

# Audit Risk & Assurance Committee

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

## Agenda

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

0 min


 Agenda\_ARAC\_13JAN2026 (2).pdf (3 pages)

#### **1.1. Welcome and Apologies**

*Verbal*          *Chair*

#### **1.2. Declarations of Interest & Board Members Register of Interests**

*Verbal/Attached*          *All*

 ARA\_1.2\_Board Members Declarations of Interest 2025 (1).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/RATIFICATIONS/DECISION**

0 min

#### **3.1. Minutes of the meeting held on the 07 October 2025**

*Attached*          *Chair*

 ARA\_3.1\_ARAC Minutes 07OCT25 (1).pdf (12 pages)

#### **3.2. Committee Action Log**

*Attached*          *Chair*

 ARA\_3.2\_Action Log 2025-2026.pdf (1 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. Internal Audit Progress Report 2025/2026**


*Attached*          *Head of Internal Audit*

 ARA\_5.1\_Internal Audit Progress Report January 26 Cover (1).pdf (2 pages)

 ARA\_5.1a\_Internal Audit Progress Report January 26 (1).pdf (12 pages)

#### **5.2. Internal Audit Reports: Digital Systems Uptake, Continuing Healthcare, Mental Health and Learning Disability Triage and Assessment process, Core Financials, Decontamination**

*Attached*          *Head of Internal Audit*

 ARA\_5.2a\_Digital System Uptake Final Internal Audit Report (1).pdf (10 pages)

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- 📄 ARA\_5.2b\_Continuing Healthcare Final Internal Audit Report (1).pdf (10 pages)
- 📄 ARA\_5.2c\_MH and LD Triage and Assessment Process Final Internal Audit Report (1).pdf (11 pages)
- 📄 ARA\_5.2d\_Core Financials Final Internal Audit Report (1).pdf (12 pages)
- 📄 ARA\_5.2e\_Decontamination Final Internal Audit Report (1).pdf (11 pages)

### 5.3. Internal Audit Trend

*Attached Head of Internal Audit*

- 📄 ARA\_5.3a\_Internal Audit Trend and Themes Presentation.pdf (12 pages)

### 5.4. External Audit Progress Report

*Attached External Audit*

- 📄 ARA\_5.4\_Audit Wales Report Update January 2026 (1).pdf (12 pages)

### 5.5. Counter Fraud update

*Attached Head of Local Counter Fraud*

- 📄 ARA\_5.5\_Counter Fraud Update Report 2026.pdf (4 pages)

### 5.6. Assurance of Risk Management arrangements

*Attached Director of Corporate Governance*

- 📄 ARA\_5.6\_Risk Management and Assurance arrangements (1).pdf (7 pages)
- 📄 ARA\_5.6a-Appendix A - SRR 012 Annual Review of Strategic Risk Assurance.pdf (2 pages)

### 5.7. Post Payment Verification Year End Report 2024/2025

*Attached Executive Director of Primary, Community Care and Mental Health Services*

- 📄 ARA\_5.7\_Mid Year PPV report April 1st to 30th September 2025.pdf (4 pages)
- 📄 ARA\_5.7a\_PTHB Mid-year PPV Report 2025-2026.pdf (5 pages)

### 5.8. Digital First Annual Plan

*Attached Executive Director of Allied Health Professions, Health Science and Digital*

- 📄 ARA\_5.8\_Digital Strategic Framework Annual Report Year 2 Cover paper Jan 2026.pdf (5 pages)
- 📄 ARA\_5.8a\_Digital\_Strategic\_Framework\_Annual\_Report\_25\_26 Final.pdf (24 pages)

### 5.9. Single Tender Waivers (including extensions to contracts)

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

- 📄 ARA\_5.9\_Single Tender Waiver Report Jan 2026.pdf (3 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. Substantial Assurance Internal Audit Reports: Primary Care Clusters Project Management Final Report and Staff Development Programme Final Report

*Attached Head of Internal Audit*

- 📄 ARA\_7.1a\_Primary Care Clusters Final Internal Audit Report (1).pdf (8 pages)
- 📄 ARA\_7.1b\_Staff Development Programme Final Internal Audit Report (1).pdf (8 pages)

### 7.2. Information Governance & Records Management Report


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*Attached*                      *Director of Corporate Governance*

 ARA\_7.2\_IG and RM Key Performance Report Q2 25-26 - FINAL (2).pdf (15 pages)


### **7.3. Committee Work Programme 2025/2026**

*Attached*                      *Director of Corporate Governance*

 ARA\_7.3\_Work Programme 25-26.pdf (2 pages)

### **7.4. PTHB Glossary**

*Attached*                      *Director of Corporate Governance*

 ARA\_7.4\_Powys Teaching Health Board Glossary.pdf (6 pages)

## **10:00 - 10:00 8. OTHER MATTERS**

0 min

### **8.1. Any Other Urgent Business**

*Verbal*                      *Chair*

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

*Verbal*                      *Chair*

### **8.3. Committee Reflections**

*Verbal*                      *All*

### **8.4. Date of next meeting: 10 March 2026 via Microsoft Teams**

### **8.5. CONFIDENTIAL In-Committee**

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:

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# AUDIT, RISK AND ASSURANCE COMMITTEE

**TUESDAY 13 JANUARY 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
	<b>1</b>	<b>PRELIMINARY MATTERS</b>		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest <ul style="list-style-type: none"><li>Board Members Register of Interests</li></ul>	Verbal/ Attached	All
	<b>2</b>	<b>CONSENT AGENDA BUSINESS</b>		
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.				
	<b>3</b>	<b>ITEMS FOR APPROVAL / DECISION / RATIFICATION</b>		
	3.1	Minutes of previous meeting held on 07 October 2025	Attached	Chair
	3.2	Committee action log	Attached	Chair
	<b>4</b>	<b>ESCALATED ITEMS</b>		
There are no items for inclusion within this section				
	<b>5</b>	<b>ITEMS FOR ASSURANCE</b>		
10:05 5	5.1	Internal Audit Progress Report 2025/2026	Attached	Head of Internal Audit
10:10 45min	5.2	Internal Audit Reports: <ul style="list-style-type: none"><li>Digital Systems Uptake (<i>Limited Assurance</i>)</li><li>Continuing Healthcare (<i>Reasonable Assurance</i>)</li><li>MH&amp;LD Triage &amp; Assessment process (<i>Reasonable Assurance</i>)</li><li>Core Financials (<i>Reasonable Assurance</i>)</li><li>Decontamination (<i>Reasonable Assurance</i>)</li></ul>	Attached	Head of Internal Audit
10:55 20 min	5.3	Internal Audit Trend Report	Attached	Head of Internal Audit
11:15 5min	5.4	External Audit Progress Report	Attached	External Audit
11:20	<b>COMFORT BREAK (10mins)</b>			
11:30 10	5.5	Counter Fraud Update & Reports	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services

11:40 20	5.6	Assurance of Risk Management arrangements	Attached	Director of Corporate Governance
12:00 5	5.7	Post Payment Verification Year End report 2024/25	Attached	Executive Director of Primary, Community Care and Mental Health Services
12:05 15	5.8	Digital First Annual Plan	Attached	Executive Director of Allied Health Professions, Health Science and Digital
12:20 5	5.9	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
	<b>6</b>	<b>ITEMS FOR DISCUSSION</b>		
There are no items for inclusion within this section.				
	<b>7</b>	<b>CONSENT AGENDA</b>		
	7.1	(Substantial Assurance) Internal Audit Reports: <ul style="list-style-type: none"> <li>Primary Care Clusters Project Management Final Report</li> <li>Staff Development Programme Final Report</li> </ul>	Attached	Head of Internal Audit
	7.2	Information Governance & Records Management Report	Attached	Director of Corporate Governance
	7.3	Committee Work Programme 2025/26 (For Information)	Attached	Director of Corporate Governance
	7.4	PTHB Glossary (For Information)	Attached	Director of Corporate Governance
	<b>8</b>	<b>OTHER MATTERS</b>		
12:20	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: 10 March 2026 Microsoft Teams		
<p>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:</p> <p><u>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</u></p> <p><b>"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"</b></p>				
12:25	8.6	Welcome and Apologies	Verbal	Chair

	8.7	Declarations of Interest	Verbal	All
12:30 20	8.8	Committee Risk Register and Strategic Risk deep dive <ul style="list-style-type: none"> <li><i>SRR011 - Failure of Digital &amp; Electrical Infrastructure</i></li> </ul>	Presentatio n	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](mailto:PowysDirectorate.CorporateGovernance@wales.nhs.uk) at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.**

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

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

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**POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26** **Updated: November 2025**

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned
<b>INDEPENDENT MEMBERS</b>								
<b>PTHB Chair</b>	<b>Carl Cooper</b>	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Vale University Health Board (non Director).	Nil	
<b>Vice Chair</b>	<b>Kirsty Williams</b>	Non Financial personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025.  Left the Health Board on 30 September 2025
		Non Financial personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsidiary of Cardiff University	None	
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Financial personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
<b>Independent Member (General)</b>	<b>Rhobert Lewis</b>	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
<b>Independent Member (Trade Union)</b>	<b>Cathie Poynton</b>	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
<b>Independent Member (finance)</b>	<b>Steve Elliot</b>	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
<b>Independent Member (General)</b>	<b>Ronnie Alexander</b>	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Partner-Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
<b>Independent Member (University)</b>	<b>Simon Wright</b>	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Variou Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
<b>Independent Member (Third Sector)</b>	<b>Jennifer Owen Adams</b>	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	07.02.2025	09.02.2028	PAVO-Vice Chair	None	

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		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	10/06/2025
		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	
<b>Independent Member (Local Authority)</b>	<b>Christopher Walsh</b>	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL	
<b>Independent Member (Capital)</b>	<b>Michael Giannai</b>	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
<b>Independent Member</b>	<b>Ian Thomas</b>	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	NIL	09/04/2025
<b>EXECUTIVE MEMBERS</b>								
<b>Chief Executive Officer</b>	<b>Hayley Thomas</b>	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
<b>Executive Director of Finance, Capital and Support Services</b>	<b>Pete Hoggood</b>	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
<b>Executive Director of Allied Health Professions, Health Science and Digital</b>	<b>Claire Madsen</b>	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
<b>Executive Director of Nursing, Quality, Women and Family Health</b>	<b>Claire Roche</b>	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025 Left the Health Board on 10 October 2025
		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery		
<b>Executive Medical Director</b>	<b>Kate Wright</b>	Non-Financial professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025

<b>Executive Director of People and Culture</b>	<b>Debra Wood Lawson</b>	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated	29/05/2025
			Outside Employment	01-Sep-25	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL	
<b>Executive Director of Public Health</b>	<b>Mererid Bowley</b>	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	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
<b>Director of Corporate Governance/ Board Secretary</b>	<b>Helen Bushell</b>	Non-Financial professional Interest	Outside Employment	Nov-21	Current	Self - School Governor - Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Partner - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
<b>Director of Strategic Improvement and Transformation</b>	<b>Lucie Cornish</b>	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
<b>Executive Director of Planning, Performance &amp; Commissioning</b>	<b>Nicola Johnson</b>	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
<b>Executive Director of Primary, Community Care and Mental Health</b>	<b>Elaine Lorton</b>	Financial Interests	Outside Employment	Apr-24	Current	Independent Member - ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	
<b>Executive Director of Nursing, Quality, Women and Family Health</b>	<b>Paul Hooton</b>	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	Nil	25/10/2025 Started with PTHB October 2025

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CYMRU  
NHS  
WALES**

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Powys Teaching  
Health Board

## AUDIT, RISK AND ASSURANCE COMMITTEE

### UNCONFIRMED MINUTES OF THE MEETING HELD ON 07 OCTOBER 2025 AT 10:00 VIA MICROSOFT TEAMS

<b>MEMBERS</b>		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ian Thomas	IT	Independent Member (General)
Ronnie Alexander	RA	Independent Member (General)
Rhobert Lewis	RL	Independent Member
<b>IN ATTENDANCE</b>		
Pete Hoggood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Hywel Pullen	HP	Deputy Director of Finance
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Stacey Jones	SJ	Finance Business Partner (Observing)
Anne Beegan	AT	Audit Wales
Sarah Pritchard	SP	Head of Financial Services
Stella Gwynne	SG	Deputy Board Secretary
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Louisa Steele	LS	Counter Fraud
Ian Virgil	IV	Head of Internal Audit
Matthew Evans	ME	Counter Fraud
Carl Cooper	CC	PTHB Chair
<b>APOLOGIES FOR ABSENCE:</b>		
Hayley Thomas	HT	Chief Executive
Bethan Hopkins	BH	Audit Wales
Mick Giannasi	MG	Independent Member
Kirsten Jones	KJ	Llais

## 1. PRELIMINARY MATTERS

### 1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/044)

The Chair welcomed everyone to the meeting, in particular those members who were in attendance observing the meeting. Apologies for absence were received as recorded above.

## **1.2 DECLARATIONS OF INTEREST (ARA/25/045)**

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

## **2. CONSENT AGENDA BUSINESS (ARA/25/046)**

No items were requested for inclusion in the main agenda.

## **3. ITEMS FOR APPROVAL/DECISION/RATIFICATION**

### **3.1 MINUTES OF THE PREVIOUS MEETING HELD ON 08 JULY 2025 (ARA/25/047)**

The minutes of the meeting held on 08 July 2025 were **CONFIRMED** as an accurate record.

Members asked whether the Co-pilot platform had been utilised to support with minute taking across Committees and whether the platform had been beneficial to staff. It was noted that Co-pilot was being tested across the Corporate Governance directorate, however due to a limited number of licenses purchased not all Committee minutes were being produced with AI at the time of the meeting. Shared experiences of using the platform would be fed back to Board members after an appropriate pilot period.

Members raised the utilisation of hot desks by other organisations and whether there were cost implications. This would be checked and confirmed to members.

### **3.2 COMMITTEE ACTION LOG (ARA/25/048)**

The Committee **RECEIVED** the action log, and the following updates were provided: **ARA/25/032** - Work was underway and remains on track for completion by January 2026.

## **4 ESCALATED ITEMS**

There were no items for inclusion within this section.

## **5 ITEMS FOR ASSURANCE**

### **5.1 INTERNAL AUDIT PROGRESS REPORT 2025/2026 (ARA/25/049)**

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

- One audit had been finalised,
- Two were in draft,
- Five were in progress,
- Eight were at the planning stage, with scopes agreed and work scheduled to commence over the coming months.

Two changes were considered to the audit plan for formal agreement by the Committee. The audits relating to the Roadmap to Sustainability and Strategic

Commissioning were removed from the plan, following agreement with the Lead Executive and Director of Corporate Governance. This was to avoid duplication, as the scope of these audits was being covered by external support commissioned by the Health Board.

It was noted that the outcome of the external support would be reviewed to assess any developments or changes in the areas previously covered by the removed audits. The review would inform the wider thinking for the 2025/26 internal audit opinion. Should new processes be introduced as a result of the external support, internal audit work could be considered in future years to provide assurance on their implementation and compliance within the Health Board.

The Committee was informed of a request to defer the timing of the follow-up audit on Deprivation of Liberty Safeguards. This followed a previous limited assurance audit, as delays in recruiting to key posts had impacted progress on the associated actions. It was agreed that deferring the audit to later in the year would be more appropriate.

The Committee raised concern of the importance of transparency to ensure the Committee were informed of any change in timescales of Internal Audits and its programme. Should there be a fundamental change to the timescales of completion, the Committee would be made aware.

*Could assurance be provided that for those planned audits in 2025/2026, financial implications were considered and the impact upon patients?*

The audit programme had been reduced for 2025/2026. It was noted that the two audits which will be deferred from the 2025/26 plan would provide a reduction in the overall costs given the number of audits undertaken.

*What was the reasons for the request to delay the Deprivation of Liberty Safeguards (DoLs) audit?*

Workforce and spend controls had been restricted and a general delay was seen in recruitment. The rationale and process timing was discussed at a recent Executive Committee which was documented within the Audit Tracker at agenda item 5.7.

Members recognised the importance of the fundamentals of delivery and the recruitment challenges which may impact patients. Reinforcement of the business case investment in DoLs was to provide additional resource. Feedback would be provided to the Director of Nursing for awareness. It was noted that as internal audits were finalised, they would be made available to Independent Members for review to avoid delay.

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 2025/2026 plan.

## **5.2 INTERNAL AUDIT REPORTS (ARA/25/050)**

IV gave an overall view of the assurance obtained from the Duty of Candour audit which confirmed a rating of Reasonable Assurance. One high priority and four medium

priority findings had been found. Management had agreed to all five recommendations which would be implemented imminently.

*Was the Duty of Candour part of mandatory training, and were the audit findings specific to Powys or known in other Health Boards?*

It was not mandatory at the time due to ongoing pressure around training, especially given the volume and scope of existing mandatory training. There was a focus on key staff who were responsible for duty-related process to complete the training.

Audits had been undertaken across other Health Boards, however the outcome was unknown. It was anticipated that the same challenges would be present across NHS Wales Trusts. This would be confirmed at the next meeting in January.

The Committee recognised that where rapid reviews were only completed for incidents involving a death, the management action was unclear. The issues related to Mental Health would be addressed to ensure consistency across the organisation in how reviews were conducted. It was agreed that feedback would be provided to the team to update the wording of the management action.

**Action: Director of Corporate Governance.**

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

### **5.3 EXTERNAL AUDIT PROGRESS REPORT (ARA/25/051)**

The Planned Care report, originally scheduled for July, was presented and resulted a time gap. Members were advised that some developments had occurred since the report was prepared. The paper indicated that several reports were due to be reported to the next meeting in January, a discussion would take place with the Corporate Governance team to manage scheduling and workload.

It was agreed that audit reports would be shared with committee members ahead of the meeting to allow sufficient time for review. A discussion would be held outside of the meeting regarding the Structured Assessment and whether there was an opportunity to present it directly to the Board, to help manage the demands of the January committee.

It was noted that the Cancer Services review had already been referenced within the update. Following discussions with the Health Board regarding the relevance and scope, particularly its focus on service provision, it was agreed that the scope was not applicable. An alternative approach to focus on commissioning arrangements was considered but overlapped with existing internal audit work. As a result, it was agreed to refund that element of the audit.

The Committee suggested that the checklist of cost savings to be shared with members of the Finance and Performance Committee given its remit. It was noted that a Board Development session was being arranged to review the checklist.

**Action: Director of Corporate Governance**

A briefing was presented at a recent meeting of the All-Wales Audit Committee on the National Fraud Initiative (NFI). A national summary was being prepared to consolidate findings and outline upcoming work on local governance arrangements for NFI within individual bodies, including a stocktake of match volumes. The briefing would be issued to all committee members outside the meeting.

**Action: Director of Corporate Governance**

The Committee **RECEIVED** and **NOTED** the External Audit Progress Report

#### **5.4 EXTERNAL AUDIT REPORTS (ARA/25/052)**

##### **Planned Care Recovery – Thematic Review**

A summary was provided which outlined the findings of the national thematic review of planned care recovery, undertaken across all Welsh Health Boards. The review assessed the Health Board's progress in addressing planned care challenges and reducing the backlog of waiting lists. Four recommendations were made:

1. Strengthen long-term service planning, focusing on demand and capacity.
2. Improve efficiency and productivity, including reducing short-notice surgical cancellations.
3. Develop and implement a plan to improve theatre utilisation and manage clinical risks associated with long waits.
4. Establish a consistent methodology for assessing and reporting patient harm due to long waits to the Quality and Safety Committee.

The Health Board accepted all recommendations. Thanks were extended to Health Board colleagues for their support during the review.

Members acknowledged the change since the report had been undertaken in relation to the arrangements with NHS England averages to conform to the Welsh average and the inequity across Wales.

*What evidence could be provided to support the existence of the Health Board appropriately managing and holding its commissioned bodies to account?*

The review included the commissioning assurance framework, routine contract quality, and performance review meetings. Despite the complexity of the system, including in-reach, outsourcing, and varied service level agreements, the Health Board was seen to be managing issues proactively and effectively.

*Was it known where some of the increase in demand was emanating from the population's demographic changes?*

It was acknowledged that while the review did not specifically examine the Health Board's population demographics, a recommendation was made to shift focus from short-term to longer-term planning. The Health Board had developed a demand and capacity modelling approach, but it had not yet been implemented at the time of the review. There was emphasis on the need to explore alternative service provision,

particularly in primary care, to help reduce outpatient referrals and manage demand more effectively.

*How does the DNA (Did not attend) rate of 3.8% in Powys compare to other Health boards?*

The chart of DNA rates would be shared with members outside of the meeting. The audit was undertaken to scope *opportunities for potential efficiencies and minimise DNA rates and associated costs.*

Members raised concern around Theatre utilisation being at a low percentage, given the investment and its unimproved position. It was noted that a theatre transformation programme was under development.

It was agreed that confirmation of the data for cancelled operations and the reporting pathway would be feedback to the committee.

**Action: Medical Director**

The investment in terms of improvement to reduce waiting lists had plateaued. A piece of work was being undertaken by Grant Thornton, and it was anticipated that a report would be received in the coming weeks and would be shared with committee members.

**Action: Director of Corporate Governance**

The Committee **RECEIVED** the External Audit report and Management responses.

## **5.5 LEARNING FROM ANNUAL EXTERNAL AUDIT OF ACCOUNTS AND ANNUAL REPORT 2024/25 (ARA/25/053)**

A summary was provided of the review of Continuing Health Care (CHC) processes following completion of the Annual Accounts. An overview of the issues identified were provided and actions taken to address the findings from the Audit of Accounts in 2024/2025.

It was noted that the lessons learnt from the Audit of Accounts and Annual report had been shared with Audit Wales who recognised the significant work undertaken by the Health Board to address the issues raised. Follow up meetings had been taken place between the Finance and Audit Wales team to discuss the mitigating actions taken. Following completion of the feedback report, this would be shared with members of the committee.

*Had consideration been given to other areas across the Health Board which may post a similar risk to the CHC accruals?*

Following completion of the audit, no other areas had been identified of concern. The team were undertaking a review of potential risk areas to ensure a similar approach would be taken.

The Committee proposed that the specific actions taken in relation to the lessons learned from the Annual Audit and accounts to be inclusive within the Approach for

2025/26 Annual Accounts. The Committee AGREED to the proposal and would be included within the report in March 2026.

The Committee **RECEIVED** the report and took **ASSURANCE** that the issues and learning identified as part of the 2024/2025 audit were being addressed.

#### **5.6 COUNTER FRAUD UPDATE AND REPORTS (ARA/25/054)**

An overview of the key areas of work undertaken by the Health Board's Local Counter Fraud Specialist were provided. It was noted that the Health Boards service level agreement with Swansea Bay University Health Board (SBUHB) for the delivery of counter fraud services was due for renewal. Discussion with the Director of Finance, Estates and Support Services was underway.

An agreement had been reached with Corporate Governance to use National Fraud Initiative (NFI) data to assess compliance with the Declaration of Interest policy. The exercise would help evaluate its effectiveness. Members discussed and noted the benefits received against the Service Level Agreement (SLA) agreement review to enable services to react and take action as required.

The Committee **RECEIVED** the update report and took **ASSURANCE** that appropriate counter fraud systems are in place.

#### **5.7 AUDIT RECOMMENDATION TRACKER (ARA/25/055)**

An overview of the Audit Recommendations Tracker was presented to Committee and it was noted that the report was provided in a revised format. Since the last report, significant improvements had been implemented based on Committee feedback and wider learning/review. A data quality and validation exercise had been completed, along with a review of the tracker to improve formatting and readability. The report focused on the following key elements:

- Overdue findings
- Revised deadlines
- High-priority items
- Issues linked to limited assurance reports

The Committee welcomed the revised report and acknowledged the work undertaken to provide a focus on overdue, revised deadlines and high priority audit findings. It was noted that future development of the report would consider the accessibility and visibility of the cover paper.

*Was there a process in place for those overdue recommendations to be reviewed and updated by Executive leads?*

The audit handbook allows the committee to invite Executive Directors to explain why recommendations have remained overdue for more than six months. The report was also reviewed by the Executive Committee, where directors assess overdue findings. Updates from these reviews would be shared with the Committee to support oversight and progress tracking.

An update was provided on the Mattresses Internal Audit findings which had received a Limited Assurance. It was acknowledged that initial expectations for resolving the issue was overly ambitious. Despite delays, progress was on track, and assurance was given that the issue should be resolved within the next month.

The Committee **RECEIVED** the position of Audit Findings and took **ASSURANCE** that the organisation has appropriate systems in place to tracking and responding to audit recommendations.

### **5.8 FINANCIAL CONTROLS (ARA/25/056)**

The Committee received an overview of current financial governance arrangements, which included:

- Standard Financial Instructions and Scheme of Delegation
- Procurement Thresholds and the role of the Non-Pay Scrutiny Group
- Policies relating to Training, Travel, and Expenses
- Overview of Long-Term Agreements and Service Level Agreements
- Continuing Healthcare (CHC) processes, with noted overlap from earlier agenda discussions
- Primary Care and Pay Expenditure, with further actions to be progressed as discussed at Board level
- Vacancy Control Processes and reference to the Investment Benefits Group
- General approach to Budgetary Control and Savings
- Arrangements for Income Management and Internal Audit, including relevant financial system audits
- CHC-related actions following the End-of-Year Audit
- Update on Level 4 Escalation work, including input from External Consultants who have undertaken a "Grip and Control" checklist. Feedback and recommendations for improvement were expected.

*What was the impact of financial changes use of Health Care Support Workers (HCSW) and had recruitment improved?*

Patient safety and the provision of appropriate care remain the highest priority. All financial controls and governance approaches are implemented with this principle at the forefront. Decisions were made under these arrangements, including the development of protocols for on-call use and the approach to agency staffing, are guided by this priority. These considerations underpin all relevant processes.

The Committee **RECEIVED** the contents of the paper and took **ASSURANCE** from the financial controls in place.

### **5.9 RISK AND ASSURANCE UPDATE (ARA/25/057)**

The Committee received a summary of the Risk and Assurance programme. Work continued to mature the Board Assurance Framework through the development of detailed assurance analysis for each strategic risk.

The rollout of the Datix System had been delayed due to long-term staff absence in the risk post and data input errors identified during the pilot phase. These issues

required corrective action to ensure reliable reporting. A workaround was identified to address the data input issue.

*Was there any feedback following the development of the Operational Leadership Group (OLG)?*

It was noted that the establishment of Operational Learning Group (OLG) was in its early stages of development, with the intention to formally bring together Deputy and Assistant Directors. The purpose of the meeting was to review a range of cross-organisational matters, including but not limited to risk management.

The Committee took **ASSURANCE** from the update on progress provided against the implementation of the Risk Management Framework (RMF) and took **ASSURANCE** from the update on progress provided against the implementation of the Board Assurance Framework (BAF).

