directorate of Planning and Performance	Directorate of Primary Care, Community Services and Mental Health	Directorate of Finance, Estates and Support Services	Directorate of Workforce	Directorate of Nursing and Midwifery	Directorate of Therapies and Health Sciences and ICT	Directorate of Transformation	Health Care Research Wales
Financial Year										
2020/21	1			9		2	1			13
2021/22		1		13	2	3		1		20
2022/23		1	3	4	1	1		2		12
2023/24				1	1	2				4
2024/25				2						2
2025/26				4					1	4
Grand Total	1	2	3	33	4	8	1	3	1	4
										60

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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Agenda item: 5.13

Audit, Risk and Assurance Committee		Date: 12 May 2026
Subject:	LOSSES AND SPECIAL PAYMENTS ANNUAL REPORT 2025-26	
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:	Executive Committee – 29.04.2026	
PURPOSE:		
To NOTE the Report of Losses and Special Payments for the period 01 April 2025 to 31 March 2026.		
RECOMMENDATION(S):		
The Audit Risk and Assurance Committee is asked to:		
RECEIVE this Interim Report on Losses and Special payments covering the period 01 April 2025 to 31 March 2026.		
Approve/Take Assurance	Discuss	Note
N	N	Y

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

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EXECUTIVE SUMMARY:

Losses and special payments are items that the Welsh Government would not have contemplated when they passed legislation or agreed funds for the NHS; such payments would also include any ex gratia payments made by the THB.

By their nature they are items which should be avoidable and should not arise. They are subject therefore to special control procedures and are included within a separate note in the THB's annual accounts.

HEADING:

The following relate to payments made on behalf of cases for which Powys THB have responsibility. Claims relating to the Residual Clinical Negligence (relating to former Health Authorities) cases are scrutinised by the Welsh Risk Pool advisory panel and therefore are not required to be included below.

This paper provides an annual report for the period 01 April 2025 to 31 March 2026.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Redress, Compensation Claims & Inquest Case Co-Ordinator, manages the claims on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support are provided by Legal & Risk Services on the processes and on the management of individual cases. Addressing learning following settlement of individual cases, learning and evidence is shared with Welsh Risk Pool (WRP) with the LFER process for reimbursement.

Systems and processes have been established and databases documenting all claims activity alongside the individual claims files exist. Decision making on payments are approved in a number of ways:

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing. All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety Committee. The last report was provided to the February 2026 Committee.

- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 01 April 2025 to 31 March 2026, the THB made payments in respect of 13 cases totalling £504,473.68 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year to date the THB has not received reimbursement in respect of cases that exceeded the £25,000 THB liability.

Details of the payments are included in Appendix Ai.

	No. of payments	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	40	13	£504,473.68
Total	40	13	£504,473.68
Welsh Risk Pool Reimbursement Receipts	3	3	£1,048,583.43
Total	3	3	£1,048,583.43

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 17 open cases which are which are inclusive of clinical negligence (11),and personal injury (6) claims with NWSSP Legal and Risk Services instructed to act on behalf of the health board. 4 cases have been closed in year.

Redress (Putting Things Right)

These relate to smaller claims that are managed by the THB in line with the Putting things Right Legislation. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 01 April 2025 to 31 March 2026 are included in Appendix Aii.

	No. of payments/receipts	No. of cases	£
Redress Payments	20	10	£45,286.01
Total	20	10	£45,286.01

There have been no reimbursements from Welsh Risk Pool. There are currently 15 open redress cases at variable stages.

General Medical Practice Indemnity (GMPI)

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 01 April 2019. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 01 April 2025 to 31 March 2026 are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
GMPI Payments	24	7	£48,243.00
Total	24	7	£48,243.00
GMPI Receipts	1	1	£20,782.30
Total	1	1	£20,782.30

There are currently 5 open GMPI cases at variable stages of review/progression.

Other Special Payments

There have been 168 Ex Gratia payments made during 01 April 2025 to 31 March 2026. The majority of payments relate to the recognition payments for Health Care Support workers rebanded from Band 2 to 3 within the year. This was reported at the March 2026 Audit Risk and Assurance meeting and Welsh Government have formally provided approval for the losses due to value.

	No. of payments	No. of cases	£
Other Special Payments	168	168	£450,314.69
Total	168	168	£450,314.69

Conclusion

The Audit Committee is asked to note the annual report for 2025/26 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

The Audit Risk and Assurance Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

