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

AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC)

CONFIRMED MINUTES OF THE MEETING HELD ON 12 MAY 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		
Anne Beegan	AB	Audit Wales
David Butler	DB	Audit Wales
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Andrea Calise	AC	Internal Audit
Carl Cooper	CC	PTHB Chair (Observing)
Vicki Cooper	VC	Chief Digital Officer
Helen Grindell	HG	Health and Care Research Wales
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
Neil Jones	NJ	Counter Fraud
Tomos Jones	TJ	Audit Wales
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Debra Wood-Lawson	DWL	Executive Director of People, Culture and Transformation
Beth Powell	BP	Corporate Governance & Risk and Assurance Officer
Sarah Pritchard	SP	Assistant Director of Finance
Hywel Pullen	HP	Deputy Director of Finance
Hayley Thomas	HT	Chief Executive
Ian Virgil	IV	Head of Internal Audit
APOLOGIES FOR ABSENCE:		
Amanda Legge	AL	NWSSP
Sue Tillman	ST	NWSSP

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/26/001)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (ARA/26/002)

HB declared that an annual declaration was made each year in conjunction with discussions of the annual accounts. It was noted that the report included provisions relating to the remuneration of both Executive Members and Independent Members.

2. CONSENT AGENDA BUSINESS

The Chair asked Members if they wished to bring forward any items from the Consent agenda to the main agenda. No items were raised.

3. ITEMS FOR APPROVAL / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (ARA/26/003)

The minutes of the meeting held on the 10 March 2026 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (ARA/26/004)

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

- ARA/25/090 (Audit related Assurance activity) was on track to be achieved and recommended for Completion in July.
- It was agreed that the remaining ten actions were closed.

The Chair experienced technical difficulties during the meeting. Consequently, MG, acting as Vice Chair, assumed responsibility for chairing the meeting.

The Committee expressed the need for the action log to provide further assurance in some areas when actions are recommended to be closed, particularly where assurance is gained outside formal meetings. Further discussion on this would be scheduled at the next PTHB Chairs Forum.

3.3 EXTERNAL AUDIT ANNUAL PLAN 2026/2027 (ARA/26/005)

MJ introduced the report and highlighted the following:

- A risk was identified relating to the organisation not breaking even, with implications for the regularity opinion.
- The disputed Wye Valley Trust invoice was highlighted as an area of focus, including its accounting treatment.
- The remuneration report was identified as a key audit area due to changes and a low materiality threshold.
- CHC accruals were noted as an area of attention, reflecting issues identified in the previous year, these areas form part of the audit plan.

Independent Members sought assurance by Asking the following questions:

Was any potential for the matter of the Wye Valley invoice to be resolved or whether it was likely to remain outstanding indefinitely?

The organisation's position remained clear and the charge relating to the Wye Valley invoice was considered invalid and lacked sufficient substantiation. All reasonable actions had been taken to resolve the matter. While there was a desire to bring the issue to a conclusion, the organisation maintained its position regarding the invalidity of the charge.

Clarification was sought as to whether the Workforce Planning Arrangements follow up, take account of subsequent developments, including the "Better Together" programme, and its impact on workforce planning?
BH confirmed that the follow-up work would review the original recommendations to assess whether the root causes had been addressed. Additional recommendations would be made to reflect the current environment.

Was the programme intended to generate new insights and actionable opportunities to support organisational improvement?
The financial audit work focused on the review of accounts for the relevant period. The follow-up review of workforce planning was considered timely, given ongoing organisational developments and the need for a resilient workforce. This work was intended to support the Health Board in progressing its strategic objectives.

The Committee **RECEIVED** the External Audit Plan 2026/2027.

4. ESCALATED ITEMS

There were no items for inclusion in this section.

5. ITEMS FOR ASSURANCE

5.1 DRAFT ACCOUNTABILITY REPORT AND FINANCIAL ACCOUNTS (ARA/26/006)

PH introduced the report and highlighted the following key themes:

- Key performance targets had not been met, including the duty to break even.
- The revenue resource limit had been exceeded, resulting in a deficit of £33.275 million.
- The capital resource limit had been achieved, with a surplus of £74,000 recorded for the year.
- Total operating expenditure over the three years was £1.4 billion against a revenue allocation of £1.3 billion.
- Capital expenditure totalled £29.2 million against an allocation of just under £29.4 million.
- Ongoing challenges were identified in relation to agency and CHC invoices, with actions in place to improve performance.
- CHC expenditure increased by £5.7m, alongside additional spend on complex mental health placements with private providers.
- Hospital and community expenditure remained largely unchanged.