#### **5.10 INFORMATION GOVERNANCE PERFORMANCE REPORT (ARA/25/058)**

Members were provided with a summary of the Information Governance (IG) performance, where the following themes were highlighted:

- **Freedom of Information (FOI):** A consistent 92% compliance rate was maintained
- **Personal Information Requests:** 171 requests were received, with a 99% compliance rate
- **DATIX Incident Reporting:** 63 IG-related incidents reported. Of these, 17 were not reported within the required 72-hour timeframe, and 2 were deemed reportable to the Information Commissioners Office (ICO).
- **Information Asset Register:** 146 new assets recorded to date. Promotion of this was in development.
- Records management remained a challenge, primarily due to the volume of paper records and the geographical spread across Powys. This remained a key focus within the development of the IG and Records Management Strategy.

*What was the rationale for the low percentage in training compliance for Bank staff?*  
A meeting was due to take place with the Temporary Staffing Unit to explore ways to target bank staff in a more effective way. An update on progress would be reported Tempo staffing unit leads explore ways to target bank staff. Challenges around ensure compliant for training.

*What were the reasons for the low training compliance across the Medical Directorate in comparison to other directorates?*

An exercise was due to be undertaken to target new staff and improve training compliance which would take place in Q3. Progress would be included within the next report. There was ongoing work with key services to address the burden of repeated FOI requests. A pilot was underway with the Finance and People and Culture directorates to explore opportunities for routine publication of information via the organisation's Publication Scheme. If successful, the approach would be extended to other services.

*Was the organisation exempt from providing information under the enactment where the cost of assimilating that information was deemed disproportionate?*

The legislation stated that there was a requirement to respond at a high level during certain circumstances.

The Committee were informed that a series of targeted exercises had been undertaken with specific services experiencing a high number of incidents. Changes implemented over the previous four months had a positive impact in reducing future occurrences with historical trend analysis inclusive within the IG Annual report. The Committee acknowledged the proactive approach taken to address these challenges.

*Given the increase of information assets, what action was being taken to address the directorates who are yet to complete this work?*

Work was planned in Q3 to work with services to support and encourage staff complete entries. Six-monthly and annual reviews were conducted and at the annual review stage, a range of data to support the Directorate's overall assessment was provided. The input was designed to be both supportive and helpful in drawing out key themes and issues.

The Audit, Risk and Assurance Committee **RECEIVED** the report, took **ASSURANCE** on areas of good compliance, acknowledged efforts and successes and **NOTED** areas of poor or non-compliance and took **ASSURANCE** a programme of work was in place to improve compliance.

#### **5.11 DIGITAL FIRST ANNUAL PLAN (ARA/25/059)**

The Committee received the report and asked the following questions:

*What was the current position on the NHS Welsh App cross border?*

There had been a renewed push from Digital Health and Care Wales (DHCW) to implement functionality as expected by Welsh Government. It was anticipated that initial results would be seen in the coming months, with referral information beginning to surface on the NHS Wales App as the first phase of delivery. Work had continued on the Cross-Border Project, it was acknowledged that information gaps remained in terms of data presented on the NHS Wales App. The gaps were expected to be minimised as the project progressed toward key milestones, with closure anticipated in the coming months.

*Was Digital inflation seen to increase the Service Level Agreement (SLA) costs with Digital Health Care Wales (DCHW)?*

Some cost pressures were unavoidable. The organisation had been actively engaged in national negotiations with Microsoft regarding the Enterprise Agreement, which represented one of the largest digital costs faced by the Health Board. Positive developments in the negotiation had been reported, and further details would be considered once fully reviewed.

*What was the rationale for the 10% of user experience and satisfaction results?*

The general theme related to expectations around response timelines. Although Service Level Agreements (SLAs) had been documented and targets clearly defined, there remained varying opinions on the urgency of issues, with some individuals expecting responses within an hour.

The team had been actively driving increased usage of remote consultations, successfully onboarding multiple new services. The issue of late funding notifications was discussed. While some delays were acknowledged as unavoidable, they posed challenges to delivering national initiatives effectively. A reporting structure of the various groups and how they interface on digital would be clarified and reported to a future committee for members awareness.

The Committee took **ASSURANCE** that the Health Board was progressing and delivering against the Digital Strategic Framework, to embed a clinically led digitally enabled service in support of Digital First as a Strategic enabler for transformation, improvement, quality, safety and efficiency, **NOTED** the key achievements and **NOTED** the key challenges.

#### **5.12 SFI EXECUTIVE FINANCIAL DELEGATION LIMITS (ARA/25/060)**

The Committee **RECEIVED** the report and **DISCUSSED** the proposed changes to the Standing Financial Instructions, which included:

- Executive authorisation levels increased to £500k for the Chief Executive;
- £250k for the Director of Finance and up to £100k for Executive team;
- A series of administrative updates would be applied to the SFIs which included Executive and other job title changes, Board Committee titles and external agency name changes where appropriate.
- The Committee **NOTED** that the Chief Executive would complete a review of the Executive portfolio scheme of delegation in readiness for the Board in November.

The Committee **SUPPORTED** the recommendations to go onward to the Board.

### **6. ITEMS FOR DISCUSSION**

There were no items for inclusion in this section.

### **7. CONSENT AGENDA**

#### **7.1 ORGANISATIONAL REGISTER OF INTERESTS (INCLUDING BUDGET OVERSIGHT), GIFTS AND HOSPITALITY (ARA/25/061)**

The Committee **RECEIVED** the Register of Interests for Board Members, Consultants, those staff with budget oversight and the Gifts and Hospitality Register.

#### **7.2 LOSSES AND SPECIAL PAYMENTS (ARA/25/062)**

The Committee **RECEIVED** the report on Losses and Special payments covering the period 1<sup>st</sup> April 2025 to 31<sup>st</sup> August 2025.

#### **7.3 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/25/063)**

The Committee **RECEIVED** the Single Tender Waiver report.

#### **7.4 INFORMATION GOVERNANCE TOOLKIT (NATIONAL AUDIT REPLACES CALDICOTT PRINCIPLES) (ARA/25/064)**

The Committee **RECEIVED** the Information Governance Toolkit.

**7.5 COMMITTEE WORK PROGRAMME 2025/2026 (ARA/25/065)**

Members **RECEIVED** the Committee Work Programme for 2025/2026.

**7.6 PTHB GLOSSARY(ARA/25/066)**

The Committee **RECEIVED** the PTHB Glossary.

**8.OTHER MATTERS**

**8.1 ANY OTHER URGENT BUSINESS (ARA/25/067)**

There was no other urgent business.

**8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/25/068)**

There were none.

**8.3 COMMITTEE REFLECTIONS (ARA/25/069)**

The following feedback was noted:

- Timely and well managed chairing
- Welcome early sight of Internal Audit reports prior to the next meeting in January 2026.

**8.4 DATE OF NEXT MEETING**

The date of the next meeting is scheduled on 13 January 2026 at 10:00 via Microsoft Teams.

*Meeting closed at 12:33*

Powell Bethan  
08/01/2026 14:26:26

Audit and Risk Assurance Committee								
<b>RAG Status:</b>								
<b>At risk</b>	Red - action date passed or revised date needed							
<b>On track</b>	Yellow - action on target to be completed by agreed/revised date							
<b>Completed</b>	Green - action complete							
<b>No longer needed</b>	Blue - action to be removed and/or replaced by new action							
<b>Transferred</b>	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
<b>OPEN ACTIONS FOR REVIEW - (13 JANUARY 2026)</b>								
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	<b>01.07.2025 update:</b> the action will be progressed in line with the target date. <b>13.01.26 update:</b> 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.	Jan-26	Mar-26	At risk
<b>OPEN ACTIONS - NOT YET DUE (13 JANUARY 2026)</b>								
07-Oct-25	ARA/25/052	DCG	External Audit report	Share the Grant Thornton report against the improvement to reduce waiting lists.	<b>13.01.2026 update:</b> The externally commissioned report remains in draft and will be shared with members once finalised.			On track
<b>ACTIONS RECOMMENDED FOR CLOSURE (13 JANUARY 2026)</b>								
07-Oct-25	ARA/25/051a	DCG	External Audit progress report	Circulate the National Fraud Initiative (NFI) Summary with members	<b>13.01.26 update:</b> A link to the checklist was shared with members on 17.11.2025.			Completed
07-Oct-25	ARA/25/051	DCG	External Audit progress report	To share the Checklist of cost savings with members and Finance and Performance members	<b>13.01.26 update:</b> A link to the checklist was shared with members on 13.11.2025.			Completed
07-Oct-25	ARA/25/050	DCG	Internal Audit Report - Duty of Candour	To update The wording of the IA management action related to Mental Health incidents to be clearer around rapid reviews.	<b>13.01.26 Update:</b> The Head of Quality & Safety has confirmed that the IA management action has been completed and all services are now engaging in rapid review meetings, including Mental Health. The RAG status for the action should be Completed.			Completed
07-Oct-25	ARA/25/052	DoAHP,HS&D	External Audit report	Low percentage of Theatre utilisation - to confirm where the data for cancelled operations is reported.	<b>13.01.26 update:</b> Theatre data is presented via a Power BI dashboard, reported to Endoscopy and Theatre meetings.			Completed

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08/01/2026 14:26:26



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

## Agenda Item: 5.1

Audit, Risk and Assurance Committee		13 January 2026
<b>Subject:</b>	<b>Internal Audit Progress Report</b>	
<b>Approved and presented by:</b>	Director of Corporate Governance / Board Secretary Head of Internal Audit	
<b>Prepared by:</b>	Head of Internal Audit	
<b>Other Committees and meetings considered at:</b>	N/A	
<b>PURPOSE:</b>		
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.		
<b>RECOMMENDATION(S):</b>		
The Audit, Risk & Assurance Committee are requested to:		
<ul style="list-style-type: none"> <li>• <b>Note</b> the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.</li> <li>• <b>Approve</b> the proposed adjustments to the 2025/26 plan.</li> </ul>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
Y	Y	Y

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
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	Y	
6. Promote Innovative Environments	N	
7. Put Digital First	Y	
8. Transforming in Partnership	N	

## **EXECUTIVE SUMMARY:**

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

The following audit reports have been finalised since the October 25 meeting of the Committee:

- Staff Development Programme (Substantial Assurance)
- Primary Care Clusters - Project Management (Substantial Assurance)
- Continuing Healthcare (Reasonable Assurance)
- Core Financials – General Ledger Management & Accounts Receivable (Reasonable Assurance)
- Decontamination (Reasonable Assurance)
- MH and LD Triage and Assessment Process (Reasonable Assurance)
- Digital Systems Uptake (Limited Assurance)

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

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

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

## **BACKGROUND AND ASSESSMENT:**

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

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

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

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

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

## **NEXT STEPS:**

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

Powys Teaching Health Board

# Internal Audit Progress Report

Audit, Risk & Assurance Committee  
January 2026

NWSSP Audit and Assurance Services



GIG  
CYMRU  
NHS  
WALES

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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board



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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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08/01/2026 14:26:26

## 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
Clinical Supervision	Draft Report	Reasonable	Delay in receiving information from management to allow completion of fieldwork.
Estates Assurance Asbestos Management	Work in Progress		Delay in completion of fieldwork due to availability of Internal Audit resources.

## 3. Outcomes from Completed Audit Reviews

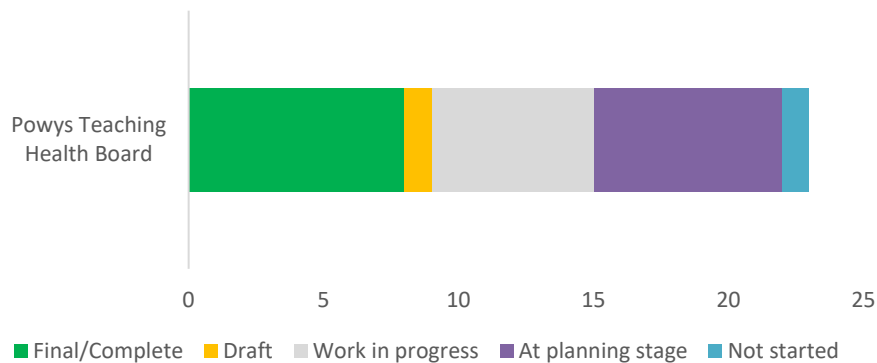
Seven assignments from the 2025/26 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Staff Development Programme	Substantial	
Primary Care Clusters – Project Management		
Continuing Healthcare	Reasonable	
Core Financials – General Ledger Management & Accounts Receivable		
Decontamination		
MH and LD Triage and Assessment Process	Limited	
Digital Systems Uptake		

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

There is a total of 22 reviews included within the 2025/26 Internal Audit Plan (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that eight audits from the 2025/26 plan have been finalised so far this year and one other has reached the draft report stage.

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

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

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

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

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

## 5. Changes to the 2025/26 Plan

- Digital Operating Model – Identified for removal from the plan due to duplication of coverage with the Structured Assessment Deep Dive into Digital Systems being undertaken by Audit Wales. Removal has been agreed with the Executive Director of Allied Health Professions, Health Science and Digital.
- Community Care – Proposed that the timing of this audit is moved from Quarter 2 to Quarter 4 due to further discussions required to agree the scope and the availability of Internal Audit resources to deliver the work.

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08/01/2026 14:26:26

## ASSIGNMENT STATUS SCHEDULE

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

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Core Financials	Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management / Accounts Receivable / Capital Asset Management.	04	Finance, Capital & Support Services	3		Final Report	Reasonable	January
Primary Care Clusters – Project Management	How are the project management processes working to enable implementation of developments.	13	Primary, Community Care & Mental Health	3		Final Report	Substantial	January
Decontamination	Review of the Health Board’s structures and processes for decontamination of equipment, to ensure compliance with standards and legal requirements.	23	Nursing, Quality, Women & Family Health	±	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		Draft Report	Reasonable	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		Work in Progress		March
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		March
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		Work in Progress		March
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		Work in Progress		March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Catering Services	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		Work in Progress		March
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		March
Follow-up DoLS	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	Planning – Final brief issued		March
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	4		Planning		May
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	3				May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance / Board Secretary	4		Planning		May
Community Care	Review of how different teams within the community are working together for care of the patient.	12	Primary, Community Care & Mental Health	2	4	Planning		May
Strategic Equality Plan	Review of delivery against the Health Board's Anti Racism Plan.	17	People, Culture & Transformation	4		Planning final brief issued		May
Vaccine Storage	Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.	25	Public Health	4		Planning final brief issued		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
<b>Reviews removed from the plan</b>								
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 the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.	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		
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. To be agreed by January 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

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## KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	<b>G</b>	May 2025	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	<b>G</b>	70% 7 from 10	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	<b>G</b>	100% 9 from 9	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	<b>G</b>	88% 7 from 8	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	<b>G</b>	100% 8 from 8	80%	v>20%	10%<v<20%	v<10%

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## Assurance Opinions

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

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**Office details:**

Audit and Assurance Services  
2<sup>nd</sup> Floor, Woodland House  
Maes y Coed Road  
Cardiff  
CF14 4HH.

**Contact details**

Ian Virgill (Head of Internal Audit) - [ian.virgil@wales.nhs.uk](mailto:ian.virgil@wales.nhs.uk)

# Digital System Uptake

## Final Internal Audit Report

### 2025/26

Powys Teaching Health Board



Limited Assurance

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Executive Summary .....1

Findings & Agreed Action Plan .....2

Appendix A .....9

Review Reference	PTHB-2526-19
Fieldwork	August to September 2025
Executive Sign Off	29 <sup>th</sup> October 2025
Audit Committee	13 <sup>th</sup> January 2026
Executive Lead	Claire Madson Executive Director of Allied Health Professions, Health Sciences and Digital.
Head of Internal Audit	Ian Virgil
IT Audit Manager	Martyn Lewis

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# Executive Summary

## Purpose

To review the level of uptake and utilisation of digital systems once they have been introduced.

## Overview

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

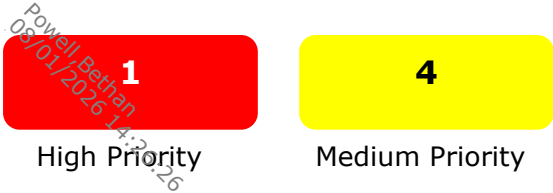
- Not all projects held a benefits log, and benefits realisations plans were absent. We also note that levels of user engagement vary with some projects lacking ongoing user involvement.
- Not all projects contained a defined training stage within the plan, and have relied on early stakeholder engagement and ad hoc training sessions.
- The management of change is generally part of the project management role and has generally been restricted to governance oversight, with no framework, no dedicated change manager or change resource within business cases and no change champions used within projects.
- Tracking of system uptake is fragmented, with monitoring carried out within individual project structures. There is no comprehensive, overall dashboard or proactive monitoring processes that provides an integrated view of adoption across the Health Board. We also note that there is a quarterly reporting which is provided to the Executive Committee, this includes reporting on digital system uptake, however not all digital systems are included.
- The analysis of the causes of low uptake is not always rigorous.

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

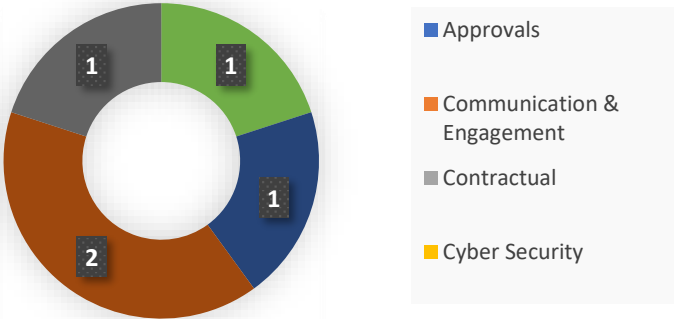
## Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 The benefits of digital systems are appropriately defined, with user engagement within business cases and articulated to all stakeholders as part of implementation projects.	1	<b>Reasonable</b>
2 The implementation stages of systems include appropriate training and change management.	2, 3	<b>Limited</b>
3 Uptake and use of digital systems is appropriately managed and reported, both within the project and on a wider basis, with the reasons for low uptake established and actions identified to address	4, 5	<b>Limited</b>

### Management Actions



### Themes



### Risk Types

Public Perception & Reputational Risk  
Financial Loss

# Findings & Agreed Action Plan

**Objective 1: The benefits of digital systems are appropriately defined, with user engagement within business cases and articulated to all stakeholders as part of implementation projects.**

**Reasonable**

The Health Board has recognised that there were weaknesses within benefits management and so has recently (April 2025) developed a Benefits Realisation Framework which provides a structured and detailed framework for benefits realisation management, designed primarily to support NHS Wales in ensuring that digital and business change programmes deliver measurable improvements. It outlines the principles, processes, and tools needed to identify, quantify, plan, realise, and review benefits, ensuring that projects are aligned with strategic objectives and deliver value for money. The guide defines different types of benefits; financial, qualitative, societal, and emergent along with dis-benefits and sets out clear categories and subcategories to standardise reporting across programmes. It explains how to manage benefits from both a portfolio and programme perspective, ensuring alignment with organisational strategy while avoiding issues such as double-counting and optimism bias. However there is no formal benefit realisation plan currently in place. It is acknowledged that going forward a benefit realisation plan will be developed and incorporated into future projects.

As part of our audit work we selected a sample of projects to examine, these were: Connected Care; Follow Me Printing; ePMA; Envoy. In addition during our work staff within the Health Board demonstrated areas where, although the sampled projects may not have fully complied with good practice in terms of all benefits defined by stakeholders and having a formal benefits realisation plan, other projects have e.g. WNCR.

As noted above a benefits framework has been developed by the Change Manager which was endorsed at the executive committee on the 30 April 2025, where a more robust process was implemented.

Levels of user engagement varied across projects. While engagement was always present to some degree, some projects demonstrated strong practice through early consultation, structured training plans, and ongoing feedback loops. Others, however, struggled to sustain involvement, which in turn threatened the sense of service ownership over the digital product. The Envoy project illustrates these difficulties: despite a well-structured business case, the provision of adoption support webinars, and the use of consultancy support to facilitate face to face onboarding, benefits tracking was inconsistent, disbenefits were overlooked, and user engagement ceased after the early stages. The organisation has since acknowledged these issues and documented them as part of its lessons learned process.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Not all projects sampled fully complied with good practice in terms of all benefits defined by stakeholders and having a formal benefits realisation plan.</p> <p>We also note that levels of user engagement vary with some projects lacking ongoing user involvement, which can lead to a loss of service ownership of the digital product.</p>	<p>There is a risk that digital projects do not deliver the anticipated benefits.</p>	<p><b>Agreed Action:</b></p> <p>This has been an area of ongoing focus, action, and improvement. The Executive team approved a Benefits Framework in April 2025. It is acknowledged that many projects since that approval are still in scoping or design / testing phases, and there are national reporting templates and local reporting templates, as such there are not the clearly defined standard benefits plans in place. A standard benefits template will be developed to support this approach which will underpin the more</p>

			<p>strategic benefits framework. Digital Services project managers will utilise this template, which will be defined in collaboration with stakeholders ensuring operational service teams take ownership and accountability of their benefit realisation logs.</p> <p>The Digital project will oversee that benefits data is collected and tracked against an agreed stakeholder map for up to six months following implementation (Go Live), after which responsibility for ongoing benefits realisation will be transferred to the agreed service leads.</p>
		<b>Medium Priority</b>	<p><b>Expected Evidence of Implementation:</b></p> <p>Standardised Benefits Template with project milestones applied for the collection and monitoring of Benefits Realisation activities.</p> <p>A project milestone tracker for all live projects to show benefits activities.</p>
	<b>Theme:</b> Planning, Delivery & Deadline Management	Control Operation	<p><b>Officer:</b> Head of Digital Programmes</p> <p><b>Target Implementation Date:</b> December 31<sup>st</sup>, 2025</p>

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## Objective 2: The implementation stages of systems include appropriate training and change management.

Limited

The Benefits Realisation Framework Guide highlights that training and change management should be embedded in system implementation. These are essential enablers of successful benefits delivery, particularly in digital transformation. The guide stresses that benefits realisation is not just about templates or metrics but depends on a supportive organisational environment, with leadership, culture, and training as foundational components.

Governance arrangements within the framework also recommend mechanisms to ensure staff are equipped to support change, and for benefits to be reviewed and evaluated post-implementation. This reinforces that training and change management are integral to the success of benefits-led projects.

The change manager that was in place has left the organisation, with the role being vacant, and there is no Change Management Framework that sets out how business change is to be managed through a project lifecycle to enable successful delivery. As such change management is left to the project managers with the individual projects applying their own variants of change and training requirements. We also note that business cases do not always include specific resourcing for change management or identify the need for change leads or champions within the service.

We observed that not all projects contained a defined training stage, instead relying on early stakeholder engagement and ad hoc sessions. The absence of structured training plans including objectives, timelines, and evaluation processes has created risks for consistent adoption of digital services. Testing found that rapidly implemented projects delivered technical solutions, but without formal training programmes, competency checks, and structured go-live support, uptake was delayed and often dependent on informal communication and workshops.

By contrast, more significant transformation programmes have demonstrated stronger change practices due to the size of the implementation team and funding received, including phased rollouts, defined benefits realisation plans, dedicated training workstreams, and pre-implementation engagement tailored to user needs and learning styles. The use of super users, digital champions, and on-site support, combined with lessons learned from earlier deployments, has strengthened delivery and mitigated risks.

We were informed that plans are currently in progress to introduce the FITT Framework, designed to assess the effectiveness of the technology in a clinical environment after implementation. This framework aims to identify any barriers to adoption that may need to be addressed. It will be incorporated into the suite of project templates, supporting a more consistent and structured approach to post-implementation change management in the future.

Key Findings	Risk & Impact	Agreed Management Action
2 Not all projects contained a defined training stage within the plan and have relied on early stakeholder engagement and ad hoc training sessions.	There is a risk that digital projects do not deliver the anticipated benefits.	<b>Agreed Action:</b> At the time of the Audit an interim arrangement was already in place with the recently recruited Training Function. To support this, training documentation will be prepared and will be incorporated into the project framework suite of templates, providing guidance for project managers during the implementation of new projects. Where training is deprioritised,

			<p>this will be reported by the project board, in the Risks and Issues Logs.</p> <p>Training schedules will be added as a clearly defined milestone, against the project, and will record the method of training that will be provided based on each project requirements and workforce considerations. Some training will have to be cascade training due to the size of the training team and the demand and this will be the responsibility of the operations team.</p>
			<p><b>Expected Evidence of Implementation:</b></p> <p>A business case will be developed to support the sustainability of a training function.</p> <p>Training documentation will be in place for each project to support the Training plans</p> <p>Clear milestone tracking for training activities</p> <p>A review of training delivery methods to be available for consideration of the project requirements and workforce considerations (e.g., Virtual/Classroom/E-Learning)</p> <p>A tracker to ensure training attendance is captured for each project</p>
		<p><b>Medium Priority</b></p>	<p><b>Officer:</b> Head of Digital Programmes &amp; Chief Nurse Informatics Lead</p>
	<p><b>Theme:</b> Training &amp; Development</p>	<p>Control Operation</p>	<p><b>Target Implementation Date:</b> February 28<sup>th</sup>, 2026</p>
<p>3</p>	<p>There is no Change Management Framework that sets out how business change is to be managed through a project lifecycle to enable successful delivery. As such change management is left to the project managers with the individual projects applying their own variants of change and training requirements. We also note that business cases do not always include specific resourcing for change management or identify the need for change leads or champions within the service.</p>	<p>There is a risk that digital projects do not deliver the anticipated benefits</p>	<p><b>Agreed Action:</b></p> <p>A Change Management Framework was started in draft as part of the EPMA programme, where an interim Change Manager was appointed on a fixed term basis up until March 2025.</p> <p>This is a known area for improvement, and we accept this is a role that is essential, however due to how digital projects are funded, there is not a permanent Change Manager in post.</p> <p>The size of the organisation, the rurality of PTHB and the funding available is often a challenge to recruit the required change management roles with experience.</p>

			<p>That said it is an identified gap and so where resources are defined, this will include Change leads or Change Champions.</p>
		<p><b>High Priority</b></p>	<p><b>Expected Evidence of Implementation:</b></p> <p>Draft a Change Management Framework for Executive approval and associated change activities that will form part of the Digital Programme suite of documentation.</p> <p>Identify champions within the operational services to support digital change and adoption.</p>
	<p><b>Theme:</b> Planning, Delivery &amp; Deadline Management</p>	<p>Control Design</p>	<p><b>Officer:</b> Head of Digital Programmes and Assistant Directors of Operational Services.</p> <p><b>Target Implementation Date:</b> 31 March 2026</p>

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**Objective 3: Uptake and use of digital systems is appropriately managed and reported, both within the project and on a wider basis, with the reasons for low uptake established and actions identified to address.**

**Limited**

Digital project leads provide monthly highlight reports (in PowerPoint format). While these provide a high-level summary of status and challenges, the narrative is limited, often lacks detail on impact and actions, and is open to interpretation. We also note that there is a quarterly reporting on active projects which is provided to the Executive Committee, this includes reporting on digital system uptake. However, reporting and tracking of uptake and use of systems stops once the project is closed which may lead to issues with digital systems penetration being missed.