Luzzer And Special Payments for 2025-26 Financial Year 1st April 2025 to 31st March 2026				Appendix Ai		
Claim Type	Payment Type	Welsh Risk Pool Reference	Date of	Payments	Amount by co	Additional Information
PI	DEFENCE COSTS	PI0301913/RHJ	P10-26	£204.50	£204.50	
CN	DEFENCE COSTS	SSPLR143880	P03-26	£14,216.70	£14,216.70	Claim concluded WRP reimbursed zero below
CN	DEFENCE COSTS	SSPLR147420	P07-26	£1,050.00	£1,050.00	
PI	DEFENCE COSTS	SSPLR149755	P01-26	£115.00	£115.00	
PI	DEFENCE COSTS	SSPLR149755	P03-26	£310.77		
PI	DEFENCE COSTS	SSPLR149755	P07-26	£421.54		
PI	DEFENCE COSTS	SSPLR149755	P10-26	£304.33		
PI	DEFENCE COSTS	SSPLR149755	P12-26	£368.22		
PI	DEFENCE COSTS	SSPLR149755	P12-26	£251.07	£1,655.93	
PI	DAMAGES	SSPLR151954	P08-26	£766.00	£766.00	
PI	DEFENCE COSTS	SSPLR152797	P12-26	£196.65	£196.65	
CN	DEFENCE COSTS	SSPLR153510	P02-26	£2,376.00	£2,376.00	
CN	DEFENCE COSTS	SSPLR153625	P05-26	£300.00		
CN	DEFENCE COSTS	SSPLR153625	P06-26	£960.00		
CN	DEFENCE COSTS	SSPLR153625	P06-26	£1,650.00		
CN	DEFENCE COSTS	SSPLR153625	P06-26	£750.00		
CN	DEFENCE COSTS	SSPLR153625	P08-26	£1,050.00		
CN	DEFENCE COSTS	SSPLR153625	P11-26	£210.00	£4,920.00	
CN	DAMAGES	SSPLR154114	P01-26	£362,500.00		
CN	DEFENCE COSTS	SSPLR154114	P03-26	£673.75		
CN	DEFENCE COSTS	SSPLR154114	P03-26	£18.00		
CN	DEFENCE COSTS	SSPLR154114	P03-26	£1,299.67		
CN	CLAIMANT COSTS	SSPLR154114	P04-26	£480.00		
CN	CLAIMANT COSTS	SSPLR154114	P04-26	£12,500.00		
CN	CLAIMANT COSTS	SSPLR154114	P04-26	£67,500.00		
CN	DEFENCE COSTS	SSPLR154114	P04-26	£485.46		
CN	DEFENCE COSTS	SSPLR154114	P05-26	£367.50		
CN	DEFENCE COSTS	SSPLR154114	P12-26	£446.36		
CN	DEFENCE COSTS	SSPLR154114	P12-26	£640.49	£446,911.23	Claim concluded WRP reimbursed zero below
CN	DEFENCE COSTS	SSPLR154920	P04-26	£1,260.00		
CN	DEFENCE COSTS	SSPLR154920	P05-26	£1,008.00		
CN	DAMAGES	SSPLR154920	P09-26	£15,000.00		
CN	CLAIMANT COSTS	SSPLR154920	P11-26	£11,000.00		
CN	CLAIMANT COSTS	SSPLR154920	P12-26	£950.00		
CN	DEFENCE COSTS	SSPLR154920	P12-26	£900.00	£30,118.00	
PI	DEFENCE COSTS	SSPLR4356277	P07-26	£868.58		
PI	DEFENCE COSTS	SSPLR4356277	P10-26	£597.39		
PI	DEFENCE COSTS	SSPLR4356277	P12-26	£184.56	£1,610.53	
CN	DEFENCE COSTS	SSPLR9036316	P08-26	£297.14		
CN	DEFENCE COSTS	SSPLR9036316	P09-26	£36.00	£333.14	
		TOTAL		£504,473.68	£504,473.68	
Reimbursements from Welsh Risk Pool						
Receipt Date	Nature of Reimbursement from Welsh Risk Pool	WRP Reference		Amount		
Feb-26	Reimbursement on closure of care	SSPLR149530		£1,924.00		
Feb-26	Reimbursement on closure of care	SSPLR154114		£496,362.75		
Feb-26	Reimbursement on closure of care	SSPLR143880		£550,296.68		
		Total		£1,048,583.43		

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Appendix Aii

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Appendix Aiii

GP Indemnity Losses And Special Payments for 2025-26 Financial Year

Appendix Aiii

1st April 2025 to 31st March 2026

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount by case
P12-26	SSPLR1246192	DEFENCE COSTS	£1,260.00	£1,260.00
P04-26	SSPLR148695	DEFENCE COSTS	£1,000.00	
P04-26	SSPLR148695	DEFENCE COSTS	£1,200.00	
P04-26	SSPLR148695	DEFENCE COSTS	£2,375.00	£4,575.00
P04-26	SSPLR149098	DEFENCE COSTS	£2,880.00	
P05-26	SSPLR149098	DEFENCE COSTS	£525.00	
P12-26	SSPLR149098	DEFENCE COSTS	£1,920.00	£5,325.00
P07-26	SSPLR149851	DEFENCE COSTS	£2,250.00	
P07-26	SSPLR149851	DEFENCE COSTS	£1,026.00	
P09-26	SSPLR149851	DAMAGES	£20,000.00	£23,276.00
P05-26	SSPLR154808	DEFENCE COSTS	£594.00	
P05-26	SSPLR154808	DEFENCE COSTS	£384.00	
P06-26	SSPLR154808	DEFENCE COSTS	£1,500.00	
P07-26	SSPLR154808	DEFENCE COSTS	£750.00	
P08-26	SSPLR154808	DEFENCE COSTS	£99.00	
P10-26	SSPLR154808	DEFENCE COSTS	£75.00	
P10-26	SSPLR154808	DEFENCE COSTS	£75.00	
P11-26	SSPLR154808	DEFENCE COSTS	£75.00	
P12-26	SSPLR154808	DEFENCE COSTS	£3,060.00	£6,462.00
P11-26	SSPLR154978	DEFENCE COSTS	£2,695.00	
P11-26	SSPLR154978	DEFENCE COSTS	£1,248.00	
P11-26	SSPLR154978	DEFENCE COSTS	£630.00	
P12-26	SSPLR154978	DEFENCE COSTS	£1,620.00	£6,193.00
P02-26	SSPLR155471	DEFENCE COSTS	£1,152.00	£1,152.00
Total			£48,243.00	£48,243.00

Reimbursements from Welsh Risk Pool

Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
P09-26	SSPLR149851	Reimbursement (previous interim reimbursement received)	£20,782.30
Total			£0.00