PH confirmed that the organisation remained a concern, supported by the submission of the 2026/27 annual plan and receipt of the Welsh Government funding allocation. Ongoing partnership working with the local authority was noted, including delivery of the joint Health and Wellbeing Strategy. Operating costs, after accounting for income and

other adjustments, increased to £504 million, reflecting a significant increase in the cost of delivering health services.

Independent Members sought assurance by asking the following questions:
What were the reasons regarding the decline in performance compared to the previous year?
SP explained that a deterioration had been experienced in continuing healthcare (CHC) invoice processing due to high volumes. Additional administrative capacity had been introduced later in the year to address the issue. Continued focus would be required to sustain progress, with confidence expressed that performance would improve and meet targets in the 2026/27 financial year.

Was the level of effort needed to reach the 95% target proportionate to the benefits, despite its relative significance compared to broader financial balance objectives?
SP acknowledged that achieving the 95% target was challenging due to the small margin for error, with even a few delayed invoices impacting performance. Efforts were focused on addressing common delays, while recognising that necessary validation checks add complexity. Despite this, improving performance remained a priority, with ongoing actions to strengthen processes and meet Welsh Government expectations.

HB introduced The Accountability Report and highlighted multi-team contributions and confirming its timely draft submission to Welsh Government and auditors. It was noted that feedback from members would be incorporated, with a revised version to be presented at the next meeting in June.

The Committee provided feedback as to whether future reports could be strengthened to include clearer articulation of the level of assurance obtained, particularly in relation to financial recovery, and how governance arrangements had evolved over the year to respond to emerging challenges. It was acknowledged that further consideration would be given to how this could be developed in future years, taking into account available resources.
The Committee **CONSIDERED** the draft Annual Accountability Report 2025/26 and provided feedback to inform the development of the final draft.

(10:49 HP left the meeting, SE resumed chairing the meeting)

5.2 DRAFT HEAD OF INTERNAL AUDIT OPINION (ARA/26/007)

IV provided an overview of the Draft Head of Internal Audit Opinion and summarised the work completed during the year. A draft opinion of “reasonable assurance” was issued, supported by the majority of completed audits, with four audits still in progress and not expected to significantly impact the final opinion. It was noted that the final opinion would

be confirmed for the June Committee and included within the Annual Governance Statement (AGS). Thanks were noted to the Health Board, Executive Directors, management and the teams that have supported the delivery of audit work through the year.

Independent Members sought assurance by asking the following questions:
Were there any risks to the overall audit opinion for the Health Board, should the outstanding audits not achieve at least a Reasonable Assurance rating?
IV advised that it was not anticipated that less favourable outcomes from the outstanding audits would materially impact the Health Board's overall audit opinion, although this could not be confirmed definitively at this stage. Further analysis of recurring themes would be undertaken and reported back to the Committee as part of a future internal audit overview.

Committee members emphasised that future focus should be on continuous improvement, particularly in progressing from reasonable to substantial assurance. It was also suggested that additional clarity be provided in relation to audits not completed within the year and not carried forward, to further strengthen the report. Appreciation was expressed to the audit team for their work.

The Committee **NOTED** the Draft Head of Internal Audit Opinion and Annual Report for 2025/26 and **NOTED** the final opinion would be confirmed for the June Committee and included within the Annual Governance Statement.

5.3 BOARD ASSURANCE POLICY, RISK MANAGEMANET POLICY AND RISK APPETITE (ARA/26/008)

HB provided the committee with an overview of the three documents and noted that an annual review had been undertaken following the introduction in May 2025. It was recommended that the Board Assurance Policy and Risk Management Policy remain in place for a further two years, subject to any required changes.

It was noted that internal audit findings provided reasonable assurance overall, with substantial assurance reported for the Board Assurance Framework. HB highlighted the proposal that the overall organisational risk appetite be set at an "open" level, while recognising that individual risk categories would continue to be applied as appropriate.