Tracking and monitoring of system uptake is carried out within individual project structures. Only one of the projects reviewed (Follow Me Print) was able to demonstrate dashboard data on outcomes, although we note that dashboards are in place for other projects from outside our sample. There is no comprehensive, overall dashboard or proactive monitoring processes that provides an integrated view of adoption across the Health Board. The maturity of uptake management also varies across projects. While some initiation documents state an intent to monitor uptake, this is not always implemented. Other projects demonstrate early engagement but lack structured monitoring or departmental follow-up. In many cases, project teams lose access to essential monitoring tools after implementation, limiting their ability to track adoption or investigate issues.

The analysis of the causes of low uptake is often limited and lacks sufficient depth to fully understand underlying barriers. Explanations of adoption challenges are frequently vague, and in some cases services have been withdrawn without full root-cause analysis or remedial actions. Although cultural and organisational barriers (e.g. staff resistance, compliance issues, geographical dispersion) are recognised, they are not systematically addressed. This reactive approach leaves barriers unresolved and prevents learning that could improve future implementations. The project closure report, incorporating lessons learned, is therefore fundamental to understanding and addressing these issues.

As noted above the plans to introduce the FITT Framework, designed to assess the effectiveness of the technology in a clinical environment after implementation. This framework aims to identify any barriers to adoption that may need to be addressed. It will be incorporated into the suite of project templates, supporting a more consistent and structured approach to post-implementation change management in the future.



Key Findings	Risk & Impact	Agreed Management Action
<p>4 Tracking of system uptake is within individual project structures. There is no comprehensive, overall dashboard or proactive monitoring processes that provides an integrated view of adoption across the Health Board. We also note that there is a quarterly reporting which is provided to the Executive Committee, this includes reporting on digital system uptake, however reporting stops once the project is closed.</p>	<p>There is a risk that digital projects do not deliver the anticipated benefits</p>	<p><b>Agreed Action:</b></p> <p>At the time of the audit, there was a Clinical Digital Systems group implemented, that has a focus for reviewing system uptake and usage. This will be an important governance hierarchy led by Clinicians and in collaboration with Finance and digital leads.</p> <p>There is currently not a project management system tracking tool in place to ensure that a method of tracking utilisation is embedded in all future projects. This will be reviewed to support the outcome for a dashboard reporting and performance.</p> <p><b>Expected Evidence of Implementation:</b></p>

			A tracker for all live projects containing benefits, training, and utilisation.
		<b>Medium Priority</b>	<b>Officer:</b> Head of Digital Programmes and Chief Nurse Informatics Lead
	<b>Theme:</b> Performance Monitoring	Control Design	<b>Target Implementation Date:</b> 31 <sup>st</sup> March 2026
5	The analysis of the causes of low uptake is not always rigorous. Adoption challenges are often explained vaguely without examining the underlying barriers, and in some cases services have been withdrawn without proper analysis and development of actions to overcome barriers. There is an awareness of cultural and organisational factors such as staff resistance, compliance issues, and geographical dispersion however these are not systematically addressed.	There is a risk that digital projects do not deliver the anticipated benefits	<b>Agreed Action:</b> This will be tracked as part of the Lessons Learned log, which will commence at the start of every project, and complete within 3 months of Go Live, where there is an ongoing requirement to capture uptake and usage, this will transition to the benefits framework logs, and be reported to the Clinical Digital Improvement group and via the Digital First performance executive update reports
			<b>Expected Evidence of Implementation:</b>  Service engagement Post go-live evaluation, utilising the FITT framework. (Frequency, Intensity, Time, and Type)  Escalation process for low adoption and engagement. This will need to be owned by the operations directorate
		<b>Medium Priority</b>	<b>Officer:</b> Head of Digital Programmes and Assistant Directors of Operational Services.
	<b>Theme:</b> Lessons Learnt	Control Operation	<b>Target Implementation Date:</b> 31 March 2026

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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

## Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

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

## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



# Continuing Healthcare

## Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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### Review Reference

PTH-2526-10

### Fieldwork

August – September 2025

### Executive Sign Off

October 2025

### Audit Committee

January 2026

### Executive Lead

Elaine Lorton, Executive Director of Primary Community Care and Mental Health

### Audit Team

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

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



# Executive Summary

## Purpose

The overall purpose of this audit was 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.

Between May 2024 and May 2025 there has been a 27.6% increase in the number of CHC cases supported by the Health Board contributing to a continually challenging financial position.

Continuing Healthcare (CHC) is a package of care arranged and funded by the NHS for individuals who have been assessed as having a primary health need due to disability, accident or illness. There is a Continuing NHS Healthcare National Framework for Implementation in Wales. This was published in July 2021 and implemented in April 2022. The document sets out the arrangements for the effective, efficient and equitable delivery of CHC in Wales.

The Health Board is required to have processes in place to assess and approve applications in line with Continuing NHS Healthcare: The National Framework for Implementation in Wales. Once approved, recipients are recorded in the All-Wales National Complex Care Database (NCCD) used for monitoring and financial forecasting purposes.

The Health Board has recently procured additional external support, linked to its current escalation status, which includes coverage of CHC. The scope of our audit, and the associated assurance provided, is therefore restricted to the specific objectives detailed below and does not cover the wider CHC processes.

## Overview

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

- The existing procedure document is outdated and the new version, currently in draft and under review, does not include references to related procedures.
- Patient placement review documentation can be slow to be filed and the file structure lacks coherence and convention.
- The Complex Care Improvement Plan is not reported on in its entirety.

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:

- A brief overview/procedure document describing operation of the electronic system used to obtain authorisation of CHC claims and reviews should be created, and this should be referenced by the general CHC procedure document.
- An action log should be implemented and used as a master, consolidated record of all actions arising from placement reviews. The log should include action details, owner, target completion dates and current status. A record should also be maintained of the date that actions are either completed, sanctioned as complete by the Scrutiny panel, or both.

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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

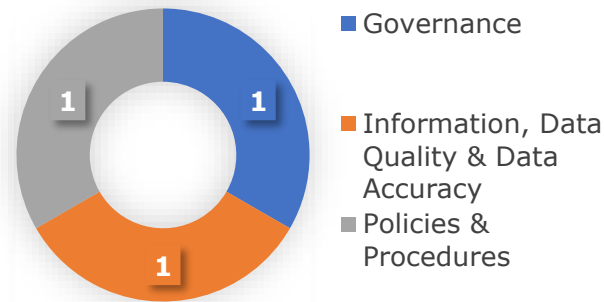
	Objectives	Related Findings	Assurance
1	The Health Board's new electronic system for managing the process of authorising CHC claims is in line with the Health Board's scheme of delegation and ensures compliance with the CHC National framework guidance.	-	<b>Substantial</b>
2	CHC placement reviews, including those for complex and / or high-cost care are completed at the required times and are adequately assessed, with required actions undertaken from the review outcome, as outlined in the CHC National Framework.	1, 2	<b>Reasonable</b>
3	The Health Board has improvement plans in place to address the current level of CHC cases and associated costs. Progress towards delivery of the plans is effectively monitored and regularly reported within the Health Board.	3	<b>Reasonable</b>

### Management Actions

**3**

Medium Priority

### Themes



### Risk Types

Financial Loss

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# Findings & Agreed Action Plan

**Objective 1:** The Health Board's new electronic system for managing the process of authorising CHC claims is in line with the Health Board's scheme of delegation and ensures compliance with the CHC National framework guidance

**Substantial**

## Overview / Summary of Observations

New applications for CHC and reviews completed on existing patient packages are subject to scrutiny via two panel reviews: "Scrutiny Panel" and "Resource panel". The Scrutiny panel reviews the patient's background, needs and details of the package placement, submitted via either an initial application or, for patients already receiving CHC, a review. If approved by the Scrutiny panel and the package necessitates new or changed cost, then the package is further reviewed at Resource Panel. If both panels approve the package, the cost of delivery will then require approval as per the Scheme of Delegation. This is obtained via the new electronic "system".

Packages requiring cost approval are added to an Excel spreadsheet. This spreadsheet is linked to the Health Board's Scheme of Delegation using automated formulae and via this link, the spreadsheet auto-populates the appropriate cost signatory.

When package details and the cost signatory have been populated, the spreadsheet is circulated between all cost signatories via an email chain until the appropriate approval has been obtained.

The spreadsheet's link to the Scheme of Delegation is maintained by the Finance department who realign the spreadsheet formulae in the event of any change. This ensures that the appropriate approval per the most up to date version of the Scheme of Delegation is always obtained.

The National Framework Guidance does not stipulate any requirements for obtaining approval over cost of a package and so, there is no risk of non-compliance with that framework in this respect.

The new email system was implemented in January 2025, replacing the previous method of obtaining cost approval via face-to-face meetings. Since its introduction, the CHC team have reported administrative time savings however, our analysis has not been able to quantify this, and we noted that approval times could still vary considerably between 0 days and 10 weeks. Despite this variation, there is no impact on patient package commencement which is critical as, per the National Framework Guidance "CHC packages provided for patients must not be delayed due to administrative processes".

At implementation, there was little training or guidance issued for recipients of the email and attached file and this resulted in some early issues bedding the process in. This was however resolved by the CHC team in time, although we note there continues to be an absence of documented explanatory guidance. Whilst a minor observation, it is suggested that for good practice and to avoid any ambiguity around the process arising with future recipients, a guidance document in the form of a sub-process be created and added to the CHC Team's procedural guidance pack.

Our review concluded that the new electronic system both aligned with the Health Board's Scheme of Delegation and ensured compliance with the National Framework Guidance and therefore, there are no key observations raised against this objective.

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## Overview / Summary of Observations

When a new package is agreed, key details including review dates are added to the National Complex Care Database (NCCD). Whilst the NCCD could be considered a legacy system for its limited functionality, it does provide ability for caseworkers in the CHC team to review upcoming and overdue package review dates, and this feature is used to schedule patient reviews.

The CHC team have an internally mandated target compliance rate of 85% of reviews to be completed "on-time". In this sense, an on-time review is one that is completed before or, within one month after, the target review date. Per the National Framework Guidance, placement reviews must be conducted (at minimum) after three and twelve months from commencement and 12 monthly thereafter.

As part of our review, we sample tested all placement reviews for the 20 patients receiving the most expensive care packages. This testing showed that 18 of 21 (86%) of reviews between January 2024 and August 2025 had been completed on time or early, exceeding the Team's internal target. Of the three reviews completed late, one remained outstanding at the time of testing and was 10 weeks overdue but, this review was responsibility of the District Nursing Team and the CHC Team were proactively following this up. Comparing 2024 against 2025, we noted a slight decrease in reviews being completed on or before target from 91% to 86% but, acknowledge that over that same period caseload per caseworker had increased by 45% from an average of 49 patients per caseworker in 2024 to 71 in 2025.

To provide assurance that reviews were compliant with the assessment criteria described by the National Framework Guidance, we also considered the documentation completed for all reviews in the sample (55). Our testing on this revealed that every review can, and usually did, result in completion and generation of many documents, but critically, all included a complete Nursing Needs Assessment (NNA). Whilst the format of this document differed depending on the type of presentation a patient displayed, the NNA is structured and was completed in such a way to ensure compliance with all areas of consideration required for CHC as stipulated by the National Framework Guidance. This includes specific sections for:

- Capture of patient capacity and consent;
- An overview assessment describing the patient's background, needs and any changes in their presentation;
- A detailed assessment against each of the 12 care domains;
- A summary description of each of the four key indicators;
- A conclusion and recommendation for ongoing provision of care; and
- A list of actions required to further tailor care or ensure the placement provider (care home) standards were of appropriate standard.

Whilst all patient records reviewed in our sample testing contained documentation to support that a full and thorough review had been conducted, identifying required documentation was a challenge. As noted, every review can result in completion and generation of many documents, and we found that digital copies of these held in patient files lacked convention both in terms of naming and filing structure. This meant that sourcing and identifying documents relating to a specific review was time consuming and difficult including for the CHC team. This is discussed in more detail below in key finding 1.

All actions recorded as part of a review are thoroughly documented on the NNA and these are discussed by the Scrutiny panel to ensure appropriateness. The CHC team maintain a record of actions discussed and approved by the Scrutiny panel in meeting minutes and have a method in place for ensuring these are followed up to completion. There is not however a master file that provides a consolidated list of all

actions in a single place, and this makes getting an overview of status for individual actions challenging. Therefore, we suggest, in order to improve transparency and aid action tracking that a file of this type is created and the CHC team maintain this going forward.

The overall process for scheduling and conducting reviews and also for following up on actions arising from reviews is well embedded with review timeline compliance above the CHC teams target and this was substantiated by our sample testing. However, during our review we noted that the general CHC procedure document describing the standard CHC process was out of date and currently under review. This is discussed more fully below in key finding 2.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Patient Placement Review Documentation Storage</b></p> <p>As part of our testing, we checked to ensure every recorded review could be substantiated with appropriate documentation. Whilst all records reviewed as part of our sample did have the appropriate documents, these were challenging and time consuming to identify, including for the CHC team as:</p> <ul style="list-style-type: none"> <li>Files were named inconsistently, lacking convention and description of the document</li> <li>Files lacked structure and order and were stored in folders containing sometimes dozens of documents</li> </ul> <p>In addition, several of the files requested within the sample had not been typed in digital format and were only available in hand-written hard copy. This included several documents that had been originally created several weeks before the audit review commenced.</p>	<p>Risk of non-compliance with National Framework Guidance and loss of patient background and history in event of caseworker change in CHC team</p>	<p><b>Agreed Action:</b></p> <p>The CHC team will design and implement a file management process and ensure consistency of use across the team. The process will include:</p> <ul style="list-style-type: none"> <li>A time target for typing up and storing documents electronically to patient files;</li> <li>A file naming convention including: document title, patient reference and date; and</li> <li>A file management structure within SharePoint for storing patient files.</li> </ul> <p><b>Expected Evidence of Implementation:</b></p> <p>New file management process in place and being utilised.</p>
<p><b>Theme:</b> Information, Data Quality &amp; Data Accuracy</p>	<p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Officer:</b> Assistant Director Complex Care</p> <p><b>Target Implementation Date:</b> March 31<sup>st</sup> 2026</p>

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Key Findings	Risk & Impact	Agreed Management Action
<p>2      <b>CHC General Procedure Document</b></p> <p>The currently documented procedure describing the general CHC procedure was created in 2015 and last reviewed in 2018. This document was due to be reviewed in 2019, but no review has been documented, and our work has shown that the procedure described does not now accurately reflect the actual procedures employed.</p> <p>The CHC team are well represented at the All-Wales CHC Management Group and so are appropriately positioned to monitor and implement any change to the National Framework Guidance. Whilst this mitigates risk of actual process not aligning with current guidance, any changes are not reflected in procedural documentation.</p> <p>The CHC team have however drafted a new procedure document, and this is currently under review. We have reviewed this document and note that it does not contain reference to other related procedures, several of which are new. Whilst care must be taken to avoid duplication or repetition between procedural documentation, including references in a procedure to related guidance can help to ensure holistic capture of the full end to end process.</p> <p><b>Theme:</b> Policies &amp; Procedures</p>	<p>Operating without a documented, approved procedure could lead to incorrect or inconsistent process exposing the Health Board to regulatory censure and denying patients of care to which they are entitled.</p> <p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Agreed Action:</b></p> <p>The procedure document currently in draft will be updated to include, where appropriate, references to other related and newly created CHC procedures. Review and approval of the draft will then be expedited and the final version circulated to all members of the CHC team for awareness.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>An updated procedure document containing appropriate references is available on the Health Board's SharePoint site</p> <p><b>Officer:</b> Assistant Director Complex Care  <b>Target Implementation Date:</b> November 30<sup>th</sup> 2025</p>

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**Objective 3:** The Health Board has improvement plans in place to address the current level of CHC cases and associated costs. Progress towards delivery of the plans is effectively monitored and regularly reported within the Health Board

**Reasonable**

### Overview / Summary of Observations

The CHC team have a master plan covering the period January 2024 to April 2026 – the “Complex Care Improvement Plan 2024 – 2026”. This plan was authored by the Assistant Director of Continuing Healthcare who also retains responsibility for operational delivery of the areas of focus detailed by the plan.

In total, there are 16 focus areas detailed by the plan covering a range of considerations and team operations including:

- Team and departmental Governance structure (2)
- The patient review process and review timeline compliance (2)
- Enhancement of digital capability (1)
- Design, documentation and delivery of new and updated Standard Operating Procedures (SOPs) (6)
- Reporting (1)
- Placement and partner relationships (2)
- Legislative and framework changes (2)

The plan includes descriptions of work and targeted benefits for each area of focus as well as target completion dates. Each focus area is also RAG (Red/Amber/Green) rated denoting progress toward completion and highlighting risks to completing the work and/or achieving the targeted benefit.

Whilst the plan document provides a succinct overview of improvement works undertaken by the department, there is no evidence that the plan has been packaged as an overall programme of work, submitted for review, scrutiny and approval by committee or, that reports on progress are delivered at programme level.

As at August 2025, workstreams listed in the Improvement Plan are described with the following statuses:

- 7 – Complete
- 1 – Complete – Ongoing action
- 6 – In progress
- 2 – In Progress – At risk

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Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>Formalise Plan Governance</b></p> <p>The CHC team have a master improvement plan – the “Complex Care Improvement Plan 2024 – 2026”. This plan effectively summarises activity and workstreams ongoing or complete across 16 different areas of focus.</p> <p>The planning document is maintained with narrative highlighting updates and key risks to achieving targeted objectives however, it is not presented in fulness to the Performance and Delivery Committee, and this may inhibit transparency over the full breadth and scope of work being undertaken by the team. Committee updates instead are formatted in such a way to provide a narrative update on key areas of focus within the plan.</p> <p>Whilst this narrative focus is appropriate for committee papers, the lack of summary provided on the full plan may inhibit the committee’s view of the full scope and breadth of work being undertaken by the team and therefore limit the assurance being provided.</p> <p><b>Theme:</b> Governance</p>	<p>Lack of governance may result in activity unaligned with strategic objectives and risk left unmitigated jeopardising achievement of objectives</p> <p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Agreed Action:</b></p> <p>To provide perspective on the scale of improvement works undertaken, tighten governance and provide greater assurance, the Improvement Plan will be summarised with a dashboard presented at every committee meeting. The “Programme dashboard” will include the summary built into the plan illustrating:</p> <ul style="list-style-type: none"> <li>• Number of workstreams completed</li> <li>• Number of workstreams in progress</li> <li>• Number of workstreams at risk</li> </ul> <p>Narrative will then be provided on key achievements for the period and, where risks have been highlighted, what actions are being implemented to mitigate.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Dashboard reporting available on committee meeting papers.</p> <p><b>Officer:</b> Assistant Director Complex Care  <b>Target Implementation Date:</b> December 31<sup>st</sup> 2025</p>

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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	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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## 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.



# Mental Health and Learning Disability Triage and Assessment Process

## Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

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### Review Reference

PTH-2526-11

### Fieldwork

August - November 2025

### Executive Sign Off

29<sup>th</sup> December 2025

### Audit Committee

January 2026

### Executive Lead

Elaine Lorton, Executive Director of Primary  
Care, Community & Mental Health

### Audit Team

Ian Virgill, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit



# Executive Summary

## Purpose

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 (the 'Health Board').

## Overview

The Health Board's 'Six Goals' Programme within Urgent Care, approved a bid from MH & LD services in June 2023 for temporary funding to introduce Community Mental Health Triage Practitioners and move to a SPOA for MH & LD, which would include '111 press 2 for Mental Health'.

The SPOA service went live in September 2024, and a Business Case was then submitted to the Health Board's Investment Benefit Group in December 2024 to secure recurrent funding for the SPOA service to continue owing to the temporary 'Six Goals' funding ending in March 2025. The recurrent funding was approved by the Health Board's Executive Committee.

A project was established to support the introduction of SPOA, which involves two key phases.

- Phase 1, which consisted of implementing a Triage team, incorporating previous Mental Health referrals administration hub forming a Single Point of Access for MH & LD, physically located and integrated with the '111 press 2 service'.
- Phase 2, which relates to the implementation of an Assessment Team into the MH & LD SPOA service and its alignment with the 'Better Together Community Model Re-design Programme'.

We note that only Phase 1 has been implemented so far, and project work relating to Phase 2 was ongoing during the time of our audit.

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

- The absence of formal governance arrangements for the SPOA Service.
- Finalisation and formal approval of the SPOA Standard Operating Procedure.
- Reporting interface issues between the Welsh Community Care Information System (WCCIS) system and Power BI.
- The absence of reporting arrangements for SPOA Service demand, capacity, and performance management data to the MH & LD Directorate senior management team.

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

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

- Inclusion of compliance timescales for each of the Colgate Triage Categories within the main body of the SPOA Standard Operating Procedure.

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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

	Objectives	Related Findings	Assurance
1	Effective project management arrangements are in place for the development and implementation of the Model, including a project group, project plan and risk register	-	<b>Substantial</b>
2	The project has received the required Health Board approval and provision of funding	-	<b>Substantial</b>
3	Phase 1 of the project covering the triage team and SPOA service has been effectively implemented with an appropriate structure and staffing establishment is in place	1	<b>Reasonable</b>
4	The triage team and SPOA service are operating effectively with a Standard Operating Procedure (SOP) in place that clearly defines the pathway from access through to triage and stages of service delivery	2,3	<b>Reasonable</b>
5	Robust mechanisms are in place for recording, monitoring and reporting the levels of demand and capacity in order to provide effective oversight and determine if the service is delivering the anticipated benefits	4	<b>Limited</b>

### Management Actions

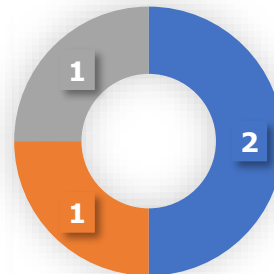


High Priority



Medium Priority

### Themes



- Governance
- Information, Data Quality & Data Accuracy
- Performance Monitoring

### Risk Types

Legal & Regulatory Non-Compliance

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# Findings & Agreed Action Plan

**Objective 1: Effective project management arrangements are in place for the development and implementation of the Model, including a project group, project plan and risk register.**

**Substantial**

## **Overview / Summary of Observations**

The inception and implementation of Phase 1 of the SPOA/111 Press 2 Service was supported by a robust and well documented project management methodology and approach that included a Project Group, Project plan and Project risk register.

Project Group meetings were regularly held, were quorate and well attended by membership, and were satisfactorily documented within workstream decision and action logs that were subject to ongoing monitoring. This enabled project milestones to be completed in accordance with project plan timescales. Project issues that were identified were appropriately documented within the workstream decision and action logs and recorded on the risk register which was subject to regular review and update.

Periodic progress reporting during Phase 1 of the project was provided to the Mental Health Transformation Programme Board and Executive Committee.

**Objective 2: The project has received the required Health Board approval and provision of funding.**

**Substantial**

## **Overview / Summary of Observations**

An Investment Business Case (IBC) was created to secure a future and recurrent funding commitment by the Health Board to the SPOA/111 Press 2 Service following temporary 'Six Goals for Unscheduled Care' funding that was made available from Welsh Government to establish the new triage and assessment model. This temporary funding stream ended on March 31st, 2025.

The SPOA/111 Press 2 Phase 1 Investment Business Case (IBC) was fully costed to determine its funding requirements and stated justification and option appraisals to support and substantiate the requested recurrent funding from the Health Board, to ensure the continuity and growth of the Service. The IBC also clearly outlined the anticipated outcomes and benefits of the project, including helping to reduce Directorate variable nursing pay, and specifically that of the dependency and usage of specialist mental health nursing agency staff.

The IBC was scheduled to go to the Investment Business Group (IBG) in December 2024, but that meeting was stood down. Given the urgency for approval, IBG Chair's Action was applied that enabled submission to the Executive Team for consideration and approval during its meeting on January 8th, 2025.

We note that the IBG has no delegated authority to approve, they make recommendations to the Executive Committee who then consider the IBG's recommendations and will approve the Investment Business Case and then advise the IBG accordingly.

Executive Committee sponsorship and approval of the IBC was granted on 8th January 2025.

**Objective 3: Phase 1 of the project covering the triage team and SPOA service has been effectively implemented with an appropriate structure and staffing establishment is in place.**

**Reasonable**

**Overview / Summary of Observations**

Phase 1 of the SPOA project was successfully implemented, and the service went live in September 2024.

The service has an appropriate structure in place supported by an adequate staffing establishment which currently allows for effective service delivery. As previously noted, the current establishment is fully funded on a recurring basis. However, management have highlighted that in due course SPOA Service referral demand may rise which would require an increase in the staffing complement.

Whilst the current establishment is fully funded, we note that the service is still reliant on a level of agency usage due to delays in appointing to full establishment levels and covering sickness and other absence.

However, there is currently no formal governance structure and arrangements in place for the SPOA Service that interfaces with the MH & LD Directorate management and wider Health Board governance apparatus.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b><u>SPOA Service Governance</u></b></p> <p>Currently there is no governance structure and arrangements in place that enables the SPOA Service to report governance related matters to the MH &amp; LD Directorate Team meetings.</p> <p>Current reporting undertaken is only that of quality &amp; safety related issues, and these appear to be reported on a very infrequent basis to the Adult Mental Health Putting Things Right (PTR) meeting.</p> <p>As such, the Directorate and wider Health Board governance apparatus may not have effective oversight of the service and may not be formally receiving any key governance issues arising that may require scrutiny and action at a higher level.</p> <p><i>Powell, Bethan 08/01/2026 14:26:26</i></p> <p><b>Theme:</b> Governance</p>	<p>Patients accessing the SPOA service may not receive appropriate and timely triage and assessment.</p> <p><b>High Priority</b></p> <p>Control Design</p>	<p><b>Agreed Action:</b></p> <p>An Operational Delivery Group will be established for the SPOA which will formalise operational governance arrangements for the service. It will report into MH&amp;LD SMT via the Service Quality Improvement and Development (SQID) workstream and align to the deliverables identified in the Transformation Workstream reporting progress to the Better Together Project Board. The SPOA will also formalise the reporting of Quality &amp; Safety related governance into the QUAILS meeting, which is an SMT workstream, this will be on a monthly basis.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Terms of Reference for SPOA – Operational Delivery Group(ODG). Standing Agenda and minutes of ODG. Report for SQID / Report for QUAILS. Transformation Programme Board standing agenda item and minutes.</p> <p><b>Officer:</b> Lauraine Hamer – Interim Head of Operations. Marielle Restall – Interim Service Manager 111#2/SPOA.</p> <p><b>Target Implementation Date:</b> 01/02/26</p>

### **Overview / Summary of Observations**

The SPOA Service has a draft SOP that outlines in a clear, comprehensive and logical format the referral and triage criteria and processes, and these are underpinned by referral and triage pathways that explain the processes in detail. The SOP also includes a copy of the Colgate Triage Guidelines and Tool which are the formal requirements relating to the triage process undertaken by SPOA nurse assessors to determine further assessment and action.

However, compliance timescales for each of the Colgate Triage Categories A to F are not directly stated within the SOP but are included within two Appendices. For ease of reference, it would be useful to include a summary of the Colgate Triage criteria and required triage timescales for each into the body of the SOP.