Appendix Aiv

Other Losses And Special Payments for 2025-26 Financial Year

Appendix Aiv

1st April 2025 to 31st March 2026

Payment Date	Losses Reference	Nature of Reimbursement	Amount
Mar-26	PTHB Band 2- 3 2025-26	166 x Recognition payment in respect of the Band 2-3 exercise. Approval provided by Welsh Government for Loss	£450,168.14
Dec-25	EG25-26-02	Reimbursement of high cost call line charges	£26.55
Oct-25	EG25-26-01	Reimbursement of travel costs	£120.00
Total			£450,314.69

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

Audit, Risk and Assurance Committee 12 May 2026		Agenda Item: 5.14
Subject:	PTHB Policy & Written Control Documents Summary Report as of 23 April 2026	
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary	
Prepared by:	Business Governance Officer/PA to Director of Corporate Governance	
Purpose:	The purpose of this paper is to provide the Committee with an overview of the position relating to Powys Teaching Health Board Policies and Written Control Documents – as at the end of March 2026.	
Recommendations:	The Committee is asked to: • CONSIDER the position (as at end March 2026) of Policies and Written Control Documents and take ASSURANCE that the organisation has an appropriate system for tracking and reviewing these documents. • CONSIDER and discuss the current position of Policies and Written Control Documents with a particular focus on those Policies given High Priority ratings	
Executive Summary:	The Corporate Governance Team are responsible for ensuring Powys Teaching Health Board’s Policies and Written Control Documents are readily available and accessible to all staff via the Policies and Written Control Documents SharePoint site. The team are also responsible for the management, monitoring and reporting of these documents. A live database of Policies and Written Control Documents is maintained and information is reported to Executive Committee and Audit, Risk and Assurance Committee for assurance. The report provides a summary of the overall position, in respect of live Policies broken down by Directorate that are • In-date • Expired • Due to expire within 3 months A summary of the overall position, in respect of Written Control Documents broken down by Directorate that are • In-date • Expired • Due to expire within 3 months • A summary of each directorates’ policies, which have expired or are due to expire in 3 months, and their risk level • The outcome of the Policy Management Internal Audit Report 2025/26 • Next steps to be taken.	

- Following a full review of how Powys Teaching Health Board manages its Policies and Other Written Control Documents across the organisation, an updated version of [CGP 004 Management of Policies and Other Written Control Documents](#) Policy was approved by Board. This policy was implemented in October 2025.
- To support the implementation of CGP 004, the [Policies & Written Control Document Toolkit](#) has been fully reviewed and updated to include:
 - A new template for both Policies; and Written Control Documents
 - A separate procedure for managing Policies and Written Control Documents
- A Virtual Policy Consultation Group was established in January 2026. This is a virtual group of key organisational functions/internal partners who receive all new policies and updated policies where material changes have been made, in draft, via email for a 10-working day consultation as standard to ensure compliance and staff safety.
- In addition to the existing Workforce Policy Review Group. The Clinical Policy Review Group and Corporate Policy Review Group have now been established. These three Policy Review Groups are responsible for the oversight of the control and management of all Clinical, Corporate and People and Culture policy documents, for which their area of expertise is responsible. All policies must be approved by the relevant Policy Review Group, though policies relevant to the entire organisation or those with the potential to be cross organisational, controversial or decision retained, may need approval by the Executive Committee or Board.

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Summary of all Live Policy documents by Directorate – 23 April 2026:

The table below provides a summary of the overall position of Live policy documents as of 23 April 2026, broken down by directorate.

- There are a total of 148 live policy documents on the Policies and Written Control Documents SharePoint site. This figure does not include All Wales/External Policies or appendices. Some policies are not held centrally.
- 101 Policies (68%) are reported as In-Date
- 46 Policies (31%) are reported as Expired
- 1 Policy (less than 1%) is due to expire within 3 months.

Count of Current Document Reference Code		Column Due To		
Row Labels	☒ Expire	Expired	In Date	Grand Total
☒ Policy				
Director of Corporate Governance / Board Secretary		1	6	7
Director of Strategic Improvement and Transformation		1	1	2
Executive Director of Allied Health Professions, Health Sciences and Digital		2	5	7
Executive Director of Finance, Capital and Support Services		4	11	15
Executive Director of Nursing, Quality, Women and Family Health		10	20	30
Executive Director of Nursing, Quality, Women and Family Health and Executive Director of Allied Health Professions, Health Sciences and Digital			2	2
Executive Director of Planning, Performance and Commissioning			1	1
Executive Director of Primary Care, Community and Mental Health		10	15	25
Executive Director of Public Health			2	2
Executive Director People, Culture and Transformation	1	15	32	48
Executive Medical Director		3	6	9
Grand Total	1	46	101	148

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Summary of all Live Written Control Documents– 23 April 2026:

The table below provides a summary of the overall position of Written Control Documents as of 23 April 2026.

- There are a total of 362 live Written Control Documents on the Policies and Written Control Documents SharePoint site. This figure does not include forms or appendices
- 229 (63%) Written Control Documents are reported as In-Date
- 119 (33%) Written Control Documents are reported as Expired
- 14 (4%) Written Control Documents are due to expire within 3 months.

Count of Current Document Reference Code	Column Labels			
Row Labels	Due To Expire	Expired	In Date	Grand Total
Written Control Documents				
Framework	1	2	2	5
Guideline	6	33	56	95
Procedure	4	39	37	80
Protocol	1	14	36	51
Service Specification		1		1
Standard Operating Procedure	2	28	98	128
Strategy		2		2
Grand Total	14	119	229	362

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SUMMARY POSITION – Live Written Control Documents by Directorate

The table below provides a summary of the overall position of Written Control Documents as of 23 April 2026, broken down by directorate.