Independent Members sought assurance by asking the following questions:
How consistent was application of the Risk Management Framework ensured across the organisation and what was the practical arrangements for monitoring compliance, including the quality assurance processes in place?
HB confirmed that a structured rollout was in place to support the consistent application of the Risk Management Framework, including training programmes and the development

of toolkits. Operational risks were monitored through the Operational Leadership Group, with Executive Directors retaining accountability. Technical issues affecting the risk recording system had been resolved, enabling improved oversight of risks.

How would the effectiveness of the Board Assurance Framework be evaluated over time and what indicators would demonstrate that it was improving organisational oversight, strengthening assurance, and providing better insight compared to previous arrangements?
HB explained that limited movement was typically expected in strategic risks, with greater change anticipated at the operational level. A key indicator of effectiveness would be the increasing integration of risk into routine discussions, with risk becoming a normalised and embedded element of Board and Committee agendas and decision-making.

The Committee discussed the adoption of a more open risk appetite and sought assurance that, in practice, controls and systems remained sufficiently robust to ensure that risks were actively managed. The approach reflected a deliberate and controlled position. It was noted that further development was required in relation to the practical application of risk appetite. However, it was recognised that further reflection was needed to fully consider the implications of risk appetite in practice.

How does the Health Board manage risks associated with external contractors, including ensuring alignment with organisational risk frameworks and addressing wider risks such as safeguarding?
It was noted that appropriate controls and frameworks were in place however, further review was required to ensure consistency and a fully integrated approach. It was agreed that this would be considered outside of the meeting.

The Committee **RECOMMENDED** CGP 005 Risk Management Framework and CGP 014 Board Assurance Framework to the Board for approval, and;
RECEIVED and **ENDORSED** the revised Board's Risk Appetite Statement for onwards consideration for approval by the Board in May 2026.

(11:00 AS joined the meeting)

5.4 COUNTER FRAUD ANNUAL PLAN AND UPDATE (ARA/26/009)

NJ provided an overview of the report and explained that unforeseen staffing challenges had impacted delivery of the previous year's Counter Fraud work plan, although active investigations in Powys were now being progressed. The following key themes were highlighted:

- It was noted that improvement actions would focus on strengthening investigation processes, enhancing fraud risk assessments, and developing a more robust counter fraud strategy.

- A new national fraud prevention platform was due to be introduced to support real-time data analysis, improve system resilience, and enable proactive identification and prevention of fraud risks.
- The 2026/27 work plan would aim to improve assurance ratings, consolidate previous progress, and further embed a counter fraud culture across the organisation.
- A key priority would be identifying emerging and previously unknown fraud risks and strengthening collaboration with partner organisations.

Concern was raised regarding the insufficient level of counter fraud resource achieved in the previous year. PH noted that, in light of the challenges faced, regular meetings had taken place. Ongoing mitigation actions, and performance improvement measures were being actively monitored through these arrangements.

The Committee:

- **RECEIVED** the update report and took **ASSURANCE** that appropriate counter fraud systems were in place;
- **APPROVED** the Counter Fraud Annual Report 2024/25 and;
- **APPROVED** the Counter Fraud Work Plan 2026/27.

(11:15 RA left the meeting
11:17 KW joined the meeting)

5.5 INFORMATION GOVERNANCE TOOLKIT (ARA/26/010)

AS provided an overview of the report and explained that the Health Board was currently assessed as not meeting minimum expectations, with two key areas outstanding:

- Progress was noted on the data quality policy, which was in draft and expected to be finalised and approved in Quarter 3.
- Training compliance remained below the 85% national standard, with actions underway to improve uptake, including enhanced induction, targeted communications, and potential national changes to training delivery.

Independent Members sought assurance by asking the following questions:
What were the implications of not meeting minimum expectations?
It was confirmed that the Health Board remained compliant from a legal and legislative perspective. It was noted that the outstanding data quality policy had been carried forward from a previous submission and was now being progressed, with plans in place to ensure its completion.

A further query was raised as to Was the level of effort required to meet expectations seen proportionate, particularly where some requirements may be outside the organisation's control or challenging to achieve in practice?

AS explained that training compliance had declined in line with a wider national trend, with challenges in ensuring new starters completed training on time. Actions were being implemented, including induction-based training, to improve compliance.

The Committee took **ASSURANCE** from the Health Board's 2025-26 Information Governance toolkit submission and performance against data protection legislation and regulator recommendations.