We can confirm that all SPOA Team members have access to the SOP and are conversant with its content, and there are no other procedures in place relating to the direct running of the SPOA Service and of its referral pathway management processes in place.

Prior to the operational commencement of the SPOA Service a range of awareness exercises were undertaken with key user groups and stakeholders to ensure that they were fully appraised of the Service's existence and also methods of user referral. These included Police, Ambulance, Local Authority, Public Health Wales, Armed and Ex-Forces, Third Sector representatives and Powys Regional Partnership Board (RPB). GP Cluster Group meetings in Powys were also informed of the Service and its referral pathways.

We undertook testing of a sample of 30 referrals into the SPOA Service between the period of April to July 2025 and sought to confirm the following:

- Triage undertaken was in accordance with the classification criteria stated in the Colgate Triage Categories A to G and notes on Welsh Community Care Information System (WCCIS) patient records recorded justifications for the Categories allocated.
- Colgate Scale Triage referral receipt dates to triage timescales were being complied with in accordance with Categories A to G.

Our testing was only undertaken in relation to the referral and triage pathway, as the assessment and onward referral pathways stages were being formalised and finalised as part of the Phase 2 project relating to the SPOA Service which was ongoing at the time of the audit and therefore outside of the current audit scope.

All 30 sampled referrals were triaged in accordance with the classification criteria and priority timescales stated in the Colgate Triage Categories A to G, and the supporting narrative and audit trail within WCCIS patient records documented this in all cases.

However, issues were identified relating to the interfacing of WCCIS and Power BI reporting output.

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Key Findings	Risk & Impact	Agreed Management Action
<p>2 <b><u>Draft SPOA Service Standard Operating Procedure (SOP)</u></b></p> <p>The SPOA Service SOP is currently in draft format and was scheduled to be submitted to the Clinical Policy Advisory Group (CPAG) in November 2025 for review/approval. However, it was deferred as it was decided that additional information was required to be added to the SOP regarding the Service's relationships and risks in respect of other Mental Health Service's respective SOPs.</p> <p>We note that at time of our audit, the draft SOP is planned to be submitted to a CPAG meeting in early 2026 for further consideration.</p>	<p>Patient referral, access and delivery pathways are fully documented and are complied with.</p>	<p><b>Agreed Action:</b></p> <p>The SPOA Service draft SOP will be updated to reflect the Service's relationships with other Mental Health Service's respective SOPs as soon as is practicable.</p> <p>This action has been completed; SOP has been reviewed and updated to reflect current operational arrangements and is currently out to comments for wider service.</p> <p>A timescale for submission to the MH&amp;LD Clinical Policy Advisory Group (CPAG) for approval will be confirmed once the SOP is updated.</p> <p>Following this, submission to SMT for approval.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Finalised SOP has been scheduled for approval at January CPAG and ratified SOP will be produced as evidence. SMT minutes will reflect decision re approval.</p>
<p><b>Theme:</b> Governance</p>	<p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Officer:</b> Marielle Restall – Interim Service Manager 111#2/SPOA</p> <p><b>Target Implementation Date:</b> 20/01/26</p>
<p>3 <b><u>Reporting interface issues between Welsh Community Care Information System (WCCIS) system and SPOA Service Power BI reports</u></b></p> <p>Whilst we can confirm that all sampled referrals were being triaged in accordance with the prescribed timescales, a number of referral to triage timescales stated on the Power BI report that was used for our sampling were erroneous.</p> <p>Initial investigations suggested that this is due to interface issues between WCCIS and Power BI whereby the triage form used by SPOA assessors is not shown as being closed down at the since time on the Power BI report as it was on WCCIS, despite the triage being undertaken in an efficient manner as documented on the WCCIS patient notes audit trail.</p> <p>Additionally, several referrals on the Power BI report stated incorrect Colgate Triage Categories, and this appears to be a</p>	<p>Patients accessing the SPOA service may not receive appropriate and timely triage and assessment.</p>	<p><b>Agreed Action:</b></p> <p>Liaison will be undertaken between SPOA management and the WCCIS Systems Team to ensure that future Power BI reporting accurately reflects content on WCCIS, and any interface reporting glitches are identified and remedied.</p> <p>Meeting with WCCIS and BI/IT staff has been scheduled to address discuss issues highlighted and to understand underlying reasons for the noted discrepancies. Based on these discussions an Action Plan will be put into place to rectify and improve data quality</p>

<p>glitch whereby they are correctly reflected on WCCIS patient notes but are not being pulled through via Power BI accurately.</p> <p>These issues will need to be addressed to ensure that future Power BI reporting accurately reflects content on WCCIS, as in due course Mental Health Directorate Management, as well as Health Board senior management may request the provision of reports, the content of which is at risk of being inaccurate.</p>	<p><b>Medium Priority</b></p>	<p><b>Expected Evidence of Implementation:</b></p> <p>Notes of meetings scheduled to discuss identified issues. Action Plan with objectives and timescales. Testing of BI dashboards following implementation with screenshots to evidence desired outcomes.</p>
<p><b>Theme:</b> Information, Data Quality &amp; Data Accuracy</p>	<p>Control Operation</p>	<p><b>Officer:</b> Lauraine Hamer, Marielle Restall.</p> <p><b>Target Implementation Date:</b> 01/03/26</p>

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**Objective 5: Robust mechanisms are in place for recording, monitoring and reporting the levels of demand and capacity in order to provide effective oversight and determine if the service is delivering the anticipated benefits.**

**Limited**

**Overview / Summary of Observations**

The SPOA Service is supported by the Welsh Community Care Information System (WCCIS) that retains the patient referral data obtained from self-referrals via 111 Press 2 function and direct clinical referrals from GPs/clinicians/EMS and other referring agencies.

This system captures patient clinical triage assessment notes and dates/times of referral, the subsequent onward actions, and provides an audit activity trail linked to the assessor undertaking the triage. The information on WCCIS can be utilised via Power BI to provide a wide suite of dashboards and reports covering referral activity and referral demand and capacity. WEBEX, the digital telephony system used by the triage assessors timestamps the call wait and duration times and this information feeds into WCCIS to support the audit trail and triage performance data.

However, at the time of our review there was no reporting of SPOA activity and no KPIs were in place. We are therefore unable to provide any assurance that the performance of the service, and associated delivery of the anticipated SPOA benefits, are subject to effective oversight.

As part of our review, we were able to confirm that there is ongoing and active management being undertaken within the SPOA Service to reduce its use and subsequent expenditure on specialist agency nursing staff, which was one of the anticipated benefits of the service. Agency nurse usage reports are produced by Finance and Workforce and are sent out monthly to the Executive Director of Primary, Community Care & Mental Health. There is also a variable pay meeting held once a month within the MH & LD Directorate which reviews SPOA agency nursing expenditure.

There has been a trend of reduced agency nursing staff usage over the period September 2024 to November 2025, with exception based periodic spikes that are attributable to sickness and seasonal staffing requirements. The fall in agency nursing usage has been most noticeable during the 2025/26 financial year to date.

Key Findings	Risk & Impact	Agreed Management Action
<p>4 <b><u>Recording, Monitoring and Reporting of SPOA Service Demand and Capacity</u></b></p> <p>At the time of our review there was no reporting of SPOA Service demand, capacity, triage call timescales and performance management data to Directorate senior management.</p> <p>We were informed by service management that no-one within the Health Board has requested any activity reports or any other performance information since the Service became operational in September 2024.</p> <p>SPOA Service management are also unclear what senior management would specifically want in the way of reports that could be provided by the Service. Additionally, no KPIs are in place for the SPOA Service, and we were informed that Health</p>	<p>The anticipated benefits of the project may not be delivered.</p>	<p><b>Agreed Action:</b></p> <p>SPOA Service management will prepare for regular reporting of its demand, capacity, triage call timescales and performance management activity data to SQID which reports to MH &amp; LD Directorate senior management.</p> <p>Improved data and reporting capacity has been highlighted as a service requirement as part of the WCCIS Replacement tendering process, it is recognised that additional work will need to be carried out to ensure that configuration of the new system delivers anticipated outcomes in terms of demand, capacity and activity reporting.</p> <p>There have been National conversations about development of KPIS for consistency purposes across Health Boards and MH&amp;LD proposal to the National Strategic Programme Board for Mental</p>

Board senior management have not to date asked for any to be introduced.

Furthermore, there is no functionality within Power BI to produce reports on agency nursing activity, or the recording of data attributable to agency nursing usage as this information is held on the financial ledgers and not on WCCIS. There is no interface between Power BI to the financial ledgers that would facilitate production of reports/dashboard to show reduction of agency spend.

As such, it is unclear if Health Board senior management and Health Board Groups/Committees are being formally appraised of the SPOA Service achieving the anticipated outcomes and benefits detailed within the IBC.

Health has included testing as part of being a 'demonstrator' pilot area which will build in measures for evaluation as well as performance monitoring for Wales. Full performance reporting is planned for the next stage of roll out and it is the assessment part of transformation that is seeking to eradicate community variable pay.

Demand and capacity modelling has been undertaken utilising available data for the purposes of planning future services as part of Better Together of which the SPOA Triage and Assessment Service is within the accelerated design scope. The wider benefits of the SPOA for access to services, equitability and consistency of triage is already recognised. However, it is acknowledged that national and local workstreams could be brought together more seamlessly into one governance structure and the service will work towards this. Financial monitoring of other variable pay and private providers is undertaken by MH&LD SMT but in consideration of the key finding of monitoring impact the of SPOA specifically against IBC, MH&LD Senior Management will take advice from colleagues in the Performance and Commissioning on how to overcome the challenge of lack of functionality within Power BI to interface with financial ledgers.

Resulting actions will form part of the work of the aforementioned ODG and reporting through the strengthened governance arrangements as previously described.

**Expected Evidence of Implementation:**

Highlight Report to Better Together Project Board. Copy of identified KPIs and ODG Action Plan. SQID Minutes. SMT Minutes.

**High Priority**

**Officer:** Louisa Kerr – Assistant Director. Lauraine Hamer – Interim Head of MH Operations.

**Target Implementation Date:** 01/02/26

**Theme:** Performance Monitoring

Control Operation

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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

## Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of 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.



# Core Financials – General Ledger Management & Accounts Receivable

## Final Internal Audit Report 2025/26

Powys Teaching Health Board



Reasonable Assurance

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### Review Reference

#### Fieldwork

#### Executive Sign Off

#### Audit Committee

#### Executive Lead

#### Audit Team

PTH-2526-04

September - November 2025

19<sup>th</sup> December 2025

January 2026

Director of Finance, Capital & Support Services

Ian Virgill, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit



# Executive Summary

## Purpose

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

## Overview

Given that previous Core Financials audits have received high levels of assurance, individual areas are now covered on a cyclical basis. In 2024/25 the audit focussed on Treasury Management with a Substantial Assurance opinion provided. This year's audit focussed on General Ledger Management and Accounts Receivable. General Ledger Management was last audited in 2017/18 with an overall opinion provided of Substantial Assurance.

The general ledger records all financial transactions of the organisation and provides the basic information for the preparation of management accounts, final accounts and financial returns. In order to maintain proper financial control, it is essential that adequate accounting routines operate to protect the integrity of the ledger and that those routines are implemented in practice.

The collection of income due in a timely manner is crucial to the financial stability of the Health Board and important in meeting its financial targets and providing patient care.

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

- The incorrect offset balance sheet financial code being used for monthly income and expenditure accruals.
- Monthly balance sheet reconciliations not detailing sufficient information, including balances brought forward from previous financial year with no supporting information, and salary sacrifice schemes reconciliations balances remaining where there has been no activity this financial year.
- The Periodic Income Register needs to be reviewed on a regular basis to ensure that all information is up to date to allow official invoices to be raised on a timely basis and at the correct value.
- The current list of outstanding debts includes a large number of debts that have been owing for a significant period of time, in some cases over 15 years.
- Reviewing the delegated financial limits for the authorisation of debt write off.
- Reviewing and updating the current versions of Financial Control Procedures.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- The schedule in place for monitoring overpayments of salary which have agreed repayment plans could be enhanced to include current staff repaying via payroll deduction and also record all monthly repayments received.

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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

Objectives	Related Findings	Assurance
1 General Ledger - Access and changes to the general ledger are appropriately managed.	-	<b>Substantial</b>
2 General Ledger - All input to the general ledger is complete, accurate, timely and valid.	1	<b>Reasonable</b>
3 General Ledger - Month end reconciliations for the balance sheet are undertaken.	2	<b>Reasonable</b>
4 Accounts Receivable - Debtor invoices are raised on a timely basis for all income due, and receipts are correctly recorded.	3	<b>Reasonable</b>
5 Accounts Receivable - Intra NHS Debtors are managed appropriately.	-	<b>Substantial</b>
6 Accounts Receivable - Overpayments of salary are managed, monitored and reported.	4	<b>Reasonable</b>
7 Accounts Receivable - Outstanding and aged debt is appropriately monitored and followed up.	4	<b>Limited</b>
8 Accounts Receivable – Debt write off is managed appropriately.	5	<b>Reasonable</b>
9 Procedural Guidance – Procedural guidance is in place and is appropriate and up to date for General Ledger and Accounts Receivable.	6	<b>Reasonable</b>

### Management Actions

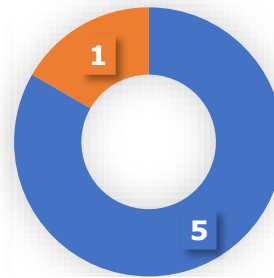


High Priority



Medium Priority

### Themes



- Finance Management & Control
- Governance

### Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance

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# Findings & Agreed Action Plan

**Objective 1: General Ledger - Access and changes to the general ledger are appropriately managed**

**Substantial**

## **Overview / Summary of Observations**

Access to the Oracle Financial System is overseen by the Health Board's Systems Team which forms part of the Corporate Finance Department. There are approved processes in place for the requesting and removal of access to the Oracle Financial System.

Regular checks are undertaken to ensure that staff access, (including functions) is still required and appropriate. Reports are issued to key staff for review who will then advise the Systems Team of any changes/actions that are required.

The Systems Team also liaises with key members of NHS Wales Shared Services Partnership (NWSSP) functions such as Procurement and Accounts Payable to ensure that Powys staff member's access to the Health Board system is still appropriate.

The processes for requesting changes to the Chart of Accounts are appropriate and well managed. The processes are outlined in the Financial Control Procedure 'FCP014 Procedure for General Ledger'.

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**Overview / Summary of Observations**

A monthly reporting timetable is in place that identifies key tasks to be undertaken and the relevant working day that they must be completed by. The timetable is available to all staff via the department’s ‘intranet’ page on SharePoint.

With regards to information uploaded from integrated feeder systems such as Payroll, the financial control procedure outlines key actions and responsibilities to be undertaken by the Finance Department.

Information is also input to the ledger via monthly journals which are completed to correct miscoded expenditure and also to record income and expenditure accruals. All journals must be appropriately authorised before being uploaded to the financial ledger.

Testing was undertaken on a sample of reversing journals that had been uploaded/input to the financial ledger to ensure that all journals had been appropriately authorised and that transactions were appropriate, timely and correctly coded.

The results of our testing found that all transactions were appropriate and actioned on a timely basis. In addition, all journals were authorised prior to upload to the ledger. We did however identify an issue regarding the incorrect balance sheet accrual code being used to offset income and expenditure accruals.

A payroll suspense code is in place to capture payroll transactions where it has not been possible to identify the correct financial code by the financial reporting monthly deadline. A monthly reconciliation is completed for this financial code. We reviewed a sample of payroll suspense reconciliations and found that they were completed and authorised on a timely basis. Furthermore, it we noted that the outstanding transactions listed were current.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Journal Accruals</b></p> <p>The testing we undertook on a sample of 15 reversing journals found that the entries were appropriate, actioned on a timely basis and authorised prior to the upload to the general ledger.</p> <p>However, we did identify several occasions where the offset balance sheet financial code was incorrect resulting in income accruals being offset against a creditor accrual code and vice versa.</p>	<p>Data being incorrectly recorded within the general ledger</p>	<p><b>Agreed Action:</b></p> <p>At financial year end all balance sheet individual transactions are reviewed to ensure the correct classification for Financial Statement Purposes.</p> <p>We will issue a reminder to all staff to check that they input the correct offset balance sheet financial code when actioning accruals for income and expenditure.</p> <hr/> <p><b>Expected Evidence of Implementation:</b></p> <p>Email to relevant staff.</p> <hr/> <p><b>Officer:</b> Assistant Director of Finance (Accounting and Systems)  <b>Target Implementation Date:</b> 31<sup>st</sup> January 2026</p>
<p><b>Theme:</b> Finance Management &amp; Control</p>	<p>Control Operation</p>	

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**Medium Priority**

**Overview / Summary of Observations**

Testing was undertaken on a sample of balance sheet reconciliations and the results showed that they were all completed on a timely basis, values match the ledger and they were appropriately authorised.

However, the results of our testing also noted that some of the reconciliations included amounts without any accompanying details of the staff or periods the amounts related to. There were also balances brought forward from the previous financial year with no breakdown of what the amount related to.

With regards to the reconciliations related to salary sacrifice schemes there were balances relating to staff where that had been no activity this financial year as well as a brought forward balance for the cycle to work scheme.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 <b>Reconciliations</b></p> <p>The testing we undertook on a sample of 15 balance sheet reconciliations completed identified the following issues with some of the payroll deductions reconciliations:</p> <ul style="list-style-type: none"> <li>• Incomplete information regarding outstanding transactions. In some cases, it was an amount with no breakdown of the individual amounts, staff payroll number and related financial period;</li> <li>• Balances brought forward from previous financial years; and</li> <li>• The reconciliations related to salary sacrifice schemes included balances for staff where there has been no activity this financial year.</li> </ul>	<p>Incorrect data may be recorded within the financial ledger.</p>	<p><b>Agreed Action:</b></p> <p>For future reconciliations we will ensure that all outstanding transactions have appropriate supporting details noted. We will also ensure that such details are included where the reconciliation has a brought forward balance from a previous financial year.</p> <p>With regards to the reconciliations concerning salary sacrifice schemes we will undertake a review for those balances where there is no longer any activity and take the appropriate action to clear the balance.</p>
<p><b>Theme:</b> Finance Management &amp; Control</p>	<p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Expected Evidence of Implementation:</b></p> <p>Reconciliation for future Months</p> <p><b>Officer:</b> Financial Accountant</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> March 2026</p>

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**Objective 4: Accounts Receivable – Invoices are raised on a timely basis for all income due, and receipts are correctly recorded**

**Substantial**

**Overview / Summary of Observations**

There is an agreed process in place for the requesting of invoices, and we note that the majority of Health Board invoices are requested via the Periodic Income Register.

The testing we undertook on a sample of invoices raised based on information held within the Periodic Income Register identified issues with the timeliness of invoices being raised and also the values of invoices.

There are formal processes in place for the recording of income received and where applicable allocation to related invoices.

There is also a financial code in place to record income received where there is insufficient information to identify which department’s financial code the money should be coded to. This financial code is included in the monthly Accounts Receivable reconciliation ensuring that the transactions are monitored and resolved.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>Raising Invoices</b></p> <p>Our testing on a sample of invoices raised from information recorded within the Periodic Income Register identified issues concerning:</p> <ul style="list-style-type: none"> <li>• The timeliness if invoices raised;</li> <li>• Difference in the value of the invoice to the value recorded within the Periodic Income Register; and</li> <li>• Delay in actioning an income accrual.</li> </ul> <p><i>Powell, Bethan 08/01/2026 14:26:26</i></p>	<p>The Health Board does not receive the income it is entitled to.</p>	<p><b>Agreed Action:</b></p> <p>We will request that the Periodic Income Register is reviewed by Finance staff to ensure all invoice values are up to date and reflect any agreed annual uplift (where applicable).</p> <p>We will ensure that all invoices are raised in accordance with the frequency detailed in the register.</p> <p>We will also remind the Finance Support Team and Management Accounts Staff to update the Periodic Income Register as soon as any changes / updates are known for existing entries as well as any new ‘recharges’ that are identified.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Email to relevant staff of the requirement for timely input and review of their related items contained within the Periodic Income Register.</p>
<p><b>Theme:</b> Finance Management &amp; Control</p>	<p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Officer:</b> Assistant Director of Finance (Accounting and Systems)</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> January 2026</p>

## Objective 5: Accounts Receivable – Intra NHS Debtors are managed appropriately

Substantial

### Overview / Summary of Observations

NHS Wales debts are managed in accordance with guidance issued by Welsh Government which includes key dates and templates for the agreement of year end balances. In addition, the details of NHS Wales debts are reported as part of the Health Board's monthly monitoring returns submitted to Welsh Government as well as the monthly Finance report completed by the Director of Finance, Capital and Support Systems that is considered at Health Board Committee meetings.

Any disputes regarding NHS Wales debts will be managed in accordance with the arbitration guidance issued by Welsh Government.

All other NHS debts are managed the same as non-NHS debts with reminders being issued as per Health Board guidance.

## Objective 6: Accounts Receivable – Overpayments of salary are managed, monitored and reported

Reasonable

### Overview / Summary of Observations

Whilst there are a number of schedules in place for monitoring overpayments of salary many of them are cumbersome and could benefit from review. The current summary for monitoring debts where repayments are received via a standing order requires updating and enhancing to include overpayments of salary for staff currently employed by the Health Board and where monies are being repaid via salary deductions.

A review of the current position re the value of outstanding debt for overpayments of salary noted that there are a significant number of debts that date as far back as 2015. The position needs to be reviewed, and appropriate action taken. This action is linked to the management of debt within objective 7 below, and the issue / key finding has been reported under that objective.

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**Overview / Summary of Observations**

The Health Board needs to improve its process for the management of outstanding debts. As at 30/09/25 the value of outstanding debts stood at £2,520k and whilst most of the debt was current, we did note that £836k of debt related to invoices from previous financial years with some invoices having been outstanding since 2006. For the financial year 2024/25, 1,143 invoices were raised with a value of £10.637M and to the end of November 2025, 650 invoices with a value of £6.113M have been raised.

Improvements are required in the timeliness of issuing reminders and also resolving the significant number of outstanding debts, whether it is through continued pursuance of the debt or considering the debt for write off. We do acknowledge that during the Covid pandemic the pursuance of some debt categories was halted which has contributed to the current debt situation, as well as the Health Board no longer using the services of a debt collection agency.

Key Findings	Risk & Impact	Agreed Management Action
<p>4 <b>Debt Management</b></p> <p>The processes in place within the Health Board for the management of long outstanding debts need to be improved. As at 30/09/25 the value of debts that had been outstanding for more than 60 days totalled over £882k of which £836k relates to previous financial years.</p> <p>We understand that during the Covid pandemic the Health Board stood down their debt management procedures and as a result when the debt management processes resumed many debtors when contacted assumed that the debt no longer applied as they had not been contacted for some time.</p> <p>We also note that the Health Board no longer makes use of a Debt Collection Agency to pursue their outstanding debts.</p> <p>Our review of the list of outstanding debts noted that some dated as far back as 2006 and have yet to be considered for write off.</p>	<p>The health Board does not receive income it is entitled to.</p>	<p><b>Agreed Action:</b></p> <p>We will review all longstanding debts to determine whether the debt should be pursued or considered for write off.</p> <p>We will ensure that all debts are pursued in a timely manner and consider whether to utilise the service of a debt collection agency.</p> <p>All overdue debts older than 6 months old are subject to a bad debt provision in the annual accounts.</p> <p>Following this review a summary of debts to be written off will be provided to the March 2026 Audit Risk and Assurance Committee to ensure enacted within the 25/26 financial year.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Engagement with a debt collection agency will be reinstated and evidence of review work captured including an Audit Risk and Assurance Committee paper to write off debt no longer to be pursued.</p>
<p><b>Theme:</b> Finance Management &amp; Control</p>	<p><b>High Priority</b></p> <p>Control Operation</p>	<p><b>Officer:</b> Assistant Director of Finance (Accounting and Systems)</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> March 2026</p>

## Objective 8: Accounts Receivable – Debt write-off is managed appropriately

Reasonable

### Overview / Summary of Observations

We note that all debts proposed for write off regardless of value can only be authorised by the Audit, Risk & Assurance Committee (the 'Committee'). Management should consider reviewing and updating the scheme of delegation for debt write off to permit Senior Finance staff to authorise lower value debts, with higher value debts still subject to Committee authorisation. All debts written off will still be required to be reported to the Committee for noting and formal approval.

We note that for this current financial year no debts have been considered for write off. Management should consider reviewing all outstanding debts to ascertain if any of the long overdue debts should be considered for write off.

Key Findings	Risk & Impact	Agreed Management Action
<p>5 <b>Debt Write Off</b></p> <p>From our fieldwork we noted that no debts have been proposed for write off this financial year.</p> <p>We also note that the Health Board has delegated authorisation of debt write off to the Audit, Risk &amp; Assurance Committee regardless of the debt value. Good practice would be to delegate authorisation of lower value debt write off to Senior Finance staff subject to a suitable financial limit with the Committee continuing to authorise larger debt values.</p> <p>All debts authorised / proposed for write off should continue to be reported to the Audit, Risk &amp; Assurance Committee for formal approval.</p> <p><i>Powell, Bethan 08/01/2026 14:26:26</i></p>	<p>Level of income Health Board is due is over reported.</p>	<p><b>Agreed Action:</b></p> <p>We will undertake a review of all outstanding debts to determine whether any long outstanding debts should be proposed for write off.</p> <p>We will consider reviewing the delegated limits for write off.</p> <p>Following this review a summary of debts to be written off will be provided to the March 2026 Audit Risk and Assurance Committee to ensure enacted within the 25/26 financial year.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Evidence of Review undertaken including an Audit Risk and Assurance Committee paper to write off debt no longer to be pursued or out of statute time period and Financial Control Procedure approval.</p>
<b>Theme:</b> Finance Management & Control	<b>Medium Priority</b>	<p><b>Officer:</b> Assistant Director of Finance (Accounting and Services)</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> March 2026</p>
Control Operation		

**Overview / Summary of Observations**

The current versions of the Financial Control Procedures for General Ledger and Debtors are overdue for review and in some sections do not reflect current working practices. In addition, the Health Board’s current version of the ‘Procedure for the Recovery of Staff Overpayments’ does not reflect updated guidance detailed in the approved All Wales Procedure for the Recovery of Overpayments.