Count of Current Document Reference Code		Column		
Row Labels	Due To Expire	Expired	In Date	Grand Total
Written Control Documents				
Director of Corporate Governance / Board Secretary	1	5	14	20
Director of Strategic Improvement and Transformation			2	2
Executive Director of Allied Health Professions, Health Sciences and Digital	1	26	28	55
Executive Director of Finance, Capital and Support Services		21	7	28
Executive Director of Nursing, Quality, Women and Family Health	8	48	73	129
Executive Director of Planning, Performance and Commissioning			1	1
Executive Director of Primary Care, Community and Mental Health	2	14	63	79
Executive Director of Public Health			7	7
Executive Director People, Culture and Transformation		2	3	5
Executive Medical Director	2	3	31	36
Grand Total	14	119	229	362

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Expired or Due To Expire Policies by Level of Risk

The table below provides a summary of the level of risk which has been assigned by Directorates to policies which have expired or are due to expire in 3 months

- There are a total of 47 live Policies which have either expired or are due to expire within 3 months.
- 1 (2%) Policy is reported as High Risk
- 9 (19%) Policies are reported as Medium Risk
- 37 (79%) Policies are reported as Low Risk

Count of Current Document Reference Code		Column Labels			Grand Total
Row Labels		High	Medium	Low	
Policy					
Director of Corporate Governance / Board Secretary				1	1
Director of Strategic Improvement and Transformation				1	1
Executive Director of Allied Health Professions, Health Sciences and Digital				2	2
Executive Director of Finance, Capital and Support Services			2	2	4
Executive Director of Nursing, Quality, Women and Family Health		1	4	5	10
Executive Director of Primary Care, Community and Mental Health			2	8	10
Executive Director People, Culture and Transformation			1	15	16
Executive Medical Director				3	3
Grand Total		1	9	37	47

Expired or Due To Expire Policies by Level of Risk

Directorates were asked to review their policies which had expired or are due to expire within 3 months, confirming the level of risk associated with this policy being out of date; and the expected review date for this policy. Below is a summary of the policies proposed high and medium risk, broken down into directorate.

Executive Director of Nursing, Quality, Women & Family Health					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update received from Directorate	Expected Date of Review
CDP 008	01 January 2018	Missing Persons Policy	High	Document has been managed and written in mental health services previously - a joint working group to update this policy to ensure applicability across services will be implemented.	Q4
GNP 001	20 April 2023	Verification of Expected Death by a Health Care Professional	Medium	To be allocated to Policy Group for review and completion - cross division working will be relevant to ensure applicability to all services.	Q2
GNP 064	11 April 2021	Policy for safe effective nutrition hydration and catering provision for patients In hospital	Medium	With Head of Nursing and Head of Dietetics for review.	Q1

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Expired or Due To Expire Policies by Level of Risk

Executive Director of Nursing, Quality, Women and Family Health continued					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
GNP 065	13 December 2020	Enhanced Care Policy	Medium	This document was reviewed and signed off by Executive Director of Nursing in 2023 but never updated on the intranet. Process issue - however, this will need to be reviewed following national changes in scoring and escalation processes. Date delayed to align with national update.	Q3
GNP 070	1 April 2023	The Care of the Deteriorating Patient in the Community and Community Hospitals	Medium	Policy review in progress, during review NEWS2 implementation took place in community and DN - pending alignment with change in national profile.	Q3

Executive Director People, Culture and Transformation					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
OHP 003	13 July 2025	Occupational Immunisation Policy	Medium	Now proceeding with some amendments and will submit to clinical governance policy group.	31/04/2026

Expired or Due To Expire Policies by Level of Risk

Executive Director of Primary Care, Community and Mental Health					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
MHP 078	1 November 2022	Rapid Tranquilisation Policy	Medium	Currently under review with Author with submission date agreed for mid-April, so comments can be applied. Aim to go through CPAG approval in June	April 2026
MHP 060	1 July 2021	Policy relating to Community Treatment Orders (code of practice for Wales chapter 29)	Medium	Work progressing on the Mental Health Act following review of the MHA office and this forms part of the MHA risks register. Allocated to appropriate author to review to consider new legislation.	April 2026

Executive Director of Finance and Support Services					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
FCP 029	01/03/2018	Counter Fraud, Bribery and Corruption Policy and Response Plan	Medium	There are absences in the Counter Fraud team, which has meant this has been delayed. This has been picked up with Swansea Bay UHB, which provide us with the service.	1/10/2026
CGP 008	6 July 2025	Bribery Policy	Medium	There are absences in the Counter Fraud team, which has meant this has been delayed. This has been picked up with Swansea Bay UHB, which provide us with the service.	1/10/2026

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

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Next Steps:

- Executive Directors to review all high and medium risk policies within their directorate.
- A summary report of Policies and Written Control Documents will be provided to Audit, Risk & Assurance Committee biannually going forward, with the next report due in October 2026.

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Agenda item: 7.1

Audit, Risk and Assurance Committee		Date: 12 May 2026
Subject:	Post Payment Verification (PPV) End of Year Report – 1st April 2025 to 31 st March 2026	
Approved and presented by:	Elaine Lorton, Executive Director Primary Care, Community and Mental Health	
Prepared by:	Amanda Legge – All Wales Post Payment Verification Manager (NWSSP)	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
The PPV process and reports are to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation. The reports detail specific risks and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.		
RECOMMENDATION(S):		
The Committee is asked to:		
Take ASSURANCE that the Post Payment Verification cycle is being managed appropriately		
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	Y	
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	N	

EXECUTIVE SUMMARY:

The reports highlight Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

BACKGROUND

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress.