5.6 FINANCE GRIP AND CONTROL (ARA/26/011)

PH provided a summary of the report which included non-workforce controls, monitoring, and governance arrangements. A separate assessment of workforce controls was reported to the People and Culture Committee which were rated as green, indicating a strong position. Overall, the position was positive, with further improvements planned to enhance control effectiveness.

Independent Members sought assurance by asking the following questions:
How frequently was budget holder training refreshed, particularly to ensure knowledge remains current over time?
PH acknowledged that the frequency of refresher training for budget holders would be reviewed, and a written update would be circulated to the Committee. It was noted that strengthening budget holder training remained an area of ongoing focus, particularly in the context of financial recovery.
Action: Executive Director of Finance, Capital and Support Services

How effective was the Investment Benefits Group seen, specifically how often proposals were challenged or declined?
PH explained that the Investment Benefits Group provided assurance on the quality and completeness of business cases prior to approval, with proposals often requiring refinement before progression. The Group also monitored benefits realisation and had strengthened its focus on identifying and reviewing areas where expected benefits had not been achieved.

What progress had been made in implementing consistent contract management and procurement training across NHS Wales?
PH confirmed that contract management and procurement training at a national level formed part of the wider training agenda. It was agreed that further consideration would be given to this area, with clarification to be provided on any national developments or actions.

The Committee noted the positive green assurance rating for cost control but sought reassurance on its alignment with the organisation's structural deficit and financial pressures. Clarification was requested on the exclusion of key high-cost areas, PH

confirmed that the assessment followed national criteria and that these areas remained subject to local oversight and ongoing improvement actions, with the deficit recognised as a separate strategic issue from day-to-day expenditure controls.

The Committee **RECEIVED** the report and took **ASSURANCE** that controls were in place across non-workforce cost areas, with clear governance, active oversight and targeted grip in higher-risk areas.

5.7 HOSTED BODY ANNUAL REPORT (ARA/26/012)

HG joined the meeting. DWL provided a high-level summary of the report.
Independent Members sought assurance by asking the following questions:

Had any challenges been presented of the alignment with the Health Board responsibilities and governance arrangements given the expanded role of Health and Care Research Wales?
It was noted that progress in expanding activity beyond NHS settings had been limited, with appropriate indemnity arrangements in place; however, the position would continue to be monitored.
Was the accountability framework seen as sufficiently clear to manage emerging risks and was there clear understanding and definition of accountability should issues arise?
It was confirmed that accountability arrangements were currently clear and supported by existing agreements; however, it was noted that these would need to be kept under review as the function developed, with potential for future revision if the scope expanded.

The Committee **RECEIVED** the hosted body annual assurance report for Health & Care Research Wales (HCRW) and took **ASSURANCE** that the hosting agreement was being managed appropriately by both host and hosted body.

5.8 INTERNAL AUDIT PROGRESS REPORT 2025/2026 (ARA/26/013)

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 four audit reports had been finalised since the previous Committee meeting. It was further reported that 17 of the planned 21 audits had been completed to date, the remaining four expected to be finalised in time for presentation to the June Committee meeting.

Independent Members sought assurance by asking the following questions:
What were the reasons for the delay in receiving the management response to the asbestos management report, noting that it had been due in mid-March but was not received until 1 May?
The delay was due to the need to address initial queries arising from the draft report, including resolving data discrepancies. The delay also reflected the complexity of the area and it was identified as an area for further internal reflection and improvement.

The Committee recognised that a balance was required between maintaining appropriate oversight and avoiding excessive focus on operational detail. Assurance was provided that statutory compliance areas were monitored through established groups. It was acknowledged that there was scope to enhance reporting to provide greater clarity. The importance of aligning estate strategy with wider organisational programmes was highlighted, with a focus on ensuring a joined-up approach going forward.

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

5.9 INTERNAL AUDIT REPORTS (ARA/26/014)

DB introduced the items and provided a summary of the following reports:

a) **North Powys Integrated Wellbeing Hub (Reasonable Assurance)**

What was the rationale for assigning a Reasonable Assurance rating and what actions were required to achieve a higher level of assurance?

DB explained that the programme was progressing with Welsh Government approval but lacks full cost certainty and some key details at this stage. The Reasonable Assurance rating reflects remaining gaps and the need to strengthen controls, rather than concerns about overall direction.

Could more detailed and comprehensive management responses be provided, reflecting the significance of the programme?