Key Findings	Risk & Impact	Agreed Management Action
<p>6 <b>Guidance</b></p> <p>The current version of the Financial Control Procedures (FCPs) for Debtors (FCP009) and General Ledger (FCP014) do not fully reflect the current practices/processes we noted as part of our audit fieldwork.</p> <p>We also noted that the current version of the Health Board’s Procedure for the Recovery of Overpayments to Staff (HR101) has not been updated to reflect the All Wales Policy that was approved for Salary Overpayments.</p>	<p>Finance refer to guidance that is out of date and does not reflect current practice.</p>	<p><b>Agreed Action:</b></p> <p>We are reviewing and updating the FCPS for Debtors and General Ledger to reflect current practices and recommendations of this audit. Once the review has been completed, we will ensure that the documents are approved in accordance with Health Board guidance and made available for all staff to access.</p> <p>We will liaise with our Workforce colleagues to ensure that the current version of the Procedure for the Recovery of Overpayments of Staff is updated to reflect current practices outlined in the All Wales Policy for Overpayments of Salary.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Adoption of updated Financial Control Procedures and communications and posting to intranet page</p>
<p><b>Theme:</b> Governance</p>	<p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Officer:</b> Assistant Director of Finance (Accounting and Services)</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> March 2026</p>

*Prepared: Bethan  
18/01/2026 14:26:26*

# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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

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# Decontamination

## Final Internal Audit Report

2025/26

Powys Teaching Health Board



Reasonable Assurance

### Contents

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Findings & Agreed Action Plan .....	3
Appendix A .....	10

### Review Reference

#### Fieldwork

#### Executive Sign Off

#### Audit Committee

#### Executive Lead

#### Audit Team

PTH-2526-23

September – November 2025

16<sup>th</sup> December 2025

13<sup>th</sup> January 2026

Paul Hooton, Executive Director of Nursing,  
Quality, Women and Family Health

Ian Virgill, Head of Internal Audit

Warren Alexander, Audit Manager

Powell, Bethan  
08/01/2026 14:26:26



# Executive Summary

## Purpose

Our review of Decontamination arrangements was completed in line with the 2025/26 Internal Audit plan for Powys Teaching Health Board (the 'Health Board').

Decontamination refers to a series of procedures such as cleaning, disinfection, and sterilisation. These procedures are designed to eliminate or neutralise contaminants, thereby preventing infectious agents or other harmful substances from reaching a vulnerable body site in amounts sufficient to cause infection or other adverse effects.

The Health Board has a legal duty under several regulations, including the Health and Safety at Work Act (1974), to ensure that the decontamination of all reusable medical devices follows recognised guidelines. Additionally, the Health Board must comply with the Welsh Health Circular WHC/2015/050, which outlines the standards for decontamination practices in healthcare organisations. Other relevant publications include the Medical Device Regulations (2002) and the Welsh Health Technical Memoranda (WHTM), which provide technical guidance for the decontamination of reusable surgical instruments, endoscopes, and other critical devices.

Regulations mandate that the Health Board ensures compliance with current national standards, legislation, and recognised guidance documents. Systems must be in place to ensure that reusable medical devices and items of patient care equipment are appropriately decontaminated prior to use and that the risks associated with decontamination processes are effectively managed.

Processes apply equally to equipment that is owned, rented or on loan. These processes should protect, as far as reasonably practical, the health, safety and welfare of staff, patients and individuals who are involved in inspection, service, repair or transportation of medical devices or equipment.

## Overview

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

- Improvements to governance arrangements – clarification of attendance requirements and ensuring consistency in record-keeping.
- A decontamination risk register needs to be developed and monitored.
- All staff training should be brought up to date and kept up to date going forward.
- Omissions or anomalies in the Endoscopy weekly water testing monitoring spreadsheet should be investigated and resolved.

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	Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination risks.	1, 2	<b>Reasonable</b>
2	Accessible Decontamination policies and procedures are in place at both a Health Board and localised level that reflect relevant national guidance.	-	<b>Substantial</b>
3	Roles and responsibilities of staff in relation to decontamination have been clearly defined and training resources are adequate.	3	<b>Reasonable</b>
4	Decontamination of reusable medical devices is consistently undertaken in accordance with the prescribed policies and procedures to ensure compliance with relevant national guidance.	-	<b>Substantial</b>
5	Record-keeping and monitoring arrangements have been established in relation to the decontamination of all reusable medical devices and patient care equipment. Audit programmes are comprehensive, and plans are in place to address any areas of non-conformance.	4	<b>Reasonable</b>

### Management Actions

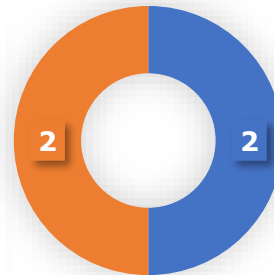


High Priority



Medium Priority

### Themes



■ Governance

■ Quality, Safety & Patient Experience

### Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

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# Findings & Agreed Action Plan

**Objective 1:** Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination risks. **Reasonable**

**Overview / Summary of Observations**

The following groups are in place in relation to decontamination:

- Decontamination Safety Group: This meets bi-annually and includes representatives from Cwm Taf Morgannwg University Health Board (CTMUHB) Sterilisation and Decontamination Unit, which undertakes sterilisation on behalf of the Health Board. Between meetings, issues would be picked up by the Head of Infection Prevention and Control or via the All Wales Decontamination and Sterilisation Advisory Group.
- Infection Prevention and Control & Decontamination Committee: Most operational responsibility for decontamination is undertaken by this committee, including oversight of the Decontamination Safety Group. It meets quarterly and is attended by representatives from across the Health Board.

Both meetings are formally structured, generally have appropriate governance arrangements in place and cover appropriate matters. However, we found a small number of inconsistencies in adherence to documented attendance requirements and shortcomings in the keeping of records.

The Decontamination Safety Group Terms of Reference states that its function includes monitoring decontamination issues and updating a decontamination risk register, and the group has had discussion regarding the best way for this to occur. However, this has not currently progressed further, and no completed decontamination risk register has been presented and discussed at either of the above groups.

An annual report is presented to the Patient Experience, Quality and Safety (PEQS) Committee which reviews decontamination activities during the previous year and planned activities going forward.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Governance arrangements</b></p> <p>Decontamination Safety Group.</p> <ul style="list-style-type: none"> <li>• While this is attended by a core group of staff and the meetings are quorate, records of meetings from December 2024 and July 2025 indicated that several staff members listed in the Terms of Reference as required attendees were not in attendance.</li> <li>• The Terms of Reference is scheduled for review by December 2025.</li> </ul> <p>Infection Prevention and Control &amp; Decontamination Committee.</p> <ul style="list-style-type: none"> <li>• While this is attended regularly by a core group of staff and the meetings are quorate, records of five meetings which took place between May 2024 and August 2025 indicated</li> </ul>	<p>Safety compromised or reputational damage due to inadequate governance of decontamination.</p>	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>• The Terms of Reference for the Decontamination Safety Group and the Infection Prevention and Control &amp; Decontamination Committee will be reviewed to ensure that they are appropriate, attendance at meetings will be matched with the Terms of Reference to evidence compliance and staff will be reminded of their responsibility to attend where necessary.</li> <li>• The action log will be used to record decisions taken at meetings.</li> <li>• SharePoint folders will be periodically reviewed to identify errors or inconsistencies such as duplicate documents.</li> </ul>

<p>that there were a large number of staff who attended less frequently, and it was difficult to match attendance against the requirements set out in the Terms of Reference.</p> <ul style="list-style-type: none"> <li>• Audio recordings of the meetings are retained, but decisions taken at the meetings are not recorded in the action logs.</li> <li>• A recording was available for one meeting for which a concise attendance list had not been produced.</li> <li>• Meeting papers are retained in individual SharePoint folders, one of which included duplicate versions of the agenda, and another included duplicate versions of the action log.</li> </ul>		<p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>• Copies of the reviewed and updated Terms of Reference for the Decontamination Safety Group and the Infection Prevention and Control &amp; Decontamination Committee. Copies of minutes confirming that attendance at meetings is matched with the Terms of Reference .</li> <li>• Copy of the action log recording decisions taken at meetings.</li> <li>• There are no duplicate documents in the SharePoint folders.</li> </ul>
<p><b>Theme:</b> Governance</p>	<p><b>Medium Priority</b></p>	<p><b>Officer:</b> Gareth Thomas – Head of Infection Prevention and Control <b>Target Implementation Date:</b> 31/01/2026</p>
<p>2 <b>Decontamination risk register</b></p> <p>The Decontamination Safety Group Terms of Reference states that its function includes monitoring decontamination issues and updating a decontamination risk register.</p> <p>Furthermore, the group has discussed this and it was agreed that one risk register would be used, which would include relevant risks from CTMUHB.</p> <p>However, this has not currently progressed further, and no completed decontamination risk register has been presented and discussed at either the Decontamination Safety Group or the Infection Prevention and Control &amp; Decontamination Committee.</p>	<p>Safety compromised if decontamination risk is not managed appropriately.</p>	<p><b>Agreed Action:</b></p> <p>A decontamination risk register will be developed and regularly presented and discussed.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Copy of the decontamination risk register and minutes of the Decontamination Safety Group confirming it has been regularly presented and discussed.</p>
<p><b>Theme:</b> Governance</p>	<p><b>Medium Priority</b></p>	<p><b>Officer:</b> Gareth Thomas – Head of Infection Prevention and Control &amp; Alex Smith – Specialist Practitioner IPC/Decontamination <b>Target Implementation Date:</b> 31/01/2026</p>

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### **Overview / Summary of Observations**

The Health Board has two policies in place which cover decontamination:

- TEP 070 Decontamination and Storage and Use of Flexible Reuseable Endoscopes which was issued August 2025 and has review date August 2028.
- IPC 004 Decontamination of reusable medical and surgical devices policy which was issued October 2025 and has review date September 2028.

Both were issued following appropriate review and approval, are detailed and comprehensive and cover relevant areas such as roles and responsibilities, procedures, storage, traceability, repair and maintenance and training. They are available on the Health Board's policies intranet site which is accessible by all staff.

In addition, Endoscopy has developed a detailed suite of action cards which set out guidance relating to decontamination.

The Health Board keeps up to date with relevant guidance via participation in various national groups including the All Wales Decontamination and Sterilisation Advisory Group, All Wales Decontamination Forum, Institute of Decontamination Sciences and the All Wales Ultrasound Decontamination Governance Group.

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**Objective 3:** Roles and responsibilities of staff in relation to decontamination have been clearly defined and training resources are adequate.

**Reasonable**

**Overview / Summary of Observations**

Both of the Health Board's policies in relation to decontamination set out detailed and comprehensive information regarding the roles and responsibilities for each grade of staff involved in decontamination processes. Both are available on the Health Board's policies intranet site which is accessible by all staff.

Key staff have attended relevant training at Eastwood Park, which is a specialised training provider for decontamination across the NHS.

An Authorised Person (Decontamination) within the PTHB Estates Team has been appointed for three years from December 2023 following a formal assessment by the Senior Decontamination Engineer, NWSSP Specialist Estates Services who is responsible for oversight of decontamination across NHS Wales.

The Health Board participates in various national groups including the All Wales Decontamination and Sterilisation Advisory Group, following which updates are provided via the Infection Prevention and Control & Decontamination Committee.

There was good representation from the Health Board at the All Wales Decontamination Forum in June 2025.

Appropriate training is also in place for the main body of staff, although the records indicated some gaps in completion or instances where it was not up to date.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>Training</b></p> <p>The Training Matrix included a number of unfilled cells highlighted in yellow, although this was partly due to training in progress or new starters.</p> <p>Similarly, Tristel and Trophon training records for annual refresher training in relation to ultrasound probes used in Radiology and Maternity indicated some outstanding training, although we were informed that this had been partly impacted by IT issues accessing online training.</p>	<p>Safety may be compromised if decontamination is not carried out appropriately.</p>	<p><b>Agreed Action:</b></p> <p>All staff training will be brought up to date and kept up to date going forward.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Records confirming that all staff training is up to date.</p>
<p><b>Theme:</b> Quality, Safety &amp; Patient Experience</p>	<p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Officer:</b> Alex Smith – Specialist Practitioner IPC/Decontamination</p> <p><b>Target Implementation Date:</b> 31/01/2026</p>

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## Overview / Summary of Observations

The decontamination arrangements at the Health Board can be summarised as follows:

- CTMUHB Sterilisation and Decontamination Unit undertakes the majority of sterilisation on behalf of the Health Board. Any issues arising are reported to the Infection Prevention and Control & Decontamination Committee within PTHB. An example of this was recorded in the meeting of October 2024, whereby a decontamination incident relating to the Air Handling Unit at the Sterilisation and Decontamination Unit had malfunctioned and sample levels far exceeded the acceptable limit. It was reported that affected equipment had to be reprocessed, including 300+ packs belonging to the Health Board, but the issue had been identified prior to any risk of exposure to patients.
- Historically, dental decontamination has been undertaken using a desktop process, which we have been informed is compliant. However, in June 2025, a trial commenced where decontamination is undertaken by Hywel Dda University Health Board which would be a 'gold standard' process.
- Endoscopy decontamination is undertaken in-house in Brecon, with a second site at Llandrindod having been decommissioned. Record-keeping and monitoring arrangements have been covered under objective 5.

An update on decontamination arrangements is included in the Infection Prevention and Control & Decontamination Committee with verbal updates having initially been provided during the period under review and subsequently formal PowerPoint presentations have been provided.

The Equipment and Devices Order Form includes a section which requires cleaning and decontamination be addressed.

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**Objective 5:** Record-keeping and monitoring arrangements have been established in relation to the decontamination of all reusable medical devices and patient care equipment. Audit programmes are comprehensive, and plans are in place to address any areas of non-conformance.

**Reasonable**

## Overview / Summary of Observations

Recording and monitoring arrangements at the Health Board can be summarised as follows.

- The sterilisation duties undertaken by CTMUHB on behalf of the Health Board are covered by the bi-annual Decontamination Safety Group which is attended by representatives of CTMUHB. Between these meetings, issues are addressed by the Head of Infection Prevention and Control, or via the All Wales Decontamination and Sterilisation Advisory Group.
- A dental decontamination trial commenced in June 2025 where decontamination is undertaken by Hywel Dda University Health Board which, although presently in its early stages, is covered by the Infection Prevention and Control & Decontamination Committee and it is understood will be subject to ongoing monitoring.
- Endoscopy is the only area where decontamination is undertaken in-house by the Health Board, which occurs in Brecon. A manual traceability system had previously been in place, but this was replaced by a new electronic system, 'Health Edge' in February 2025. This offers full traceability via use of a barcode system which records each step of the decontamination process and has built-in safeguards to prevent steps from being omitted. Weekly water testing is also undertaken which forms part of the Health Board's Endoscopy validation process and is recorded in a spreadsheet. However, while review of this spreadsheet confirms that results are generally being recorded and monitored weekly as required, we noted a small number of omissions or anomalies which are detailed in the Key Finding below.

Relevant audit activity has occurred which has included the following:

- An annual review of Flexible Endoscope Decontamination Facilities was undertaken by the Decontamination Engineer, NWSSP Specialist Estates Services which was detailed and comprehensive. It provided Amber/Green assurance and its findings, which have been actioned by the Health Board, will be followed up at the next annual review.
- An Endoscopy Decontamination Audit was undertaken by the Specialist Practitioner, Infection Prevention & Control (Decontamination) using an Infection Prevention Society template. It only identified a small number of issues which have since been resolved.
- Endoscope traceability audits of the Health Edge system have been undertaken in May and September 2025 by the Theatre & Endoscopy Co-Ordinator, with a further audit scheduled for January 2026.
- A Cleaning of Ultrasound Probe Process audit template is ready to be used for an audit of decontamination of ultrasound probes / transducers which is planned and an audit template for the Trophon machine high level disinfection equipment for ultrasound probes in radiology and maternity is also ready for use. Both appear well structured and fit for purpose.

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Key Findings	Risk & Impact	Agreed Management Action
<p>4 <b>Endoscopy weekly water testing</b></p> <p>Endoscopy weekly water testing is undertaken which forms part of the Health Board's Endoscopy validation process, which is recorded in a spreadsheet.</p> <p>However, while review of the spreadsheet confirms that results are generally being recorded and monitored weekly as required, we noted that no result was recorded for one machine for week commencing 14 April 2025 and no follow up was included to a comment querying this anomaly. Furthermore, no results were recorded in the spreadsheet for the two preceding weeks to it being provided to us.</p>	<p>Safety may be compromised if Endoscopy water quality issues are not promptly identified.</p>	<p><b>Agreed Action:</b></p> <p>Endoscopy weekly water testing results will be promptly recorded in the monitoring spreadsheet, and any omissions or anomalies will be promptly investigated and resolved.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Copy of the spreadsheet confirming that there are no omissions or anomalies in the Endoscopy weekly water testing.</p>
<p><b>Theme:</b> Quality, Safety &amp; Patient Experience</p>	<p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Officer:</b> Gareth Thomas – Head of Infection Prevention and Control</p> <p><b>Target Implementation Date:</b> 31/12/2025</p>

Powell Bethan  
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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
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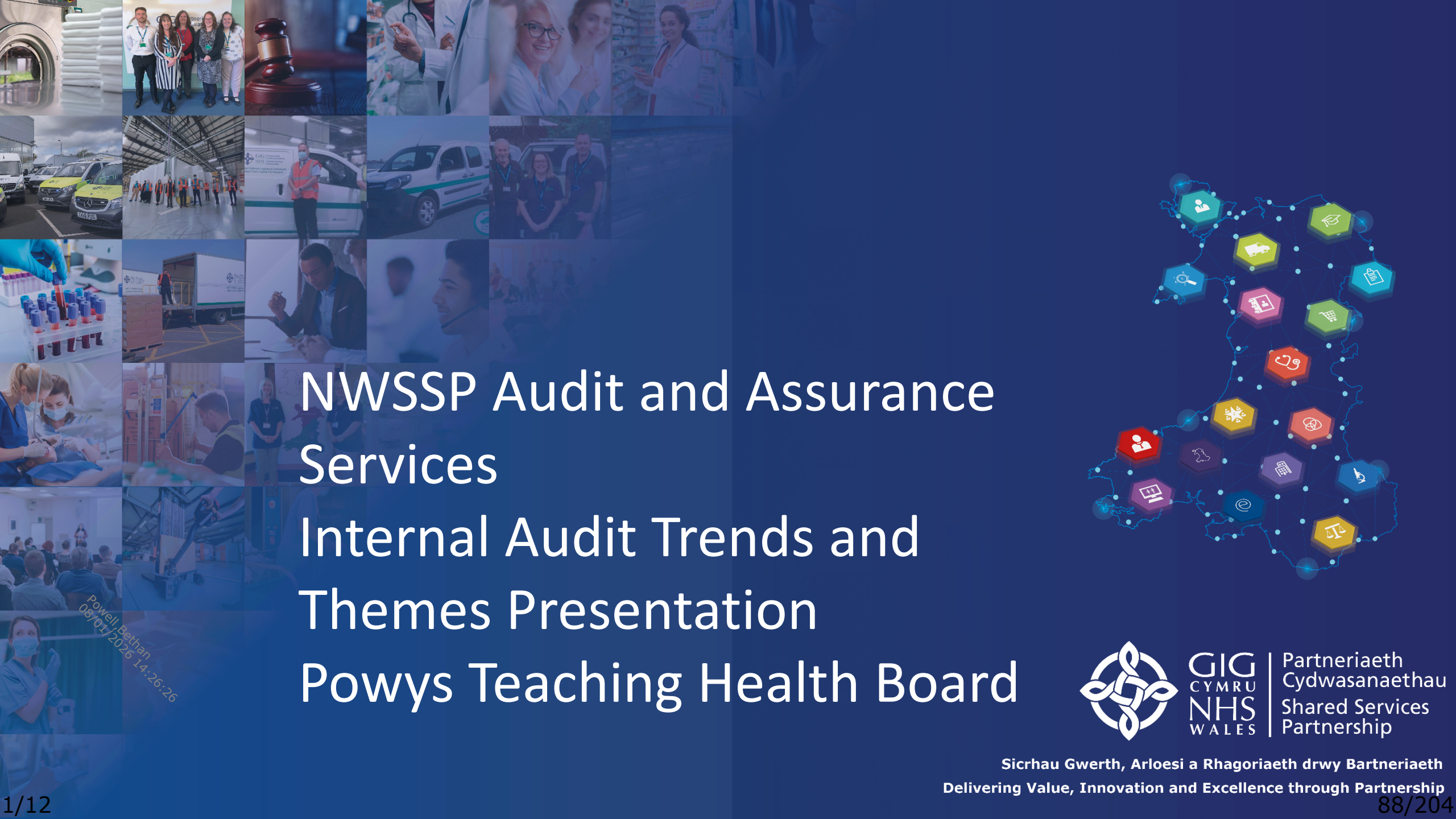
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# NWSSP Audit and Assurance Services

## Internal Audit Trends and Themes Presentation

### Powys Teaching Health Board



GIG  
CYMRU  
NHS  
WALES

Partneriaeth  
Cydwasaethau  
Shared Services  
Partnership

Sicrhau Gwerth, Arloesi a Rhagoriaeth drwy Bartneriaeth  
Delivering Value, Innovation and Excellence through Partnership

Powell Bethan  
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<b>Subject:</b>	Internal Audit Trends and Themes Presentation
<b>Approved and Presented by:</b>	Ian Virgil, Head of Internal Audit
<b>Prepared by:</b>	Head of Internal Audit
<b>Purpose:</b>	To provide the Committee with information regarding trends and themes that can be identified through the analysis and review of the outcomes from previous internal Audits.
<b>Recommendations:</b>	The Audit and Risk Assurance Committee is asked to: <ul style="list-style-type: none"><li>• <b>RECEIVE</b> the presentation as a basis to consider data trends over the reported period and where appropriate inform future Internal Audit planning</li></ul>
<b>Executive Summary:</b>	The Committee first received a similar Internal Audit Trends and Themes Presentation in 2024, at that time it was agreed that an updated presentation to include current data would be helpful in 2025/26. The timing of the presentation has been set to help inform internal audit planning for 2026/27 and beyond.

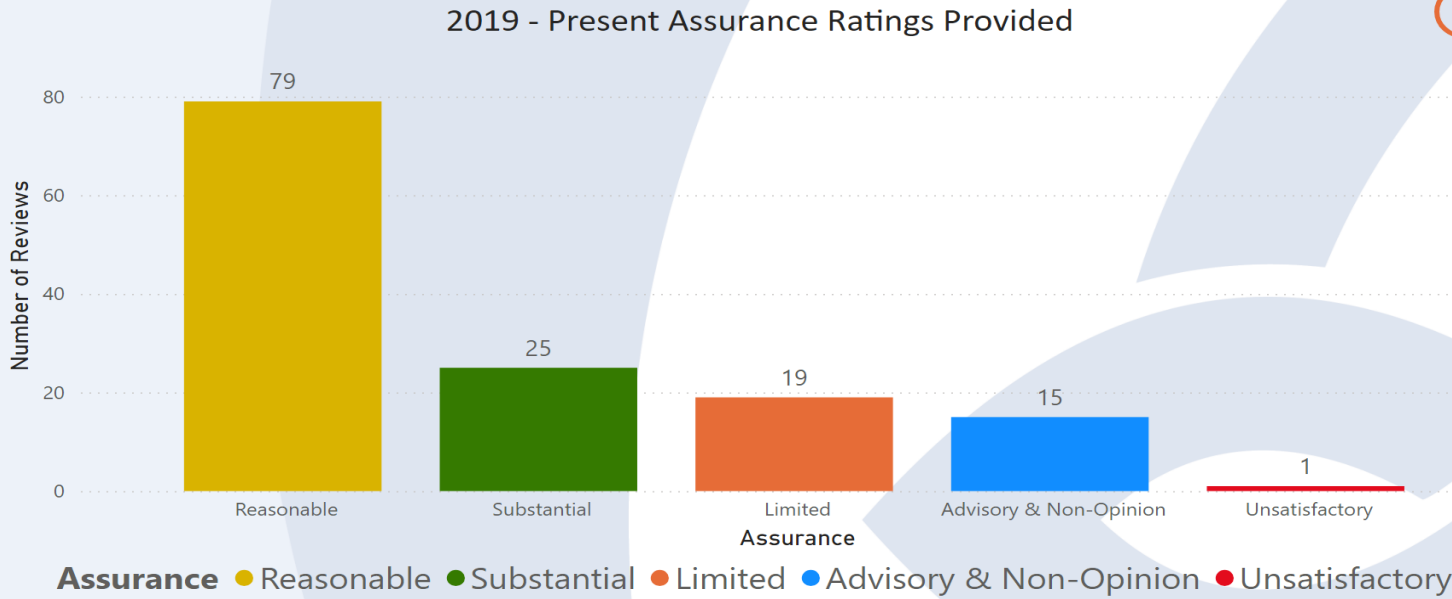


# Outcomes of Powys Audits completed for the period 2019/20 to 2025/26 to date

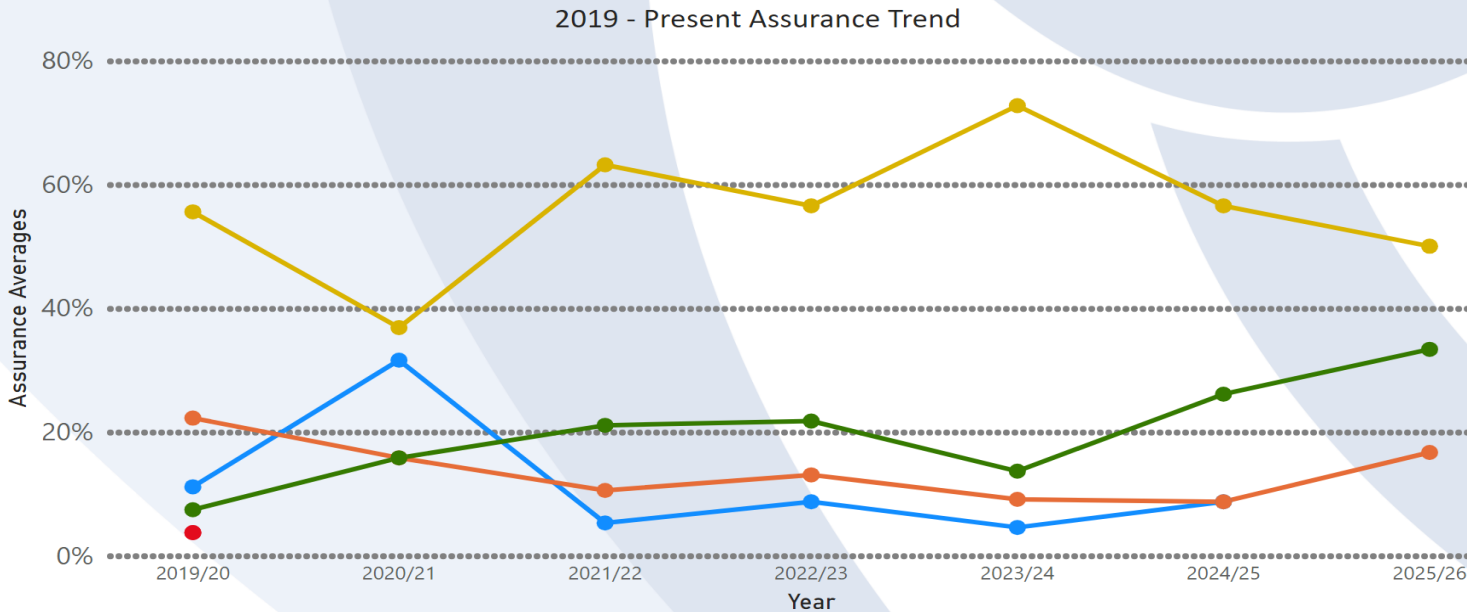
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[Organisation Comparison](#)

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Year	Number of Reviews Completed
2019/20	27
2020/21	19
2021/22	19
2022/23	23
2023/24	22
2024/25	23
2025/26	6
<b>Total</b>	<b>139</b>



\* 2023/24 & 2024/25 review information includes draft reports.