The following key points should be noted:

General Medical Services (GMS): We progressed well this year with our GMS routine visits and all are either closed or in progress by the end of this financial year. Beginning 2026/27, we will be concentrating the first quarter on GMS visits only and incorporating both revisits and the practice routine visit. This is part of our ongoing recovery plan.

Some vaccination claims are now being claimed on the Welsh Immunisation System (WIS) and due to PPV highlighting the issues we found whilst conducting our verification checks, new internal process changes have been implemented to stop the duplicate vaccination payments prior to payment and not post payment, which is beneficial to everyone.

General Ophthalmic Services (GOS): The visit plans for GOS 2025/26 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We have had to still carry out elements of physical visits too, as not all contractors are using electronic systems. In 2025/26, we verified claims for an additional two services, which were the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5). These checks have been going well, with learning shared with our contractors and our teams.

General Pharmacy Services (GPS): In 2025/26, the PPV team undertook checks on the Collaborative Working Scheme, along with the Quality and Safety Scheme, which we conduct remotely by verifying the data we hold against the evidence that we request from the contractors. This again has been positive for all HB, PPV team and contractor learning.

Additional Service: The team progressed well with its quarterly dispensing data checks and has introduced a robust service moving forward into the new financial year, which resulted in future financial recoveries. The results for the eleven dispensing practices in Powys Teaching Health Board have been added to PPV reports.

The PPV team manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and

Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our GOS contractors into our clinical waste process in the next financial year. Meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks. The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services. The team also arrange bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend. PPV training requirements continue to be delivered to Health Boards and contractors, whenever needed and we also facilitate one-on-one training requirements when requested, particularly for new practice staff within the Primary Care setting. We currently have our data analysts looking at producing some PPV dashboards with information for submission to future committee meetings.

GMS Summary									
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate	Advisory Notes • The planned visits were sent to the HB for 2025/26 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers. • All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed. • The duplicate amount of recovery is due to the practice submitting certain additional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors. • The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns. • PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise. • Training/support is given to practices by PPV after their visit when requested. • Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims. • Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole. • Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.
Practice 1	Revisit	106	14	13.21%	£489.94	£0.00	£489.94	Imms, Minor Surgery and Minor Injury	
Practice 2	Routine	190	13	6.84%	£531.69	£134.35	£666.04	Contraceptives, Gonadorelin, Imms, Lithium, Minor Injury and Minor Surgery. Duplicate recoveries on Contraceptives and Transgender	
Practice 3	Revisit	148	7	4.73%	£216.78	£30.75	£247.53	Gonadorelin and Warfarin A. Duplicate recoveries on Gonadorelin	

GOS Summary										
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Breakdown of Recoveries and individual services with 10% or more error rate			Advisory Notes	
Practice 1		103	0	0.00%	£0.00	All claims verified			• The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers. • As contractors are transitioning to electronic records, remote access and physical visits are progressing well	
Practice 2		103	0	0.00%	£0.00	All claims verified				
Practice 3		0	0	0.00%	£0.00	Unable to undertake visit - Practice closure				
Practice 4		103	7	6.80%	£92.67	GOS 4 claims				
Practice 5		103	0	0.00%	£0.00	All claims verified				
Practice 6		103	3	2.91%	£156.00	Claim recovery under 10% per service				
Practice 7		103	0	0.00%	£0.00	All claims verified				
Practice 8		103	2	1.94%	£98.62	Claim recovery under 10% per service				
Practice 9		103	6	5.83%	£109.07	GOS 4 claims				

GPS Summary			
PRACTICE	In progress	Closed	Value of recovery
Practice 1	New owners with new		£0.00
Practice 2		Y	£0.00
Practice 3		Y	£0.00
Practice 4		Y	£0.00
Practice 5		Y	£0.00
Practice 6		Y	£0.00
Practice 7		Y	£0.00
Practice 8	Y		

Advisory Notes
No recoveries have yet been made in the last financial year as we are awaiting evidence and HB responses.

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Powys Teaching Health Board – Annual Audit Summary 2025

Date issued: April 2026



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Foreword



Adrian Crompton

Auditor General for
Wales

I am pleased to share my Annual Audit Summary for Powys Teaching Health Board the Health Board. It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work, reviewed planned care services and digital transformation, and followed up quality governance work. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

At the time of publishing this summary, the Health Board was escalated to Level 4 for finance, strategy and planning under the Welsh Government's escalation and intervention arrangements.

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit Risk and Assurance Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Health Board's staff for their help and cooperation throughout my audit.

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Your audit at a glance



I received the draft accounts in line with the statutory deadline of 2 May 2025. Generally, the quality of the draft accounts and working papers was good, but there were issues with the supporting documentation for Continuing Healthcare accruals.



I issued an unqualified true and fair opinion, and a qualified regularity opinion on 1 August 2025, after the statutory deadline of 30 June 2025, I also issued a substantive report on the accounts.

There was one significant issue to report, relating to the Health Board’s accounting of Continuing Healthcare accruals, which resulted in the delay of the audit opinion.



My performance audit work found that the Board operates effectively and transparently, has clear strategic intent for digital transformation, and a commitment to quality, engagement and improvement.

The Health Board needs to strengthen the consistency of scrutiny, improve clarity in planning and risk management, strengthen its focus on commissioned services, address its significant financial challenges, and develop a clear plan to meet rising demand for planned care.



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My audit team made several recommendations to the Health Board which focus on further strengthening governance arrangements, risk and reporting frameworks, financial transparency and controls, including continuing healthcare accruals, the management of clinical risk, oversight of commissioned services, digital assurance and advancing longer-term planning, demand and capacity, efficiency and productivity work.



There is still some work outstanding from my Audit Plan dated February 2025. My team expects to complete this work by the end of June 2026.