The management responses were reviewed and approved by both the Health Board and audit leads, and were considered appropriate given the programme's stage. Some recommendations were retrospective and aimed at improving future stages and programmes. While the responses could be strengthened, they were deemed acceptable overall.

There was acknowledgement of the challenge in achieving substantial assurance in a complex, fast-paced environment, with a commitment to reflect further. It was also emphasised that progress towards higher assurance should be tracked to ensure the desired position was reached.

b) **Risk Management & Assurance (Reasonable Assurance)**
c) **Asbestos Management (Reasonable Assurance)**

Was there a trigger point from a general survey which would bring in a more specialist survey in terms of asbestos?

DB responded that asbestos surveys are required at different stages under regulations and should be carried out regardless. If asbestos was identified during a general survey or works, it triggers further inspections and necessary follow-up actions.

d) **Mattresses Follow-up. (Not Rated)**

IV provided a summary of the follow-up review of the previous limited assurance mattresses audit, which found that all seven identified actions (including five high-priority ones) have now been fully implemented by the Health Board.

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

(12:19 AC, CC, VC and DB left the meeting
12:30 PH joined the meeting)

5.10 EXTERNAL AUDIT PROGRESS REPORT (ARA/26/015)

AB provided a summary of the report and highlighted that the urgent and emergency care review report on managing demand had now been finalised and would be presented at the next meeting in June alongside the agency report.

Members' attention was also drawn to the Regional Integration Fund follow-up report. This included a recommendation relating to the scrutiny of Partnership Boards by Health Boards and local authorities. Members were encouraged to review the report and consider whether it should be brought back to the Committee for further discussion. It was noted that the report should be shared with the Vice Chair to ensure awareness of the recommendation and its implications. It was suggested that, in addition to members reviewing the report, consideration be given to whether a formal process was needed to address and follow up the recommendation.

Action: Director of Corporate Governance

The Committee **RECEIVED** and **DISCUSSED** the External progress Report.

(12:38 PH left the meeting)

5.11 EXTERNAL AUDIT REPORTS (ARA/26/016)

BH provided an overview of the following Audit Reports and outlined the current position.

- **Digital Transformation**

Was there sufficient capacity to address the number of recommendations given other key digital priorities?

CM responded that funding for the programme had not yet been confirmed and may necessitate revisions at a later stage. However, consideration had been given to current capacity constraints, and timescales had been set accordingly to reflect the need to prioritise other work in the short term. While the proposed timelines were considered realistic, it was acknowledged that time and capacity remain ongoing challenges.

Committee members recognised the significant gaps across key areas and raised concern around whether there was sufficient capacity to deliver it, with assurance lacking a clear, systematic approach. It was noted that the service was maintaining essential operations while progressing its digital strategy, but must remain flexible due to shifting priorities,

financial pressures, and capacity constraints, with a longer-term focus on building organisational capability rather than just delivering digital projects.

The committee agreed that further discussion with colleagues was needed to ensure the approach was appropriate, particularly in light of the overall organisational risk. It was agreed there was a need to identify any gaps and determine what further work was required.

- **Quality Governance Follow-up**

How would the proposed commissioned provider performance measures align with existing metrics and reporting arrangements and how would duplication be avoided?
PH explained that the aim was to strengthen assurance of commissioned services by enhancing how quality and safety information was collected from providers. This includes developing templates to support the commissioning framework and contracts, to enable consistent data collection and better scrutiny to ensure care standards were met.

- **Structured Assessment Management Response**

HB explained that the Structured Assessment report was presented in May, the management responses had been slightly delayed following ongoing discussions with Audit Wales and internal colleagues. All actions except one had been accepted and were either complete or in progress, with one partially accepted recommendation relating to the presentation of strategic and annual plan objectives.

The Committee **RECEIVED** and **DISCUSSED** the External Audit Reports.

5.12 SINGLE TENDER WAIVERS AND ANNUAL REPORT (ARA/26/017)

SP provided a summary of the report and outlined that although single tender waiver use increased in 2025/26, overall volumes remain low and not significant, with limited ability to identify trends due to their typically unique nature.

Committee members raised concern around the use of single tender waivers for Health and Care Research Wales, noting unease due to their contribution to the recent increase, and highlighting the need for ongoing monitoring.