Assurance	2018-23 Present (%)
Advisory & Non-Opinion	10.8%
Limited	13.7%
Reasonable	56.8%
Substantial	18.0%
Unsatisfactory	0.7%

## Organisation

- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW
  - PHWSSP
  - PHW
  - Velindre
  - WAST

# Assurance Ratings for Powys THB and All Health Boards for the period 2019/20 to 2025/26 to date

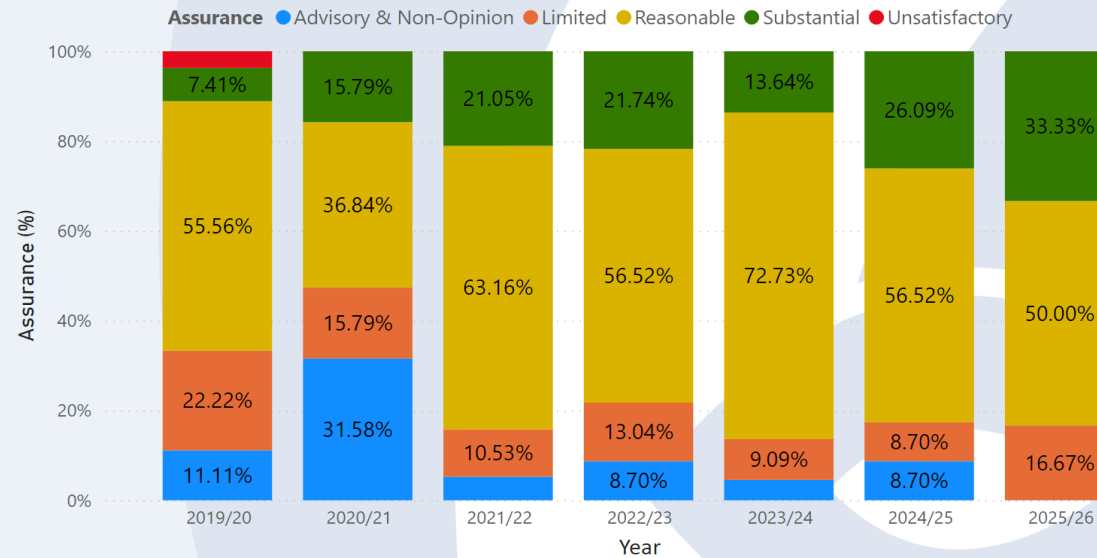
← Back to report

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## Organisation

- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW

## 2019 - Present Assurance Breakdown



Show Assurance Trend

139

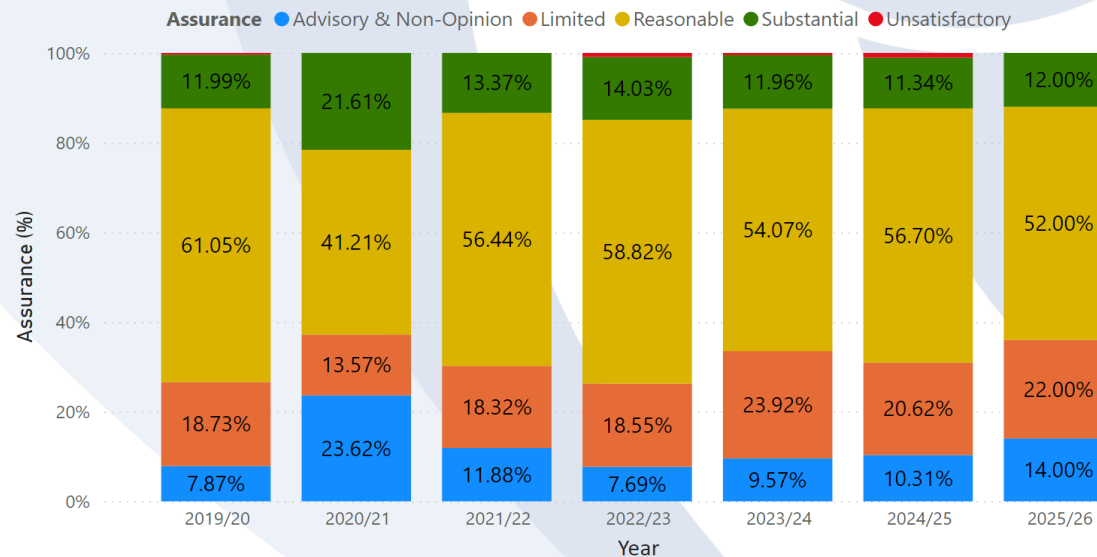
Number of Reviews

Assurance	Number of Reviews
Advisory & Non-Opinion	15
Limited	19
Reasonable	79
Substantial	25
Unsatisfactory	1

## Organisation

- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW

## 2019 - Present Assurance Breakdown



Year

All

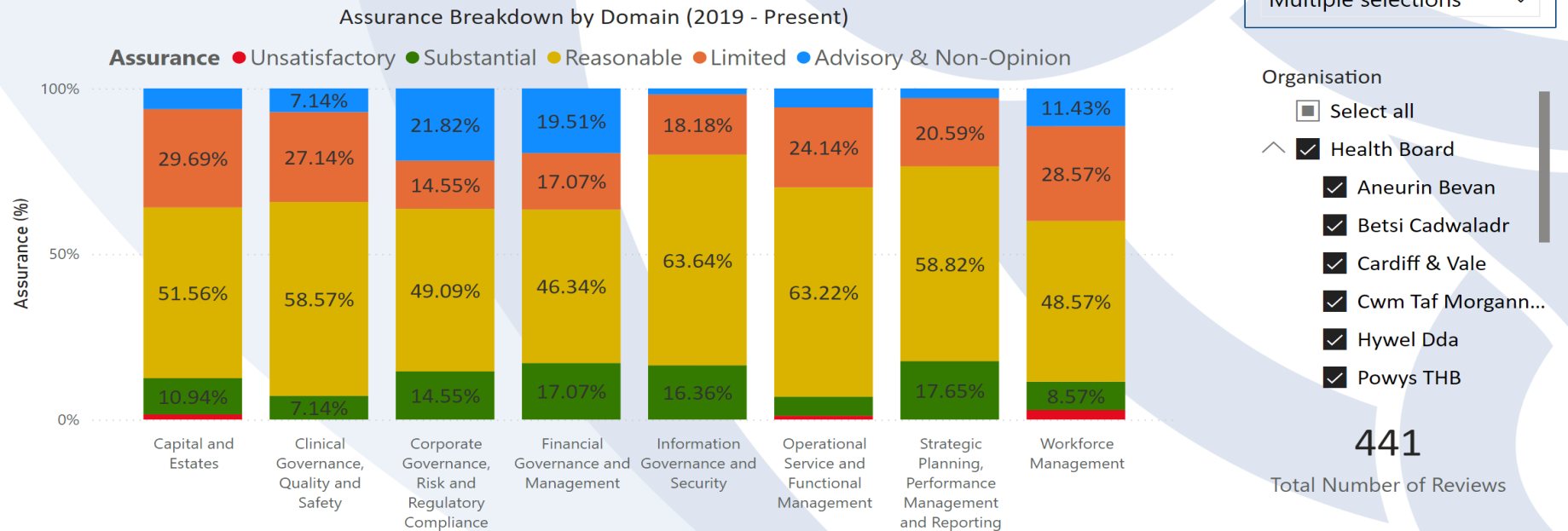
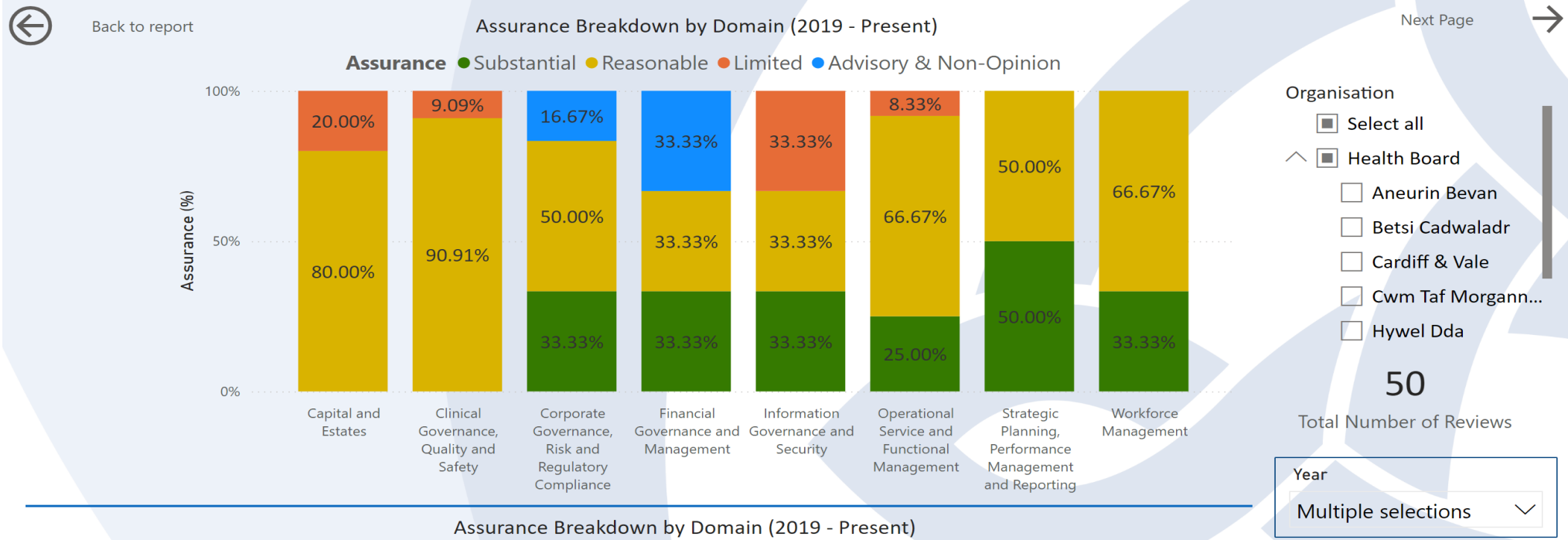
1342

Number of Reviews

Assurance	Number of Reviews
Advisory & Non-Opinion	156
Limited	256
Reasonable	738
Substantial	186
Unsatisfactory	6

Powell Bethan  
08/01/2026 14:26:26

# Assurance Ratings by Domain for Powys THB and all HBs for the period 2023/24 to 2025/26 to date



Powell Bethan  
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# Analysis of Powys Findings Across The Period 2019/20 to 2025/26 to Date

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Matters Arising/Recommendations Overview 2019 - Present

Themes Overview 2022 - Present

Themes/Risks Overview 2022 - Present

Recommendation implementation

Themes defs

Year: 
 Organisation: 
 Domain:

**486**

Total Matters Arising/Recommendations

**3.87**

Average recommendations per review (exc. Advisory)

**47%**

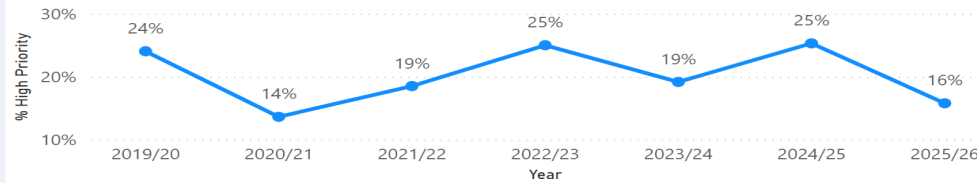
% Design

**53%**

% Operation

**22%**

High priority recommendations

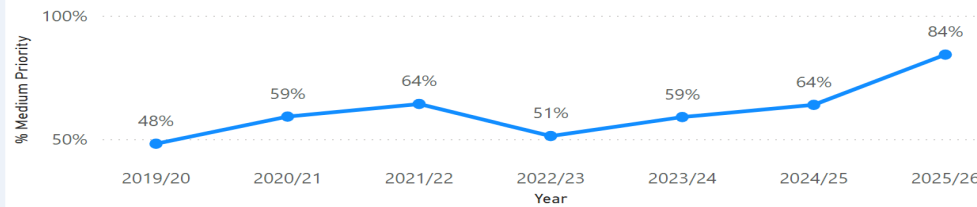


**105**

High priority recommendations

**58%**

Medium priority recommendations

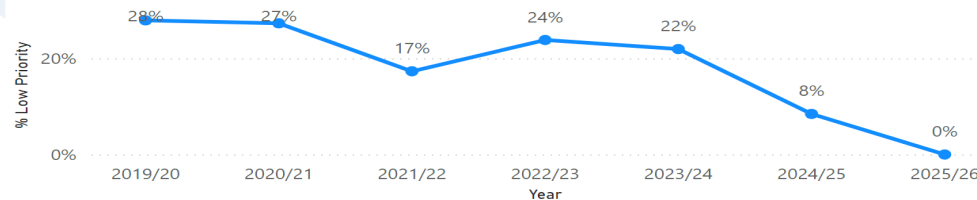


**283**

Medium priority recommendations

**20%**

Low priority recommendations



**98**

Low priority recommendations

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# Analysis of The Top 10 Themes for Powys for the Period 2023/24 to 2025/26 to date

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Annual Plans

Outcomes Overview

Visual Summaries

## Filters:

**Organisation**  
Powys THB

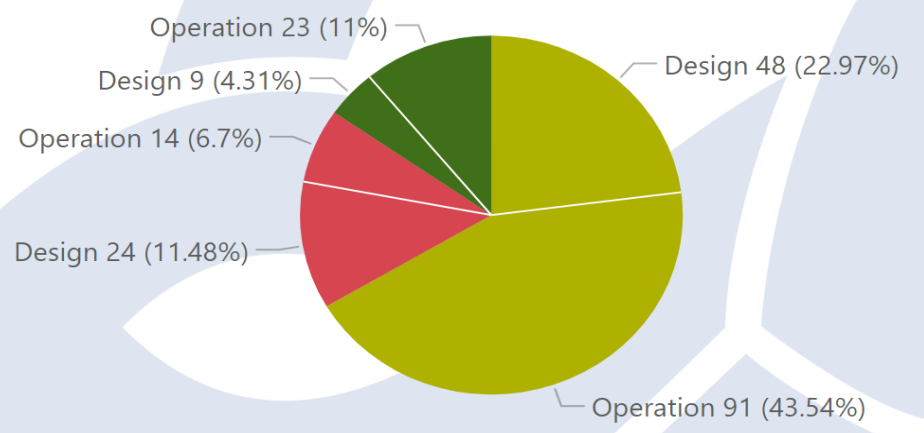
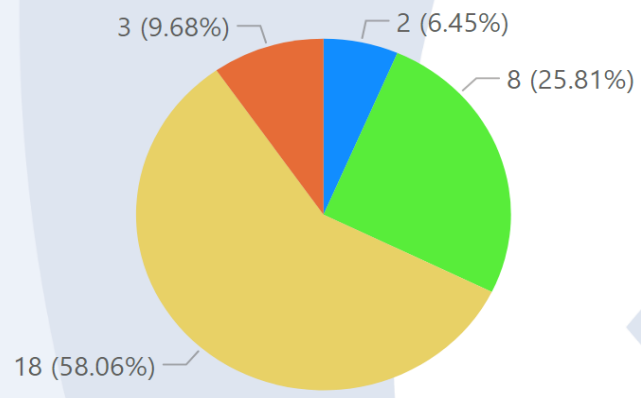
**Audit Title**  
Search

**Domain**  
All

**Year**  
Multiple selections

**Assurance** Advisory & Non-Opinion Substantial Reasonable Limited

**Recommendation Priority** Medium High Low



## Top 10 themes



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# Analysis of The Top 10 Themes for All Health Boards for the Period 2023/24 to 2025/26 to date

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Visual Summaries

## Filters:

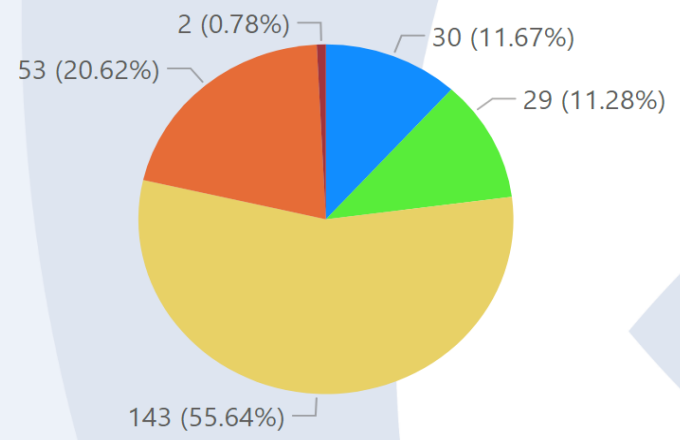
**Organisation**  
Multiple selections

**Audit Title**  
Search

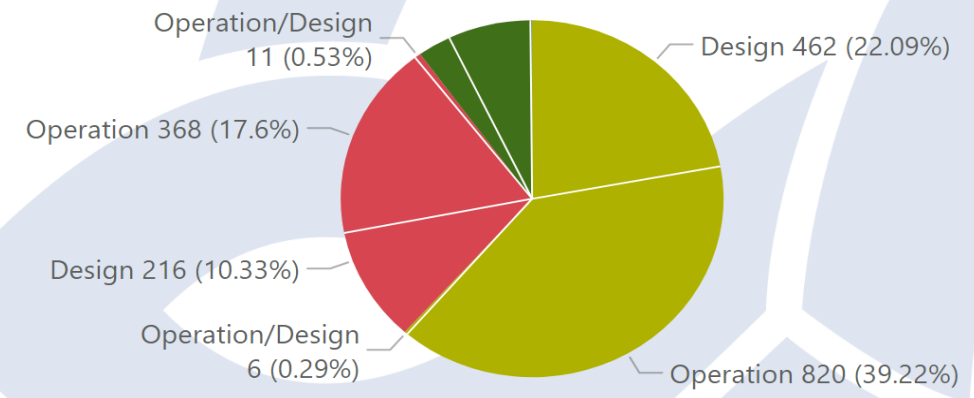
**Domain**  
All

**Year**  
Multiple selections

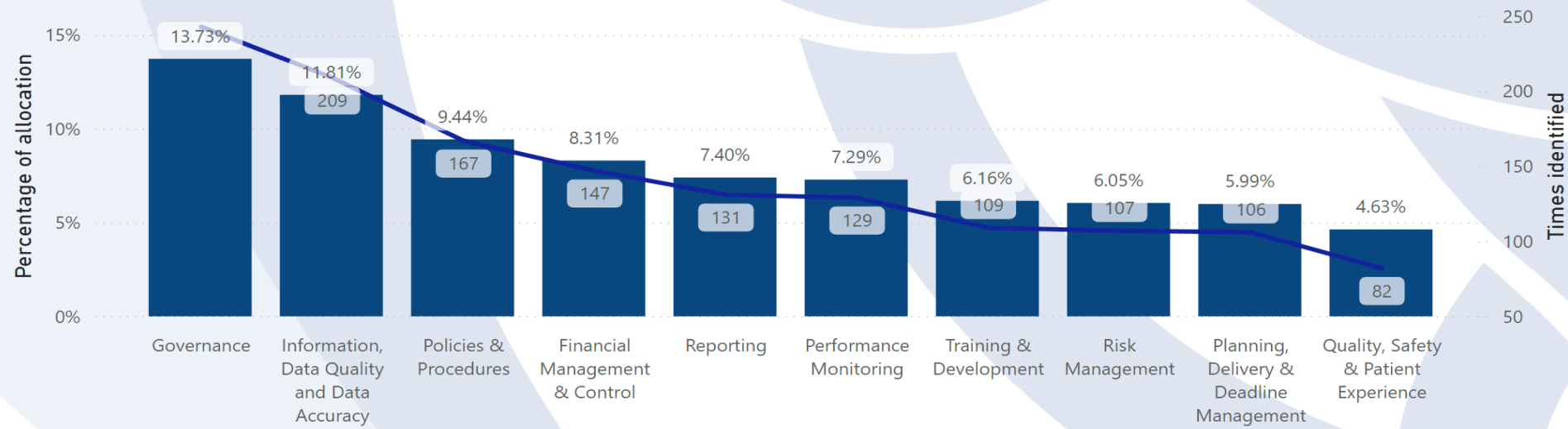
**Assurance** ● Advisory ... ● Substantial ● Reasona... ● Limited ● Unsatisf...



**Recommendation Priority** ● Medium ● High ● Low



Top 10 themes



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# Theme definitions

<p>Information, Data Quality and Data Accuracy</p>	<p>Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality.</p> <p>There is limited/ no guidance on the expected arrangements for data and information management.</p> <p>Insufficient records are maintained and/ or there are key gaps that would impact decision making.</p> <p>Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.</p>
<p>Governance</p>	<p>Inadequate / ineffective governance and oversight structures in place, which may include:</p> <ul style="list-style-type: none"> <li>· Absence of key roles and associated responsibilities to provide good governance.</li> <li>· Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees.</li> </ul> <p>General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.</p>
<p>Policies &amp; Procedures</p>	<p>There are no policies or procedures in place, or they are inadequate to manage the risk.</p> <p>Policies or procedures are overdue for review or do not reflect current operational and/or best practice.</p>
<p>Planning, Delivery &amp; Deadline Management</p>	<p>A lack of timescales or deadlines being set.</p> <p>Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.</p>
<p>Training &amp; Development</p>	<p>There is no defined strategy for training &amp; development.</p> <p>Training needs have not been identified.</p> <p>There is no plan in place to address identified training needs.</p>
<p>Reporting</p>	<p>Reporting and escalation requirements not clearly defined, including what gets reported where and when.</p> <p>Defined reporting does not provide adequate information to support robust assurance, escalation and risk management.</p> <p>Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place.</p>

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# Theme definitions Cont...

Risk Management	Inadequate/ ineffective risk strategy, appetite and/or management arrangements. The approach to risk management and/ or arrangements applied are not operating as intended.
Performance Monitoring	There are no/ limited systems in place to capture performance information. The systems are ineffective in capturing the required information to manage performance. Performance information is not monitored and/ or shared. Corrective action to address performance issues is not determined or is ineffective.
Financial Management and Control	Financial controls and management information requirements have not been properly considered. The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.
Quality, Safety & Patient Experience	Findings impacting on the quality and safety of service delivery, or patient experience for example: Concerns management - delays in investigation, high volume of open incidents/complaints etc Non-compliance with quality & safety related statutory/policy requirements (e.g. failing to undertake risk assessments) Issues relating to infection control, waiting list management, patient discharge Issues identified by external reviews (e.g. HIW) have not been addressed

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# Key Observations for Consideration:

\* Positive overall annual assurance opinion for each of last 7 years.

\* The level of Limited Assurance reports has been consistent over the last 4 years at around 10%, which is lower than the average for all Health Boards.

Limited Assurance reports have been concentrated within the following 4 domains:

- \* • Information Governance and Security.
- Capital and Estates.
- Clinical Governance, Quality and Safety.
- Operational Services and Functional Management.

The Limited Assurance reports include the following:

- 21/22 – Fire / Llandrindod Project / Partnerships / Contractors / Occ Health
- 22/23 – Cyber Security / IT Infrastructure / Welsh Language Standards
- 23/24 – Estates Condition / Information Governance
- 24/25 – DoLS / Mattresses
- 25/26 – Digital Systems Uptake

\* There is a relatively even split of findings between Design (47%) and Operation (53%).

\* This demonstrates that issues have been identified around the absence or incompleteness of controls, along with issues around the inconsistent application of the controls that are in place.

The most identified themes are:

- \* • Information Data Quality and Data Accuracy (16.75%)
- Governance (13.88%)
- Policies & Procedures (11%)
- Planning Delivery and deadline Management (9.09%)

These are relatively consistent with the most identified themes for all Health Boards, except for the Planning theme which is replaced with Financial Management and Control for all Health Boards.

Diolch yn fawr  
Thank you

*Delivering  
Value, Innovation and  
Excellence through  
Partnership*

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

Date issued: January 2026



Powell, Bethan  
08/01/2026 14:26:26

# Contents

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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.

Powell, Bethan  
08/01/2026 14:26:26

# Introduction

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This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board (the Health Board). We presented our most recent Audit Plan to the committee in February 2025.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Powell, Bethan  
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# Accounts audit update

## Audit of the 2024-25 Health Charities Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive.
- **Focus of the work:** To provide an audit opinion on the 2024-25 Health Charities Annual Report and Accounts
- **Status:** Audit Plan issued and audit work largely complete. Audit of Accounts report with proposed audit opinion to be issued December 2025. AGW opinion January 2026.
- **Expected committee date:** January 2026

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

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive.
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning Commenced December 2025. Some interim work to be completed December 2025 to March 2026. Final Audit to commence once draft Accounts received May – June 2026.
- **Expected committee date:** June 2026

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# Performance audit update

## Structured assessment 2025 – core

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

## Review of urgent and emergency care

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

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

We have also reviewed progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).

- **Status:** Draft reporting
- **Expected committee date:** March 2026

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08/01/2025 14:26:26

### 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:** Report drafting
- **Expected committee date:** March 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:** Report drafting
- **Expected committee date:** March 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:** Fieldwork
- **Expected committee date:** May 2026

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### **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:** Planning
- **Expected committee date:** May 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.

<a href="#"><u>Positive action on fraud and error in community pharmacy but more analysis could reap rewards   Audit Wales</u></a>	December 2025
<a href="#"><u>Facing the Future – Auditor General for Wales Podcast – Episode 4</u></a>	November 2025
<a href="#"><u>Opportunities for Change – Auditor General for Wales Podcast – Episode 3</u></a>	November 2025
<a href="#"><u>Under Pressure – Auditor General for Wales Podcast – Episode 2</u></a>	November 2025
<a href="#"><u>A Unique Perspective – Auditor General for Wales Podcast – Episode 1</u></a>	November 2025

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

<a href="#"><u>Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028</u></a>	December 2025
<a href="#"><u>Interim Report 2025-26</u></a>	November 2025
<a href="#"><u>Estimate of Income and Expenses for the year ended 31 March 2027 (supporting information)</u></a>	November 2025
<a href="#"><u>Equality Report 2024-25</u></a>	October 2025

We are also currently running a [consultation on proposed Audit Wales equality objectives for 2026-2030](#). Closing date for submissions is 20 January.

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## Further information

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

Visit our [website](#) to find:



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



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



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



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



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

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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: [info@audit.wales](mailto:info@audit.wales)

Website: [www.audit.wales](http://www.audit.wales)

We welcome correspondence and telephone calls in Welsh and English.