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Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give a true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my [Statement of Responsibilities](#) publications, which are available on the [Audit Wales website](#).

The draft accounts were presented for audit on 2 May 2025. This was in line with the deadline of 2 May 2025 set by the Welsh Government. The quality of the draft accounts presented for audit was generally good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Board on 30 July 2025.

True and fair

Several changes were made to the draft accounts arising from my audit work.

There were two uncorrected misstatements. One relating to an overstatement in Continuing Healthcare accruals, and the other being a misclassification within trade payables. Both were immaterial.

I reported one significant issue in relation to Continuing Healthcare accruals where, in some cases, appropriate information was not factored into calculation of the accruals. In other cases, Continuing Healthcare accruals were misclassified as payables.

My work did not identify any material weaknesses in internal controls, but I made one recommendation on Continuing Healthcare accruals. Progress against the recommendation will be monitored during the 2025-26 audit.

I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Health Board is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Health Board did not achieve financial balance for the three-year period ending 31 March 2025, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2024-25 accounts. The Health Board breached its resource limit by spending £34.7 million over the amount that it was authorised to spend in the three-year period 2022-2023 to 2024-2025.

Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

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Performance audit findings

Structured assessment

My team looked at how well the Health Board is governed and whether it makes the best use of its resources.

I found that 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.

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 the Health Board is mapping partnership working more effectively. 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.

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. 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.

I made seven recommendations focused on:

- referrals in committee action logs;
- strategic and organisational risk registers;
- the format of the Integrated Quality Report;
- linking corporate plans;

- actual savings to date in finance reports;
- activity and impacts of financial working groups; and
- financial training for Independent Members.

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.

Managing planned care

My team looked at the progress the Health Board is making in tackling its planned care challenges and reducing its waiting list backlog.

I found that following some early success, performance against some ministerial priorities has plateaued and the overall number of patients waiting has continued to rise. The Health Board's service demand is increasing. It needs a plan to meet current and future service needs, which considers its strategic commissioning environment and maximises local service efficiencies.

I made four recommendations focused on longer term planning and costing, demand and capacity planning, efficiency and productivity and managing clinical risks associated with long waits.

Quality governance

My team looked at the progress the Health Board is making in implementing my 2021 quality governance audit recommendations. The review also looked at the progress made to review and implement corporate arrangements to meet the new Duties of Quality and Candour requirements, and related oversight and scrutiny.

The Health Board has made some progress against my previous audit recommendations. New frameworks are in place to better articulate the arrangements for commissioning services, supported by improved monitoring of quality and safety measures. The Health Board has also met its statutory and mandatory training compliance target.

However, the Health Board still needs to set out its expected standards of care for commissioned services, and to ensure it produces regular Commissioned Services Performance Reports. These should include oversight of complaints about commissioned services, which is still a gap.

Although the Health Board has made some progress to improve access to data, analytical capacity is also a gap, and the Health Board would still benefit from having a quality dashboard. The Health Board also needs to ensure appropriate corporate staff have received DATIX training.

The Health Board has made reasonable progress in embedding the duties of quality and candour. There was a clear implementation plan, and the Board receive regular updates on compliance. However, oversight of the uptake of relevant training needs to improve.

I made six recommendations, of which four replace recommendations outstanding from my 2021 review. These recommendations focus on

- performance measures and outcomes for commissioned services;
- oversight of complaints about commissioned services;
- DATIX training;
- data analytics;
- the Commissioned Services Performance Reports; and
- oversight of duty of quality e-learning.

Digital transformation

My team looked at how the Health Board's approach to digital transformation is supporting service improvement.

The Health Board has a clear Digital Strategic Framework that is aligned to national priorities and supports long-term service improvement. The Health Board has strengthened its governance arrangements for digital transformation, and a structured programme of digital projects is in place. However, weaknesses in financial planning, benefits realisation, and assurance reporting limit the Board's ability to fully understand progress, risks, and impact. While digital infrastructure and cyber controls have improved, assurance over long-term resilience remains limited, particularly in relation to capital planning, legacy systems, and disaster recovery.

Although the Health Board recognises the potential of Artificial Intelligence (AI), governance arrangements remain underdeveloped. The Digital Strategic Framework sets out high-level ambitions but lacks clarity on implementation, resourcing, risk management, and oversight. At the same time, the organisation does not yet have a comprehensive understanding of its digital skills and workforce capacity, with low uptake of self-

assessment tools, no co-ordinated training plan, and reliance on small numbers of specialists creating resilience risks.

Engagement with staff and service users has supported some positive digital developments, but approaches are inconsistent and lack formal structure, including the absence of a Board-approved digital engagement or inclusion plan. Overall, the Health Board is progressing a range of digital initiatives and shows commitment to transformation. However, gaps in strategic risk management, workforce planning, benefits evaluation, and long-term investment planning weaken assurance that digital investment will consistently deliver sustained improvements in service quality, efficiency, and accessibility.

I made seven recommendations focused on:

- the Digital Roadmap;
- digital transformation risks;
- an annual plan to comply with the NIS 2018 Cyber Assessment Framework;
- arrangements for the safe use of AI;
- the approach to assessing and developing digital skills;
- leadership for digital inclusion; and
- post-implementation reviews.

Performance audit work still underway

At the time of reporting, the following reviews from previous audit plans were still underway at the Health Board

- agency staffing;
- urgent and emergency care; and
- estates management.

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Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2024](#).