Why was a contract specification and formal tender process not being used for this, particularly if it was a recurring requirement, rather than relying on more ad hoc arrangements except in urgent situations?
SP responded that clarification would be sought and reported back to the Committee, as the current arrangement appeared to be a short-term single tender waiver, possibly due to a gap between frameworks. Assurance would be obtained from procurement and the

service to confirm the rationale, particularly as a new framework was expected later in the year.

Action: Director of Finance, Capital and Support Services

The Committee:

- **NOTED** there had been three Single Tender Waiver requests made between 1 March 2026 to 31 March 2026;
- RECEIVED the report covering the period 2020/21 to 2025/26 and;
- took **ASSURANCE** that appropriate reporting mechanisms were in place.

5.13 LOSSES AND SPECIAL PAYMENTS ANNUAL REPORT (ARA/26/018)

SP introduced the report and explained that members had previously reviewed key elements during the year, and the report confirmed that most payments related to clinical negligence and personal injury, managed under the scheme of delegation, with all payments now formally notified.

Independent Members sought assurance by asking the following questions:

What processes were in place to identify and learn from avoidable losses, and how were lessons learned used to inform improvements?

SP explained that learning from losses and special payments was addressed through established processes, including oversight by legal and risk advisors. Trends in areas such as clinical negligence were reviewed through relevant committees, with additional detailed updates provided to the Executive Team where necessary.

The Committee **RECEIVED** the Interim Report on Losses and Special payments covering the period 01 April 2025 to 31 March 2026.

5.14 PTHB POLICIES AND WRITTEN CONTROL DOCUMENTS (ARA/26/019)

HB introduced the report and highlighted to committee that it was in its early stages and would continue to develop. The report reflected ongoing work to strengthen policy and control document management, including new systems, processes, and guidance. The report identified that 68% of policies were in date, while 31% have expired but were subject to risk assessment, with higher-risk items prioritised for update. Further insight into policy management processes would be presented at a future meeting.

When was it expected to see a clear, structured timeline showing when expired policies would be updated and how overall compliance would improve, and how would this be tracked?

HB agreed that a clear trajectory could be provided, both at an individual policy level and across the overall report.

What assurance was there that risk assessments by departments were applied consistently and rigorously?
HB explained that risk assessments were currently undertaken by policy authors, reviewed by executive leads. While this provided a level of assurance, it was acknowledged that the approach could be further strengthened.

What was the rationale for the high-risk overdue policy for 'Missing Persons' being overdue and what was being done to address it urgently?
HT noted that further discussion would be taken to Executive Committee to review whether timescales for policy updates reflect the assessed level of risk. Concern was raised that higher-risk policies were not clearly prioritised within the current timelines, including the overdue Missing Persons Policy. It was acknowledged that ownership of this policy has historically sat within the Mental Health Directorate rather than corporately, and this would be addressed. Assurance was provided that the phasing and prioritisation of actions would be revisited, with a focus on ensuring that high and medium-risk policies were addressed as a priority.
Action: Director of Corporate Governance

The Committee:

- **CONSIDERED** the position (as at end March 2026) of Policies and Written Control Documents;
- **DISCUSSED** the current position of Policies and Written Control Documents with a particular focus on those Policies given High Priority ratings and;
- took **ASSURANCE** that the organisation has an appropriate system for tracking and reviewing these documents.

6 ITEMS FOR DISCUSSION (ARA/26/020)

There were no items for discussion.

7 CONSENT AGENDA (ARA/26/021)

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

- **FOR ASSURANCE:**
  - **7.1** Post Payment Verification Year End
  - **7.2** Annual Audit Summary 2025
  - **7.3** Annual Committee Work Programme 2026/27
  - **7.4** Committee Annual Report
- **FOR INFORMATION:**
- **7.7** PTHB Glossary

8 OTHER MATTERS

8.1 ANY OTHER BUSINESS (ARA/26/022)

No other business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (ARA/26/023)

No items were raised
8.3 COMMITTEE REFLECTIONS (ARA/26/024)
The following feedback was noted: • Thanks were expressed to the Vice Chair for stepping in due to technical issues. • Themes of good governance and maturing frameworks recognised. • Consideration to be given to driving towards substantial assurance ratings
8.4 DATE OF NEXT MEETING (ARA/26/025)
23 June 2026 via Microsoft Teams
8.5 CONFIDENTIAL MATTERS
The following motion was passed: ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***

Meeting closed at 13:06.