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





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Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**Agenda item: 5.5**

<b>AUDIT, RISK AND ASSURANCE COMMITTEE</b>		<b>Date: 13 January 2026</b>
<b>Subject:</b>	Counter Fraud Update Report	
<b>Approved and presented by:</b>	Pete Hopgood, Executive Director of Finance, Capital and Support Services	
<b>Prepared by:</b>	Local Counter Fraud Specialist	
<b>Other Committees and meetings considered at:</b>	N/A	
<b>PURPOSE:</b>		
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.		
<b>RECOMMENDATION(S):</b>		
The Audit Risk and Assurance Committee is asked to: <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> the update report for discussion;</li> <li>• Take <b>ASSURANCE</b> that appropriate counter fraud systems are in place.</li> </ul>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
		Y

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
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	

Powell Bethan  
08/01/2026 14:26:28

## **EXECUTIVE SUMMARY:**

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.

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).

## **HEADING:**

### **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 AND STRATEGIC GOVERNANCE**

The Health Board's service level agreement with Swansea Bay University Health Board for the delivery of counter fraud services is due for renewal. Negotiations will be taken forward with the Executive Lead to ensure that the appropriate resource and capacity is in place to meet the Health Board Counter Fraud needs and to deliver the work programme going forward. The full time PTHB LCFS has been attending forums as needed to ensure that any Counter Fraud updates and developments across NHS Wales are fully up to date for PTHB. There are no additional updates to report on at this time.

### **4. INFORM AND INVOLVE**

Viva Engage, an internal social media platform part of the Microsoft 365 package suite, has a growing staff Counter Fraud Community embedded within Powys. Lead PTHB LCFS is systematically adding all staff to the Counter Fraud Community, which will be completed in full during Q4.

In addition, fraud awareness sessions are being well attended with increased requests for bespoke awareness delivery direct to specific workstreams and teams, with targeted audiences in mind. Manager and General Fraud Awareness Refresher Sessions will be fully embedded and bookable via ESR, linked to the PTHB Counter Fraud Intranet page, by the end of January 2026.

## 5. PREVENT AND DETER

Due to increased levels of Fraud awareness being delivered across the Health Board, specifically with new employees and those staff attending the Managers Programme, there has been a marked increase in contact being made to the PTHB LCFS for fraud advice and guidance, effectively strengthening strong working relationships with Managers and Supervisors across the Health Board, thus opening further doors of opportunity to increase fraud awareness, whilst building on a resilient preventive approach to fraud.

Initiative-taking Fraud Risk Assessments are ongoing, with a strong drive at the start of Q4 to delivery to workplan schedules by the end of February 2026.

## 6. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is set out below in anonymised data.

Reference	Title	Type	Subtype
INV/25/03419	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/03391	Overclaimed Travel Expenses	NHS Staff Fraud - Employee fraud	Expenses overclaimed
INV/25/03024	Claiming additional hours not worked	NHS Staff Fraud - Employee fraud	Claiming hours not worked
INV/25/01658	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01647	Private treatment on NHS patient	NHS Staff Fraud - Dental	Charging for NHS Treatment
INV/25/01522	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01520	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick

INV/25/01519	Abuse of Position	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/25/01215	Selling prescription medication	NHS Staff Fraud - Employee fraud	Theft of Prescription Medication
INV/25/01130	False Representation - Volunteer Public Member Validation	NHS Staff Fraud - Employee fraud	Travel/subsistence fraud
INV/25/00156	Prescription Fraud - Patient living in England	NHS Patient Fraud	NHS Patients - Misuse of prescriptions
INV/24/03253	Working Elsewhere - Dual Working	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/01904	Theft of NHS Assets	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/00525	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick

## 7. CONCLUSION

The committee are asked to note the current status of the Counter Fraud Work Programme and take assurance in the action being taken.

### NEXT STEPS:

Reporting will continue as scheduled.

## IMPACT ASSESSMENT – NOT REQUIRED

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<b>Subject:</b>	Assurance of Risk Management arrangements
<b>Approved and Presented by:</b>	Helen Bushell, Director of Corporate Governance/Board Secretary
<b>Author:</b>	Deputy Board Secretary
<b>Purpose:</b>	This presentation provides a summary of the progress made and associated risks to the implementation and ongoing development of the Health Board’s Risk Management Framework (RMF) and Board Assurance Framework (BAF). The presentation builds on the paper presented to the Committee at its last meeting in October 2025.
<b>Recommendations:</b>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• <b>Take ASSURANCE</b> regarding the progress made in the implementation of the RMF and BAF since the last report and the plans in place to further mature and integrate risk management;</li> <li>• <b>RECEIVE</b> the proposed template for the Annual Review of Strategic Risk Assurance provided Appendix A and provide and comments/feedback as appropriate; and</li> <li>• <b>NOTE</b> the current risks associated with the implementation of all aspects of the RMF and BAF</li> </ul>
<b>Executive Summary:</b>	<p>In March 2025 the Board approved a revised Risk Management Framework (RMF). Significant progress on implementation has been made to date including increased integration and development of the associated Board Assurance Framework (BAF), approved in it’s first iteration by the Board in May 2024.</p> <p>This report provides an update to the Committee on current progress as well as the plans in place to further implement and integrate the two key frameworks for assurance.</p>

*Powell Bethan  
08/01/2026 14:26:26*

As previously reported there has been significant progress in year, following the approved of the revised Risk Management Framework (RMF) in March 2025 including:

- The key fundamental change within the revised framework was the closure of the Corporate Risk Register (CRR), to be replaced with a Strategic Risk Register (SRR), owned by the Board and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk, owned by the Executive Committee.
- As of November 2025, the Strategic Risk Register is well established and reports to the Board three times annually. The first iteration of the Organisational Risk Register also reported to the Board in November 2025.
- In July 2025, the Board approved a revised Risk Appetite Statement following a period of review including input from the ARAC and Finance and Performance Committee and detailed discussions at a number of Board Development sessions. This also led to establishment of a practice of reviewing the Risk Appetite Statement in Q4 alongside the development of the Annual Plan.
- Committee Risk Registers continue to report to each Committee as standing agenda items.
- Updates to the sub-structure of Executive Committee have strengthened the approach to risk management by ensuring integration of risk in key operational discussions and decisions.
- Support continues to be provided where required at Directorate level in terms of directorate and service level risk management.

A key associated framework of the RMF, is the Board Assurance Framework (BAF). A core element of the BAF is focused of risk assurance which has been a conscious area of development in year. Progress made has included:

- A 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 facilitates opportunity to undertake further action where gaps or weaknesses are identified. The 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 BAF Dashboard reported to the Board alongside the SRR and ORR in November 2025 and is now routinely established and reported.
- In October 2025 the Committee received the Board Assurance Framework Analysis Principles which demonstrates the mechanism and standards by which the information is analysed to produce the ratings and findings within the dashboard.

Powell Bethan  
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Since the last report:

- Throughout Q3 focused discussion was undertaken by the Executive Committee and Operational Leadership Group to develop the Organisational Risk Register (ORR), the first iteration of which was reported to the Board in November 2025 alongside the SRR and BAF Dashboard. This will continue to be developed and matured and will report to the Board alongside the SRR to enhance the Boards awareness of operational level risk.
- A comprehensive review of each Strategic Risk has been undertaken by the Corporate Governance team to produce a detailed analysis of the assurance against the controls for each risk. Initially it has been intended to report this information to the Board, but due to the detailed and technical content of the report it is proposed that this information is shared with the Audit, Risk and Assurance Committee as the Committee responsible for the oversight of risk and assurance on behalf of the Board.
- It is proposed that the above report comes forward annually as part of the Annual Review of Strategic Risk Assurance. A draft excerpt of the report, intended to provide Committee Members with the opportunity to review and provide feedback on the proposed contents and layout in provided as Appendix A.
- The purpose of the Annual Review of Strategic Risk Assurance will be to build upon the summary information provided within the BAF Dashboard by providing the opportunity to review the balance of controls as highlighted within the Board Assurance Framework Analysis Principles .

Power to the People  
08/01/2026 14:26:26

The progress made to date has been as planned, though we recognise that risk maturity is a continuous development process with the following actions planned for delivery Q4 and beyond. Planned Q4 activity includes:

1. Review of the Risk Appetite Statement at Board Development in January/February in the context of the Annual Plan development.
2. A review of the Risk Management Framework and Board Assurance Framework policy documents will be undertaken in Q4 and will return to this Committee in March 2026, for consideration and recommendation to the Board in May 2025. This review will focus on:
  - Ensuring currency of terminology and reflection of the progress made and learning arising from 2025/26
  - Ensuring alignment between the two documents as fundamental pillars of the Health Board's approach to good governance
  - Continued maturing and integration of risk and assurance principles across the Health Board
3. Continued development of the approach to reviewing in detail Strategic Risk Assurance arrangements with the first Annual Review of Strategic Risk Assurance to report to this Committee in March or May 2026.
4. Planning for the further implementation of the Board Assurance Framework, beyond the risk assurance focus to integrate assurance reporting across other key elements of the framework such as governance and compliance.

The key risks to the further development and implementation of our approach to risk and assurance management within the Health Board are set out below for the Committee’s awareness:

There is a risk that:	Caused by:	Resulting in:	Controls:
Capacity constraints within the Corporate Governance will reduce the pace of development and implementation in 2026/27.	There has longstanding absence of the risk management post throughout 2025/26 with remaining risk capacity affected by a further planned absence until Q3 of 2026/27.	Reduced capacity and capability to continue to develop and implement the associated frameworks. Requirement to focus on the delivery of fundamental aspects of the RMF and BAF.	Upskilling plans and cover arrangement have been developed for risk and assurance by the Corporate Governance team to ensure delivery of the core elements of the RMF and BAF will continue despite absence.
System issues with the Datix Risk Management will continue to delay and negatively impact the improvements needed regarding the management of operational risk in 2026/27	Current technical issues with the system make users unable to add controls, workarounds have been explored and have failed rendering the system unusable at present. The issues are unable to be addressed within NHS Wales, with only Datix able to provide a fix. A timeline for this fix remains unknown.	Confusion around the preferred process for recording operational risk. Delays of the ability to produce the risk management toolkit and risk management training material due to uncertainty and a current complex hybrid system.	Services continue to utilise excel spreadsheet risk registers to ensure continuity of legacy arrangements as an interim measure. Once for Wales team have raised a ticket with Datix for a fix in early 2025 which they continue to chase of behalf of the Health Board.

In summary:

- Considerable progress has been made so far in 2025-26 in regards to the implementation of both the Risk Management Framework and Board Assurance Framework at corporate level, with further actions planned for Q4 to continue to develop and mature our arrangements.
- There are some risks to implementation in 2026-27, with the expectation that progress will continue albeit at a reduced pace particularly in the first half of the year.
- It is acknowledged that deeper organisational roll out is required which includes risk training as well as system development for risk / risk register management. Teams will continue to be supported within the resources available and plans for deeper deliver in 2027/28 and beyond will continue to be developed.
- The established reporting cycles to the Operational Leadership Group, Executive Committee, Audit, Risk and Assurance Committee and Board will continue for the remainder of 2025-26 and for 2026-27.
- The Audit, Risk and Assurance Committee will continue to receive assurance and development of reports relating to the overall, and key aspects of the Health Board's risk management and assurance arrangements.

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<b>SRR 012</b>	<b>There is a risk that:</b> The Health Board is unable to maintain and build public confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.	
<b>Current Risk Score:  15</b>	<b>Risk rating detail:</b> (likelihood x impact)  Current: 3 x 5 = 15 Inherent: 4 x 5 = 20 Target: 2 x 4 = 8	<b>Risk Category:</b> Reputation and Public Confidence
		<b>Boards Risk Appetite:</b> Open
<b>Executive Lead:</b> Director of Corporate Governance / Board Secretary		<b>Assuring Committee:</b> Finance and Performance Committee

**BAF DASHBOARD ASSURANCE SUMMARY STATUS**

<b>Adequacy of Controls</b> <i>Are there enough controls in place?</i>	<b>Effectiveness of Controls</b> <i>Are those controls working as intended?</i>	<b>Associated Assurance</b> <i>How do we know/evidence?</i>
Multiple Controls	Controls largely effective	Assurance largely reasonable

Key Risk Controls:		Preventative, Corrective or Detective	Gaps in Control
12.1	Better Together programme in place in order to make lasting decisions about the permanent future shape of safe and sustainable health services, with Stage One engagement completed and Stage Two engagement nearing completion	Preventative	<ul style="list-style-type: none"> <li>Significant challenges to public confidence remain possible, particularly given the pressing need for significant transformation of health services to ensure that they are fit for the future The scope for managing these challenges is reduced due to the highly complex environment in which the health board operates (very large rural geography, hyperlocal needs and expectations, complex cross-border commissioned pathways with both England and Wales). Trust has been further challenged by decisions the health board has needed to make in the context of in-year financial challenges (e.g. waiting list measures) and to address risks to safety and sustainability (e.g. temporary service changes).</li> <li>Capacity to communicate back to the public on their influence from feedback</li> </ul>
12.2	Communication and engagement team in place (substantive team = 4.0wte, additional temporary posts) with active management of priorities aligned with organisational priorities and risks	Preventative	
12.3	Weekly informal communications report to Board including reputation risk portfolio to support internal review and scrutiny	Preventative	
12.4	Twice Yearly Engagement and Communication Report supports ongoing review of capacity against opportunities and risks	Preventative/ Corrective	
12.5	Temporary strengthening of communications and engagement function including non-pay resources to support Better Together programme	Corrective	
12.6	Procurement of additional engagement delivery and analysis support to Stage Two Better Together engagement	Corrective	

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12.7	Procurement of additional consultation delivery and analysis support to Stage Three Better Together	Corrective	<ul style="list-style-type: none"> <li>Lack of structured feedback from key partners</li> </ul>	
12.8	Stakeholder Map in place	Preventative/Detective		
12.9	Priority stakeholder engagement mechanisms in place (e.g. regular MS/MP briefings, Board to Cabinet meetings with PCC, Joint Leadership Team meetings with PCC, RPB and sub-structures, PSB and sub-structures)	Preventative		
12.10	OD programme in place linked to Better Together transformational change programme	Preventative		
12.11	Channel strategy in place and kept under review (web, govDelivery, Facebook, NextDoor etc.)	Preventative		
12.12	Out of hours media protocol in place via Gold On Call but currently insufficient team capacity for on call comms	Preventative		
12.13	Powys Engagement and Insight Network in place to support pan-organisational co-ordination of engagement and insight (joint sub-group of RPB and PSB)	Preventative		
<b>Control Improvement Actions:</b>				
	Action	Owner	Status	Due Date
	Establish annual Insight Report from community engagement activities for Board review and to inform annual planning	DCG	Underway	March 2026
<b>Key sources of assurance</b>		<b>Associated Line (Three Lines Model)</b>	<b>Gaps in assurance</b>	
	Comprehensive reporting programme linked to the Better Together programme	L1 – Management	<ul style="list-style-type: none"> <li>No third line assurance</li> <li>Citizen experience reporting</li> </ul>	
	Quarterly Communication and Engagement Team reporting	L1 – Management		
	Regular reporting to the Executive Committee, Planning, Partnerships and Population Health Committee, People and Culture Committee and Local Partnership Forum.	L2 – Risk Oversight		

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**Agenda item: 5.7**

<b>Audit, Risk and Assurance Committee</b>		<b>Date: 13 January 2026</b>
<b>Subject:</b>	<b>Post Payment Verification (PPV) Mid-Year Report – 1st April 2025 to 30<sup>th</sup> September 2025</b>	
<b>Approved and presented by:</b>	Elaine Lorton – Executive Director Primary Care, Community & Mental Health	
<b>Prepared by:</b>	Amanda Legge - Post Payment Verification (PPV) Manager	
<b>Other Committees and meetings considered at:</b>		
<b>PURPOSE:</b>		
This report provides a mid-year summary of Post Payment Verification action and findings.		
<b>RECOMMENDATION(S):</b>		
The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.		
The Audit, Risk & Assurance Committee is asked to:		
<ul style="list-style-type: none"> <li><b>RECEIVE</b> the report and take <b>ASSURANCE</b> that effective PPV management is in place.</li> </ul>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
Y	Y	Y
<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
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:

This paper highlights PPV progress and how practices have been performing over the current Post Payment Verification (PPV) cycle. It also compares the overall performance of the Health Board against the national PPV visits.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board Audit Committees, which should provide reasonable assurance that public monies are being appropriately claimed and that PPV continue to maintain an excellent level of PPV across all disciplines.

The following key points should be noted:

We did not start this financial year planned work until July 2025 which was a national issue and is not specific to any individual Health Board.

**General Medical Services (GMS):** We check 100% of the services that have been triggered for a revisit, and these take a long time to finalise. Unfortunately, last year we experienced unexpected absence in the team in a disproportionate number and are in progress of recovering.

In the first 2-3 months of this new financial year, we completed all outstanding routine visits that were overdue before we began the new visit plan.

We have begun to undertake the additional verification of Covid and RSV vaccines as requested by Welsh Government which are claimed on the Welsh Immunisations System.

**General Ophthalmic Services (GOS):** The visit plans for GOS 2025-2026 are progressing well and more contractors have transferred to electronic patient records so we can undertake the visit remotely, however we do have to carry out elements of physical visits for the contractors who do not have electronic patient records.

We also began verifying claims for an additional 2 services this year for WGOS 4 (Glaucoma and Medical Retina) and IPOS (Independent prescribing) 5 urgent claims.

**General Pharmacy Services (GPS):** In 2025/2026 we continue to PPV the Collaborative Working Scheme along with the Quality and Safety Scheme which we can undertake remotely.

**Additional Services:** We have progressed with our quarterly dispensing data checks and have introduced a robust service moving forward into the new

financial year, which have resulted in financial recoveries. The results will be included in our PPV reports for this year once finalised.

Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this year to align to the WGOS reform and the managing of clinical waste. The PPV team also manage the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management. We are continuing to investigate other avenues for savings from the provision of Clinical Waste services.

Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training events will continue to be delivered to our Health Boards and contractors when required, including one-on-one training requirements, particularly for new practice staff within the Primary Care setting.

#### **NEXT STEPS:**

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving throughout the claiming process.

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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				
Timely				
Effective				
Efficient				
Equitable				
Person Centred				
Workforce				
Leadership				
Culture				
Information				
Learn, Improve, Research				
Whole Systems Approach				

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.

### EQUALITY:

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

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.

### RISK ASSESSMENT:

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

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.

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## Audit Report - 1st April to 30th Se

<b>General Medical Services (GMS) for 2024 - 2025</b>		<b>PtHB = 12 visits were c</b>	
<b>GMS</b>	<b>Visit Type</b>	<b>HB Annual Visits Due</b>	
	Routine	1	
	Revisit	5	
	<b>TOTAL</b>	<b>6</b>	
<b>General Ophthalmic Services (GOS) for 2024 - 2025</b>		<b>PtHB = 8 visits were</b>	
<b>GOS</b>	<b>Visit Type</b>	<b>Annual Visits Planned</b>	
	Routine	10	
	Revisit	0	
	<b>TOTAL</b>	<b>10</b>	
<b>General Pharmacy Services (GPS) for 2024 - 2025</b>		<b>PtHB = 8 visits were c</b>	
<b>GPS</b>	<b>Visit Type</b>	<b>Annual Visits Planned</b>	
	Q&S Scheme / Collaborative Working Scheme	8	
	<b>TOTAL</b>	<b>8</b>	
<b>New Recovery process</b>			
<b>DISPENSING</b>	<b>Quarter Period</b>	<b>Amount of Dispensing GP Practices</b>	
	Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy	Quarter 4 2024/25 (Jan to Mar 2025)	11

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September 2025 = Powys Teaching Health Board

completed with a total of recovery of £21,438.95 **ALL WALES = 193 v**

No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due
1	13	£531,69	£134,35	£666,04	103
0	0	£0,00	£0,00	£0,00	148
<b>1</b>	<b>13</b>	<b>£531,69</b>	<b>£134,35</b>	<b>£666,04</b>	<b>251</b>

completed with a total of recovery of £636.95 **ALL WALES = 100 v**

No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
4	16	£357,74	164	39	£6 243,53
0	0	£0,00	11	0	£0,00
<b>4</b>	<b>16</b>	<b>£357,74</b>	<b>175</b>	<b>39</b>	<b>£6 243,53</b>

completed with a total of recovery of £2,049.30 **ALL WALES = 238 v**

No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries
2	0	£0,00	232	0	0

Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
Pending	64	Pending

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**visits were completed with a recovery of £216,100.90**

All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
65	£44 544,91	£57 371,51	£101 916,42
0	£0,00	£0,00	£0,00
<b>65</b>	<b>£44 544,91</b>	<b>£57 371,51</b>	<b>£101 916,42</b>

**visits were completed with a recovery of £16,316.67**

**visits were completed with a recovery of £48,153.27**

All Wales Value of Recoveries
£0,00

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## GMS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries
Practice 1	Routine	190	13	6,84 %	£531,69	£134,35	£666,04	Lithium. Duplicate recovery

## GOS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% recovery	Value of recovery	Breakdown of Recoveries and
Practice 1	Routine	103	7	6,80 %	£92,67	GOS 4
Practice 2	Routine	103	3	2,91 %	£156,00	Claim
Practice 3	Routine	103	In progress			
Practice 4	Routine	103	6	5,83 %	£109,07	GOS 4

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**visory Notes**

- The planned visits

**visory Notes**

- The planned visits were sent

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**Agenda item: 5.8**

<b>Audit, Risk &amp; Assurance Committee</b>		<b>Date: 13 January 2026</b>
<b>Subject:</b>	<b>Powys Teaching Health Board (PTHB) Digital Strategic Framework Annual Report Year 2 2025/26</b>	
<b>Approved and presented by:</b>	Claire Madsen Executive Director of AHP, Health Science and Digital, Vicki Cooper Chief Digital Data Officer	
<b>Prepared by:</b>	Vicki Cooper Chief Digital Data Officer Dai Owen Chief Technical Officer Sue Hamer Head of Digital Programmes Emma McGowan Chief Nurse Informatics Officer	
<b>Other Committees and meetings considered at:</b>	Executive Committee - 29 October 2025	
<b>PURPOSE:</b>		
The report marks Year 2 of 3 of the Digital Strategic Framework (2023–2027), highlighting a commitment to a “Digital First” approach for Powys. The focus is on delivering measurable benefits for patients, staff, and partners through digital innovation, aiming for safe, effective, and person-centred care.		
<b>RECOMMENDATION(S):</b>		
The Audit, Risk & Assurance Committee is asked to:		
<ul style="list-style-type: none"> <li>• Take <b>ASSURANCE</b> that appropriate arrangements are in place to ensure ongoing delivery of the Digital Strategic Framework, with significant progress made to align with Ministerial digital priorities.</li> <li>• Take <b>assurance</b> that relevant actions and workstreams are being implemented to enhance and modernise the Digital Services offering as outlined in the Framework.</li> <li>• <b>Recognise</b> that alongside these assurances and achievements, significant challenges remain; while digital solutions should enable faster discharge and more accurate transfer notes, delays with the Cross Border programme, competing national and local priorities, workforce pressures, and capacity constraints are slowing adoption across the organisation.</li> </ul>		
<b>NOTE</b> the report will be provided to the Board in January 2026.		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>

Y	Y	Y
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<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
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	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

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## EXECUTIVE SUMMARY:

### Context

We are proud to present the Powys Teaching Health Board's second Digital Strategic Framework Annual Monitoring Report (2025-2026). This report reflects on the past year and looks forward as we continue to deliver the Digital Strategic Framework, 2023 – 2027, approved July 2023.

**Key Achievements (2024/25) Framework Integration:** Embedded the Digital Strategic Framework across core programmes.

- **Infrastructure Upgrades:** Delivered significant digital infrastructure improvements.
- **Transformation:** Advanced clinically led, digitally enabled transformation.
- **Alignment:** Ensured alignment with Welsh Government Digital Priorities, the Health Board's IMTP, and Ministerial expectations.

### Year 2/3 Highlights

- **Citizen-Centred Care:** Progressing integrated care records, digital maternity, NHS Wales App adoption, and digital communications.
- **Leadership & Partnerships:** Strengthened clinical digital leadership, expanded training, and improved operational support.
- **Infrastructure & Cyber Security:** Upgraded telephony, enhanced data centres, expanded Wi-Fi, eliminated legacy systems, and improved cyber security.
- **Efficiency & Effectiveness:** Automated inventory, improved care review processes, and enhanced reporting and prioritisation.
- **Big Data & AI:** Developed key applications, improved data quality, piloted AI initiatives, and expanded dashboard and analytics capabilities.

### Performance & Impact

- Uplifted services to electronic referral prioritisation.
- Migrated hundreds of scripts and dashboards to the cloud.
- Closed thousands of referrals, corrected data errors, and exceeded clinical coding targets.
- Maintained high customer satisfaction and efficient service desk operations.

### Staff Experience & Impact Stories

- Staff testimonials highlight supportive teamwork, professional growth, and a positive workplace culture.
- Training initiatives have empowered staff and improved digital confidence.
- Continuous feedback is used to enhance digital services and support.

### Risks & Challenges

- Ongoing cyber threats and workforce capacity constraints.
- Cultural resistance to digital change and delays in cross-border projects.

- Challenges in digital inclusion, system interoperability, and sustaining financial investment.
- Capacity and capability to deliver at pace and scale
- Competing national and local priorities

### Looking Ahead (Year 3 and Beyond)

- Scale digital tools and expand automation/AI pilots to reduce admin time for clinical and operational services.
- Strengthen patient-facing services and improve data integration to reduce paper records by digitalising processes and freeing up more time to care.
- Continue providing safe quality equipment and systems for connected care, maternity services and prescribing services.
- Prepare for the next Digital Strategic Framework (2027–2030) and further integrate health and social care solutions.

## BACKGROUND AND ANNUAL PROGRESS REPORT

We are embarking on an ambitious and exciting journey over the next two years, as detailed in our Digital Strategic Framework. This vision is not only bold but also rooted in our commitment to excellence and innovation in the digital sphere. Our aim is to continue delivering on our five strategic themes while aligning our digital priorities with the Health Board's Integrated Medium-Term Plan, Route map to Sustainability, and the national Digital Health and Care Strategy, A Healthier Wales.

The Health and Care Strategy for Powys, Strategic Objective **"Digital First"** details three key aims:

**Digital Care** - Telehealth/Care; Improve access to information about health and wellbeing and use digital technologies.

**Digital Access** – National ICT Programme; Implement systems to improve digital access to support care co-ordination, referral and diagnostics.

**Digital Infrastructure & Intelligence** – Including information storage, hosting, security, and recovery, back up and archiving, connectivity, and professional/user skill development of digital transformation.

Our framework is built around **five core strategic themes**, each of which is critical to our vision and success. These themes guide our actions and initiatives, ensuring that we remain focused on our goals and deliver tangible outcomes.