Our People

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality

Selection of right team

• Audit platform	• Learning and development
• Ethics	• Leadership
• Guidance	• Technical support
• Culture	



Independent assurance

• EQRs	• Peer review
• Themed reviews	• Audit Quality Committee
• Cold reviews	• External monitoring
• Root cause analysis	

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Further information

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- 

Our publications which cover our audit work at public bodies.
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Information on our upcoming work and forward work programme for performance audit.
- 

Data tools to help you better understand public spending trends.
- 

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

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

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Audit, Risk and Assurance Committees 2026-27

Theme	Item Title	Exec Lead	May 12/05/2026	June 23/06/2026 (Annual Accounts)	July 07/07/2026	Oct 06/10/26	Jan 12/01/2027	09-Mar
Governance	Minutes of previous meeting	DCG	✓		✓	✓	✓	✓
Governance	Declaration of Interests	DCG	✓		✓	✓	✓	✓
Governance	Action Log	DCG	✓		✓	✓	✓	✓
Governance	Committee Risk Register	DCG						
Governance	Annual Work Programme	DCG	✓		✓			
Governance	Work Programme (updated through year)	DCG			✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	DCG			✓			
Governance	Committee Governance Action Plan	DCG			✓	✓		✓
Governance	Committee Annual Report	DCG	✓					
Governance	Audit Findings Tracker	DCG			✓			✓
Governance	WHC/MD Tracker	DCG			✓			✓
Governance	Organisational Register of Interests	DCG			✓			✓
Governance	Organisational Register of Gifts and Hospitality	DCG			✓			✓
Governance	Board Assurance Framework	DCG	✓					
Governance	Review of Terms of Reference	DCG						✓
Governance	Review of Standing Orders and Standing Financial Instructions	DCG						✓
Governance	Confirmation of Clinical Audit Programme	EMD			✓			
Annual Accounts	Approach to the Annual Accounts	ED FC&SS/DCG						✓
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	ED FC&SS	✓					
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	ED FC&SS		✓				
Internal Audit	Head of Internal Audit Opinion Draft	DCG	✓					
Internal Audit	Head of Internal Audit Opinion Final	DCG			✓			
Internal Audit	Internal Audit Annual Plan	DCG						✓
Internal Audit	Internal Audit Progress Report	DCG	✓ 25/26	✓ 26/27	✓	✓	✓	✓
Internal Audit	Internal Audit Reports (as required)	DCG	✓	✓	✓	✓	✓	✓
Internal Audit	Internal Audit Trend Report	DCG					✓	
External Audit	Enquiries of Management and Those Charged with Governance	ED FC&SS/DCG		✓				

External Audit	External Audit Annual Plan	ED FC&SS/DCG	✓					✓
External Audit	External Audit Progress Report	DCG	✓		✓	✓	✓	
External Audit	External Audit Reports (as required)	Lead	✓	✓	✓	✓	✓	✓
External Audit	Structured Assessment	DCG						✓
Counter Fraud	Counter Fraud Annual Plan	ED FC&SS	✓					✓
Counter Fraud	Counter Fraud Update	ED FC&SS	✓		✓	✓	✓	
Counter Fraud	Counter Fraud Reports (as required)	ED FC&SS	✓		✓	✓	✓	✓
Finance and Procurement	Single Tender Waivers Annual Report	ED FC&SS	✓					
Finance and Procurement	Single Tender Waivers (including extensions to contracts)	ED FC&SS	✓		✓	✓	✓	✓
Finance and Procurement	Losses and Special Payments Annual Report	ED FC&SS	✓					
Finance and Procurement	Losses and Special Payments	ED FC&SS	✓			✓		✓
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Jan	ED FC&SS	✓				✓	
Finance and Procurement	Financial Controls	ED FC&SS			✓		✓	
Risk	Review of Risk Management Framework	DCG	✓					
Risk	Assurance of Risk Management arrangements inc. revised Risk Management Toolkit	DCG						✓
Hosted Bodies	Hosted Body annual report (HCRW)	DWOD	✓					✓
Information Governance	Information Governance and Records Management Annual Report	DCG			✓			
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)	EMD	✓					
Information Governance	Information Governance and Records Management Performance and Assurance Monitoring Report	DCG					✓	
Digital First	Strategic risk deep dive: Digital Infrastructure (In-Committee)	DoAHP,HS&D			✓		✓	
Digital First	Digital First Annual Plan	DoAHP,HS&D					✓	
Digital First	Digital First 6monthly monitoring report (including cyber security)	DoAHP,HS&D	✓			✓		
	SFI executive financial delegation limits	DCG				✓		
	WCCIS Update	DoAHP,HS&D			✓		✓	✓
	Policy Management Assurance Report	DCG				✓		
	Grip and Control	ED FC&SS	✓					
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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Powys Teaching
Health Board

Agenda item: 7.4

Audit, Risk and Assurance Committee		Date of Meeting: 12 May 2026
Subject:	Audit, Risk and Assurance Committee Annual Report 2025/2026	
Presented & Approved by:	Director of Corporate Governance/Board Secretary	
Prepared by:	Corporate Governance Assurance and Risk Manager	
Other Committees and meetings considered at:	N/A	
PURPOSE:		
The purpose of this report is to provide the Audit, Risk and Assurance Committee Report for 2025/2026.		
RECOMMENDATION(S):		
It is recommended that the Audit, Risk and Assurance Committee:		
• CONSIDER the Audit, Risk and Assurance Committee Annual Report for 2025/2026 summarising the key areas of business activity undertaken; • RECOMMEND the report to the Board for the 20 May 2026 meeting.		
Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	

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ARAC Committee Annual Report
2025/26

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2025/26

1. Introduction

The Audit, Risk and Assurance Committee has been established by the Board in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

This report summarises the key areas of business activity undertaken by the Audit, Risk and assurance Committee over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

2. Roles and Responsibilities

The Terms of Reference for Committee were reviewed and agreed by the Board in March 2025.

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

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk managements arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

2.1 Membership of the Committee

The membership of the Committee during 2025/26 was:

Name	Role	Attendance
Steve Elliot	Independent Member and Chair of the Committee	5/5
Christopher Walsh	Independent Member (until 03 June 2025)	1/1
Mick Giannasi	Independent Member (from 03 June 2025)	2/4
Ronnie Alexander	Independent Member	5/5
Rhobert Lewis	Independent Member	4/5
Ian Thomas	Independent Member	5/5
Kirsty Williams	PTHB Vice Chair (Until 30 September 2025)	2/2

2.2 Others in Attendance

During 2025/26, the following staff attended the Committee:

Name	Role	Attendance
Pete Hopgood	Director of Finance, Capital and Support Services	5/5
Hayley Thomas	Chief Executive Officer	5/5
Carl Cooper	PTHB Chair	5/5
Helen Bushell	Director of Corporate Governance/Board Secretary	5/5

Other Directors and officers attended during the year to present reports which related to their areas of responsibility as required.

2.3 Meeting frequency

During 2025/26 the Committee met five times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held four times a year and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business. The Committee holds a planned additional meeting each year to review the Draft Annual Report and Accounts, this was held on 17 June 2025.

3. Activity in 2025/26

3.1 Main Areas of Committee Activity 2025/26

ITEMS FOR ASSURANCE	
Internal Audit Update and Reports (as required)	Each Meeting
External Audit Progress Report and Annual Report	May 2025 and July 2025
External Audit Update and Reports (as required)	Each Meeting
Counter Fraud Update and Reports (as required)	Each Meeting
Single Tender Waivers (including extensions to contracts) (as required)	Each Meeting
PTHB Draft Accountability Report and Financial Accounts	May 2025
Internal Audit Progress Report	May 2025 and March 2026
Audit Findings Tracker	October 2025 and March 2026
Head of Internal Audit Opinion Draft	May 2025
Welsh Health Circular (WHC) Tracker	May 2025 and March 2026
Counter Fraud Annual Report	May 2025
Information Governance Records Management and Annual Report	May 2025
Losses and Special Payments Annual Report	May 2025
Post Payment Verification Year End	May 2025 and January 2026
Head of Internal Audit Opinion Final 2024/25	June 2025
Hosted Body annual report (HCRW)	June 2025
Structured Assessment Management Response	June 2025
Confirmation of Clinical Audit Programme	July 2025
Digital First Quarterly Monitoring (including Cyber Security)	July 2025
Information Governance Toolkit (National audit replaced Caldicott Principles)	July and October 2025
Board Assurance Framework and Strategic Risk Register	July 2025 and March 2026
Learning from Annual External Audit of Accounts & Annual Report 2024/25.	October 2025
Risk and Assurance Update	October 2025

Losses and Special Payments	October 2025
Information Governance Performance Report	October 2025
Digital First Quarterly Monitoring	October 2025
SFI Executive Financial Delegation Limits	October 2025
Standards of Behaviour: Declarations / Register of Interests and Gifts and Hospitality	October 2025 and March 2026
Financial Controls	October 2025
Internal Audit Trend Report	January 2026
Assurance of Risk Management arrangements	January 2026
Digital First Annual Plan	January 2026
Approach to the Annual Accounts	March 2026
ITEMS FOR APPROVAL / RECOMMENDATION TO THE BOARD	
Committee Annual Report	May 2025
PTHB Final Accountability Report and Financial Accounts (letter of representation)	June 2025
Enquiries of Management and those charged with Governance	June 2025
Risk Appetite (Financial Sustainability)	June 2025
Losses and Special payments	March 2026
Internal Audit Annual Plan 2026/27	March 2026
External Audit Annual Plan 2026/27	March 2026
ESCALATED ITEMS	
Digital – NHS Wales App	January 2026
ITEMS FOR INFORMATION	
Information Governance and Records Management Report	January 2026
Review of Standing Orders and Standing Financial Instructions	March 2026
Committee Governance Action Plan	March 2026

IN-COMMITTEE ITEMS	
Committee Risk Register	October 2025 and March 2026
Committee Risk Register and Strategic Risk deep dive	January 2026
WCCIS Assurance Update	March 2026
CORPORATE GOVERNANCE	
Review of Committee Terms of Reference	May 2025 and March 2026
Annual Review of Committee Effectiveness	May 2025
Committee Annual Report	May 2025
Committee Annual Work Programme	May 2025
Committee Work Programme	Each Meeting
Annual Corporate Governance Development plan	July 2025

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3.2 Work programme and action log

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

4. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2025/26, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report or that are already visible in the corporate risk register.

The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board. The reporting template was developed in year and made consistent across all committees.

5. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach balancing the need to reduce pressure on staff where possible, whilst ensuring the Committee fulfils its responsibilities.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key adaptations made this year included:

- The construct of the Committee meeting agendas remained flexible, and the application of a risk-based approach to the selection of agenda items.
- The use of the consent agenda where appropriate to ensure the timeliness of information to the Committee given the fast-moving pace of some agenda areas.
- The introduction of circulation of final internal audit reports to members when received rather than with the papers to lessen the length of papers to be absorbed in the lead up to the Committee.

The Committee has undertaken its annual effectiveness review process. The outcome and recommendations following this review will be reported to the Board in May 2026.

6. Planned Activity in 2026/27

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme when it is presented to the Board in May 2025.



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Powys Teaching Health Board Glossary (Last updated February mai 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
IBG	Investment Benefit Group
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
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PMVA	Prevention and Management of Violence and Aggression
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance

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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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