**Theme 1 - Citizen Centred Care and Support**

**Theme 2 – Leadership, Partnership and Alliances**

**Theme 3 – Infrastructure and Security**

**Theme 4 – Enabling efficiency and effectiveness**

**Theme 5 – Big Data and Artificial Intelligence**

## Digital Strategic Framework 2023 – 2027 on a page



### OUR MISSION FOR 'DIGITAL FIRST'

- Empower individuals to care for themselves and take control of their own health and wellbeing
- Make Powys an area of digital innovation in community health and care
- Achieve a joined up, efficient and informed patient journey, based on secure, real-time patient data
- Enable our staff to have access to high quality information, equipped with the digital resources they need to deliver safe, high quality and efficient care

### WILL BE DRIVEN FORWARD BY FIVE THEMES:

Citizen-centred care and support

Leadership, partnership and alliances

Infrastructure and security

Enabling efficiency and effectiveness

Big Data and Artificial Intelligence

### ...AND DELIVERED THROUGH:

- Digital Leadership, Alliances and Multi-Professional Team Working
- A Phased Portfolio of Programmes
- A new Target Operating Model

### RESULTING IN:

- Whole population health intelligence
- Shared Care Record
- Digital Care Pathways
- Patient experience and journey tracking
- Self Help and Service Portal
- Apps, wearables, home devices
- Intelligent automation
- Interoperability of systems
- Standardisation of processes
- Shared decision making
- Flexible and Agile Estates Strategy
- Digital skills and capability
- Resilient and reliable data platform
- Greater cyber security and data protection



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### NEXT STEPS:

Continue with the planned programme of work aligned to the delivery of the Digital Strategic Framework 2023-2027.

## IMPACT ASSESSMENT – NOT REQUIRED

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# Digital Strategic Framework Annual Report 2025/2026



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## Foreword

### “Our focus has sharpened on delivering real, measurable benefits for patients, staff, and partners”

The past year has marked a pivotal phase in our journey towards a “Digital First” Powys. As we enter Year 3 of our Digital Strategic Framework (2023–2027), our focus has sharpened on delivering real, measurable benefits for patients, staff, and partners.

The achievements set out in this report are a testament to the commitment and collaboration across our digital, clinical, and operational teams. We remain steadfast in our ambition: to harness digital innovation as a driver for safe, effective, and person-centred care—now and for the future.

**Claire Madsen,**  
Executive Director of Therapies, Health Science and Digital



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## Executive Summary

2024/25 has been a year of consolidation and acceleration. We have:

- Embedded the Digital Strategic Framework across core programmes
- Delivered key significant digital infrastructure upgrades
- Advanced our clinically led, digitally enabled transformation.

Our work is directly aligned to the five key themes of the Framework, ensuring every step supports our mission for a healthier, more connected Powys.

Furthermore, this report provides assurance that delivery is aligned with the Welsh Government's Digital Priorities for Health and Care, the Health Board's IMTP, and the Digital Strategic Framework. All core milestones have been progressed in line with Ministerial expectations and internal performance plans.

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## Digital Strategic Framework Themes

Citizen-centred care and support

Leadership, partnership and alliances

Infrastructure & Security

Enabling efficiency and effectiveness

Big Data & Artificial Intelligence

## Themes & Principles



### OUR MISSION FOR 'DIGITAL FIRST'

- Empower individuals to care for themselves and take control of their own health and wellbeing
- Make Powys an area of digital innovation in community health and care
- Achieve a joined up, efficient and informed patient journey, based on secure, real-time patient data
- Enable our staff to have access to high quality information, equipped with the digital resources they need to deliver safe, high quality and efficient care

### WILL BE DRIVEN FORWARD BY FIVE THEMES:

- Citizen-centred care and support
- Leadership, partnership and alliances
- Infrastructure and security
- Enabling efficiency and effectiveness
- Big Data and Artificial Intelligence

### ...AND DELIVERED THROUGH:

- Digital Leadership, Alliances and Multi-Professional Team Working
- A Phased Portfolio of Programmes
- A new Target Operating Model






### RESULTING IN:

- Whole population health intelligence
- Shared Care Record
- Digital Care Pathways
- Patient experience and journey tracking
- Self Help and Service Portal
- Apps, wearables, home devices
- Intelligent automation
- Interoperability of systems
- Standardisation of processes
- Shared decision making
- Flexible and Agile Estates Strategy
- Digital skills and capability
- Resilient and reliable data platform
- Greater cyber security and data protection

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## Year 2 Highlights

Managed Print Solution Deployed	Eliminated Fax Machines	 ePMA Solution Procured	 Digital Maternity System Procured
Board Approval to Replace WCCIS Platform	Implementation of Scan 4 Safety Stock Management System	RISP Platform Deployment	 12 Digital Apps Developed
New Digital Telephony Service	New Guest Wi-Fi Service	Almost 150,000 data quality issues addressed	33 New Dashboards
Nearly 350 items of Infrastructure Deployed	567 Digital Devices Procured	187 Software Licences Procured	56 Security Assessments
 35 Security Incidents Investigated	189 Vulnerabilities Patched	 92% - Average Customer Satisfaction	10,257 - Phone Calls Answered

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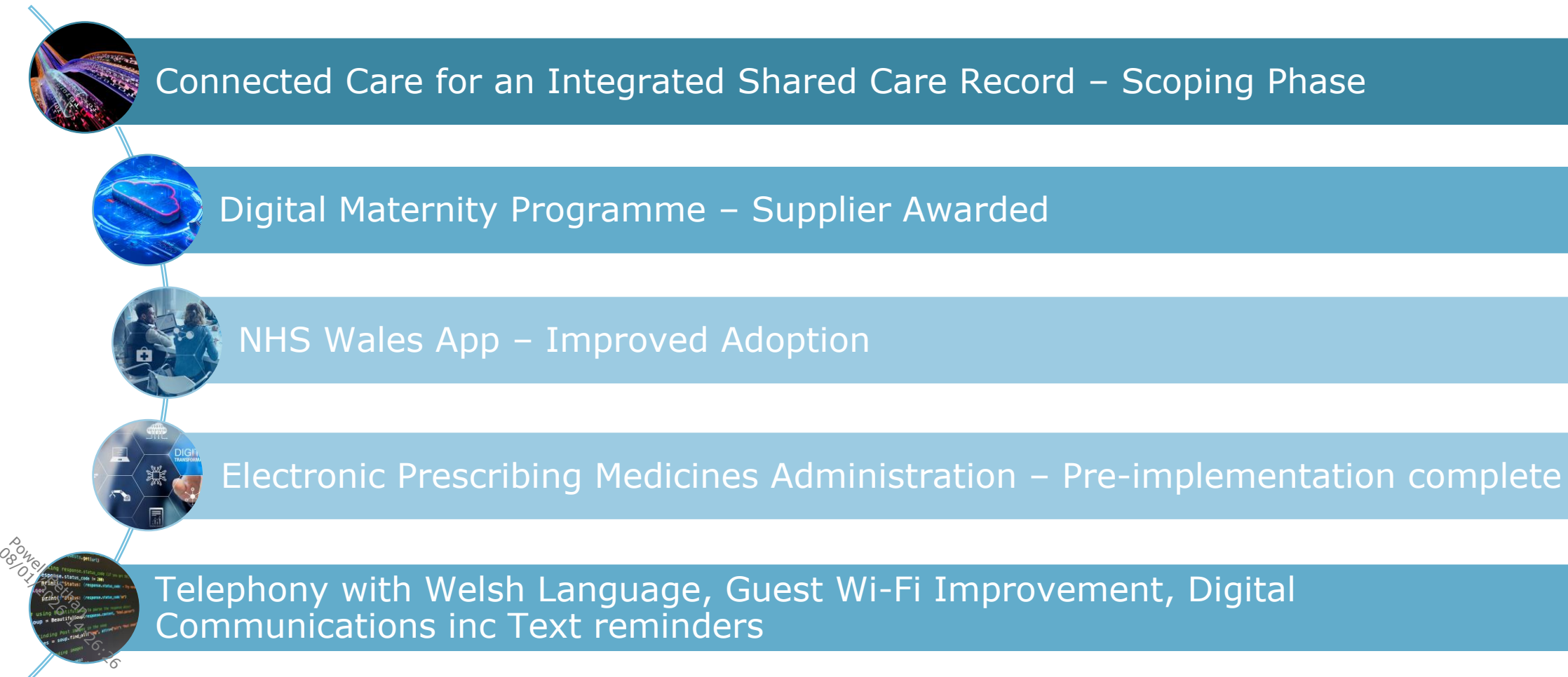
# Digital Strategic Framework 2023 - 2027

## Five Themes

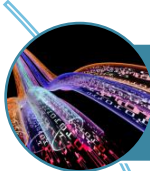






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## Citizen Centred Care Achievements



## Leadership, Partnership and Alliances Achievements

-  Clinically Led, Digitally Enabled Leadership strengthened with the establishment of a joined up Clinical Digital Board
-  Development SharePoint articles, help guides, and sites for operational service management.
-  Clinical Informatics team expanded to include Clinical Digital Trainers and conducted training awareness and Digital Skills confidence workshops.
-  Service led large Transformation programmes recognising Digital First as a Strategic Enabler
-  Target Operating Model extended for all Digital and Data functions, with increased availability for the IT Service Desk Hours and access to support when and where needed.

## Infrastructure & Cyber Security Achievements



### Connectivity

- **New Digital Telephony Service upgrade** across all sites, to a modern, Teams-integrated digital platform
- **Data centre enhancements** and security improvements
- **96 New Wireless Access Points** installed, extending Wi-Fi beyond hospital wards



### Security

- **Legacy operating systems** entirely eliminated
- **Cloud migration** of 387 data scripts and 409 dashboards
- **Cyber security training** and phishing campaigns delivered; improved audit score
- **Removal of legacy infrastructure** and unsupported systems



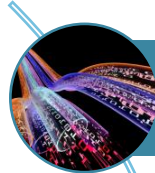




### Modernisation

- **Secure Guest Wi-Fi** implemented across all health board sites
- **Infrastructure Redesign and Refresh** replaced aging network hardware; all procured equipment deployed for improved reliability and performance
- **Highly available hosting platforms** increase reliability and service availability

## Enabling Efficiency & Effectiveness Achievements

-  Scan4Safety to automate inventory management, minimise waste and streamline ordering and receipting processes, better financial forecasting and stock control.
-  Support Planned Care review with ongoing process mapping and stakeholder engagement to ensure changes are sustainable and aligned to broader transformational goals.
-  Single point of Access for digital services to support and provide a transparent demand and capacity model of reporting and prioritisation.
-  Supported the Better Together Programme with timely data and analysis.
-  Internal Audit has identified key improvements for business change gaps and how we are tracking benefits realisation to ensure measurable improvements.


## Big Data & AI Achievements

-  Data Quality Improved with 30% reduction in reported errors
-  AI Policy and Guidance reviewed and Pilot AI initiatives scoped
-  Actioned 198 access requests, 152 data extract requests, and completed 137 information requests. They also resolved 87 technical issues and 56 reference data issues, ensuring data integrity and reliability
-  33 new dashboards, providing valuable insights and improving decision-making processes.
-  In-House Application Development Capabilities are improving efficiency across the health board with an addition 12 New Apps built

## Key Applications Developed




## Performance Benchmarking Model



387 scripts migrated to cloud



14,202 – Tickets Created



Closed 3733 referrals on Deceased patients



Palliative Nurses moved to bespoke solution in WCP



152 Development Requests



409 Dashboards migrated to the cloud



3853 – Incidents



Created 37 unique data quality checks



Colposcopy moved to bespoke solution in WCP




7 Incidents



33 New Dashboards



10,349 – Service Requests



Assigned 32k missing GPs



Clinic and Discharge letters from Wye Valley Trusts into WCP



24 New Automations Flows



198 Access requests actioned



12,149 – On Time Resolution



Corrected 53k incorrect GPs



Standardised Recording of Inpatient data as part of co-location workstream



15,788 Automation Events



168 Report amendments and updates



5.39 hrs – Average Resolution Time



Exceeded the Clinical Coding completeness target



13 UAT Cycles complete for major software releases



22 Maintained Applications



152 Data extract requests



93% - Average Customer Satisfaction



Reduced number of VASS errors by 49,0666



11 Services uplifted to electronic referral prioritisation



12 Applications Created 24/25



137 Freedom of Information Requests



10,257 - Phone Calls Received



Reviewed WPAS Location Table



11 Services uplifted to electronic referral prioritisation



12 Applications Created 24/25



87 Incidents Resolved



28% - Average Abandoned Rate



Corrected 8.5k missing or incorrect data items April - August



11 Services uplifted to electronic referral prioritisation



12 Applications Created 24/25

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# Digital Strategic Framework Impact Stories



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## Staff Testimonials



### Supportive Teamwork

*"It has felt like the people in Health ICT either understand or take the time to understand the issues and processes and then come with actual solutions and changes, this would not have been my previous experience."*



### Professional Growth Opportunities

*Maternity: Staff survey led to targeted training → faster adoption.*

*Radiology/PACS: 'We simply wouldn't have been able to go live without ICT's support.'*



### Positive Workplace Culture

*The IT support to Planned Care has noticeably improved in the last 12 months particularly in terms of switchboard/telephony infrastructure upgrades and the general increase in response time/positive outcomes for the operational service delivery*



### Supportive Teamwork

*"Since starting my role at the Health Board in July 2024 and becoming part of the RISP project the support from ICT has been invaluable to Radiology."*



### Professional Growth Opportunities

*District Nursing: ICT understood frontline issues and co-designed solutions.*

*Therapies Hub: Good support at operational level to develop changes/access to the system.*



### Positive Workplace Culture

*Outside of the RISP project any other contact I have had with ICT services has been met with a level of helpfulness that I just haven't experienced before. They are a great team and should be proud of themselves.*

## Impact Stories

Using feedback to constantly improve our working practices, services and support we aim to ensure that our clinical teams are able to utilise digital to support their day-to-day work and feel supported throughout.



### Leadership in Training

Emma our CNIO facilitated Digital Skills training that empowered nursing staff to confidently use new systems, devices & workflows.

### Boosting Confidence

The training initiative significantly increased staff confidence in navigating digital tools and systems.

### Fostering Continuous Learning

Emma's approach promoted a culture of ongoing learning and support within the team.

### Positive Organisational Impact

Investing in targeted staff development created positive ripple effects across multiple departments.

*"In my role as Professional Nurse Advocate for the District Nursing teams, my conversations with staff highlighted the need for additional ICT support.*

*The issues ranged from connectivity, moving to electronic record keeping and hardware issues.*

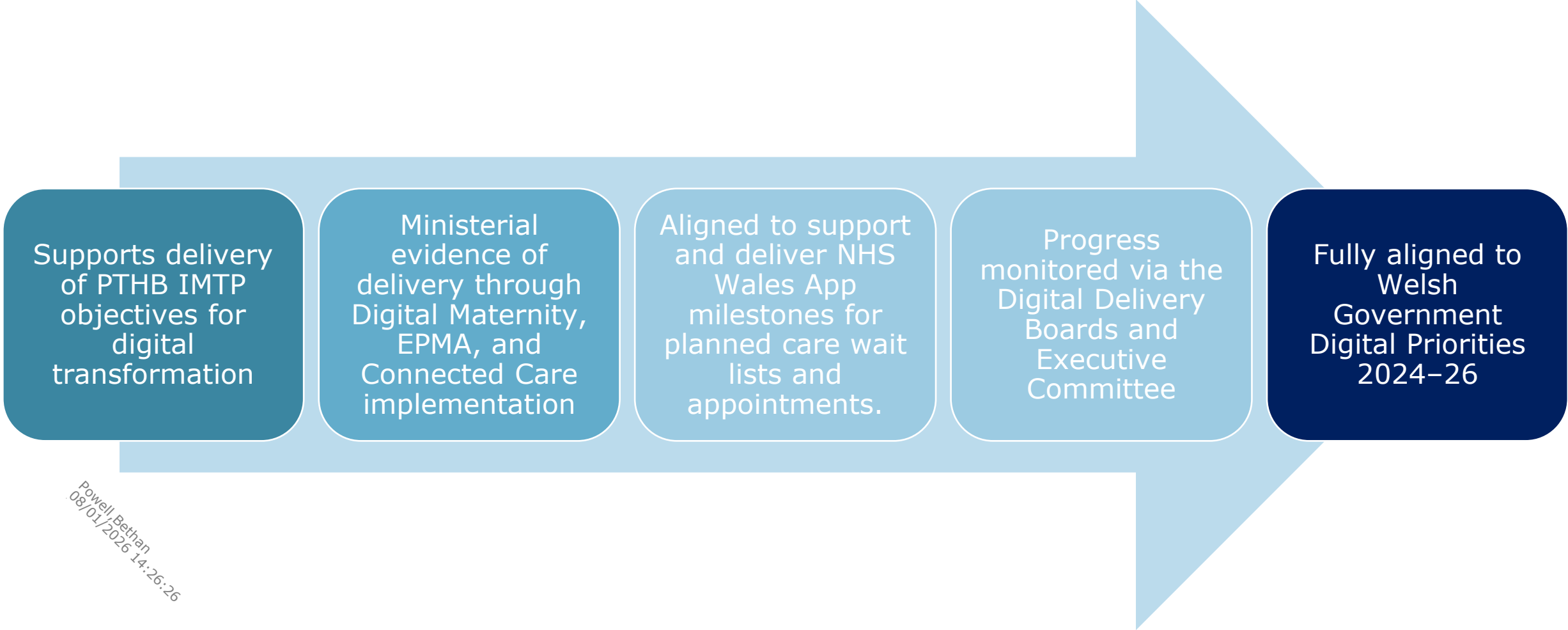
*The ICT day brought together the nurses on the frontline, experiencing the problems, with the experts in each field that were able to help.*

*The day was a great success with staff reporting that long standing difficulties had been rectified and the staff from ICT found it incredibly helpful to understand the difficulties that staff were facing.*

*We hope to be able to hold similar days at regular intervals in the future."*

**Testimony – Staff Nurse**

## Ministerial Alignment & Local Assurance



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# Risks and Challenges



## Risks

⚠️ Ongoing Cyber Threats may lead to loss of sensitive information or disruption to critical services, impacting patient care and organisational trust.

⚠️ National and Local driven dependencies for large Digital Transformation Programmes

⚠️ Limited workforce capacity and ongoing recruitment challenges may hinder timely delivery of Digital Transformation objectives.

⚠️ Cultural resistance to digital ways of working may slow the adoption and impact of digital transformation initiatives.

⚠️ Delays impacting the Cross Border project have limited the achievement of intended outcomes and impact to service delivery.

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## Challenges

⚠️ Digital Inclusion & Literacy areas of limited skills among staff and patients may reduce equitable access to digital services and hinder adoption of new technologies.

⚠️ System interoperability causes fragmented systems which may impede seamless data sharing and integrated care delivery.

⚠️ Sustaining Financial Investment constraints may restrict growth in digital infrastructure and innovation, impacting long-term transformation goals.

⚠️ Change fatigue and low engagement may reduce staff willingness to adopt and sustain digital initiatives.

⚠️ National and Local Alignment through digital priorities may complicate collaboration and delay progress on shared objectives.

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# Looking Ahead








GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

## Looking ahead to Year 3

Year 3 priorities continue to directly support the Welsh Government Ministerial Digital Priorities, expanding citizen access via the NHS Wales App, embedding Connected Care, Maternity and Electronic Prescribing solutions across Health and Social care.

Additionally:

-  Scale digital tools to release time to care
-  Expand Automation & AI pilots
-  Strengthen patient-facing services (portal, NHS Wales app links)
-  Continue improving Standardisation, data quality & integration across borders
-  Deliver smarter, more efficient ways of working despite financial pressures

## Further Ahead

- Data Intelligence
- Data Standards
- Clinical Application efficiencies
- Review the Digital Strategic Framework
- Complete EPMA implementation
- Rollout of Connected Care Programme
- Benefits Realisation fully Embedded



2025



- Guest Wi-Fi Implementation
- Senior Leadership Team restructure
- Internal Audit for Digital solutions
- Digital Maternity Solution procurement
- Connected Care Mental Health a
- Community Care System scope and approval
- EPMA pre-implementation complete

2026



2027



- Patient Portal
- Telehealth, AI & Robotics
- Commence a follow-on Digital Strategy 2027-2030 engagement process.

2028



2029














- Fully integrated and seamless Health and Social Care Solutions

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## Programme Timeline

Despite national and financial pressures, the Digital Programme remains primarily on track to deliver against core commitments within the WG Digital Priorities and PTHB IMTP.

KEY	Complete
	On Target
	At Risk
	Delayed

Project	Ministerial / HB Priority	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	
Cross Border (Digital Pathways)		Clinic & Discharge Letters viewable in WCP from WVT		Pathology results available from WVT	Closure & Eval report																	
Electronic Prescribing (ePMA)		Config & formulary	Dev Testing	UAT & Develop Training Materials				Early Adoption	Ward by Ward Go Live Inpatients			Phase 1 complete	Phase 2									
Digital Maternity Cymru (DMC)		Regional Governance		DPIA, Infrastructure, Configuration, Integration, Migration				Training	Go live	Benefits Realisation												
Connecting Care (WCCIS replacement)		Business Case Approval		Draft ITT	Publish Tender	Tender Eval	Contract Award		Configure, Build, Data Migration, Training						UAT			Go live				
Patient Comms		Business Case & user Requirements		IBG Approval	Exec Committee	Tender	Contract Award		Implementation										Benefits Realisation			
Digital Dictation		On Hold																				
Scan 4 Safety Inventory Management		Project Board	Inventory Stock Management System across 10 Hospital sites (identify service leads, champions, configure change, hardware setup, training)								Benefits Realisation				Decision if further efficiencies required							
Virtual Consultations		Increase adoption by 10%			Contract Extension		BAU															
Welsh Emergency Care Data Set (WECDS)		Develop / Agree Implementation Plan		MIU Comms	Config & Migration		UAT Preparation		End User Training (MIU)	Go live	Decommission WPAS ED Module											
NHS App		Onboarding info for outpatient clinics		Planned Care Go Live (referral to waiting list)	Planning workshop	Priority Patient Pathway extension																
Online Clinic Room Booking (outpatients)			Discovery work with outpatients			Develop Business Case																

## Our Digital Team



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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**Agenda item: 5.9**

<b>Audit Risk and Assurance Committee</b>	<b>Date: 13 January 2026</b>
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<b>Subject:</b>	SINGLE TENDER WAIVERS
<b>Approved and presented by:</b>	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services
<b>Prepared by:</b>	Assistant Director of Finance (Accounts and Services)
<b>Other Committees and meetings considered at:</b>	N/A

**PURPOSE:**

To report to the Committee the inform the Single Tender Waiver requests made between 25 September 2025 and 31 December 2025.

**RECOMMENDATION(S):**

The Committee is asked to:

- **NOTE** there has been five Single Tender Waiver requests made between 25 September 2025 and 31 December 2025.
- Take **ASSURANCE** relevant reporting and review mechanisms are in place.

Approve/Take Assurance	Discuss	Note
N	N	Y

**ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:**

1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

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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 October 2025 meeting which covered the period from 1 July 2025 and 30 September 2025. Two single Tender Waiver had been processed at the end of September 2025 but were not communicated to the Assistant Director of Finance until October 2025 therefore these are now being reported within the summary table below.

A summary of the use of Single Tender Action from 25<sup>th</sup> September 2025 and 31 December 2025 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
2526-009-SQA-POW	Tender	Adcuris Consulting Limited	Value for Money and Consistency to previously purchased equipment for programme	Continuation of work linked to previous undertaking	25/09/2025	£40,000	6 months	Prospective	A1
2526-037-SQA-POW	Tender	Parkway Clinic	Dental Surgical Interventions for Children and Young Adults	No NHS Provision available and clinical need	25/09/2025	£80,000	2 years	Prospective	A2
2526-038-STA-POW	Tender	Cardiff University	Research Development Advisor secondment position	Specialist Expertise	15/12/2025	£83,212	2 years	Prospective	A3

2526-039-STA-POW	Tender	Swansea University	Research Development Advisor secondment position	Specialist Expertise	15/12/2025	£163,050	2 years	Prospective	A4
2526-065-SQA-POW	Quote	YouGov	Commission of survey	Specialist Expertise	09/12/2025	£9,648	1 month	Prospective	A5

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 forma; reference on the table states it is 065 STW document issued it is confirmed this is the fifth 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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# Primary Care - Clusters Project Management

## Final Internal Audit Report

### 2025/26

Powys Teaching Health Board



Substantial Assurance

#### Contents

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<u>Findings &amp; Agreed Action Plan</u> .....	3
<u>Appendix A</u> .....	7

#### Review Reference

PTH-2526-13

#### Fieldwork

October – November 2025

#### Executive Sign Off

18 December 2025

#### Audit Committee

January 2026

#### Executive Lead

Elaine Lorton, Executive Director of Primary  
Community Care and Mental Health

#### Audit Team

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



# Executive Summary

## Purpose

The purpose of our review was to assess how the project management processes within the clusters are working to enable effective identification and implementation of developments.

## Overview

There are currently three Clusters across Powys covering North, South and Mid-Powys but from April 2026 the South and Mid-Powys clusters are to merge. Under the Accelerated Cluster Development Programme as part of the Strategic Programme for Primary Care, clusters receive funding to undertake projects to support their development across Wales. In the 2024/25 financial year, there were 34 live projects across the three Powys clusters with a total value of £870k. There has been limited guidance available nationally in terms of how the project management and governance arrangements should be undertaken, and the Health Board has therefore developed its own procedures, albeit with reference to an informal network across the other Health Boards. The current approach is very comprehensive and robust, and there is regular consultation with Cluster members to ensure that it remains appropriate.

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

- The terms of reference for the Clusters need to be amended to more accurately reflect the reality of members that are eligible to vote to approve individual projects.

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:

- Whilst the procedures for the management and governance of projects taken forward with clusters are well documented and robust, reliance for their effective completion is heavily dependent on the Cluster Development Manager; and
- Currently the procedures and reporting requirements are the same for all projects, no matter whether the value is £5k or £300k. There is, however, a proposal to introduce a more streamlined approach for projects with a value of under £10k.

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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

	Objectives	Related Findings	Assurance
1	A robust, documented process is in place for the identification, evaluation, selection and approval of the developments that are to be taken forward within the clusters.	1	<b>Reasonable</b>
2	There are standardised, documented project management arrangements in place to ensure the effective implementation of the approved developments. The arrangements are proportionate to the respective value of projects and include identification of project leads, development of project plans and allocation of resources.	-	<b>Substantial</b>
3	Progress towards the implementation of the individual developments is effectively monitored and reported, including the identification and management of any risks to delivery	-	<b>Substantial</b>
4	Robust governance arrangements are in place to ensure that overall progress with the developments is effectively monitored and reported both locally and via appropriate escalation through the Health Board where required.	1	<b>Reasonable</b>

### Management Actions



High Priority



Medium Priority

### Themes



■ Governance

### Risk Types

Financial Loss

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# Findings & Agreed Action Plan

**Objective 1:** A robust, documented process is in place for the identification, evaluation, selection and approval of the developments that are to be taken forward within the clusters;

Reasonable

## Overview / Summary of Observations

Comprehensive procedures have been developed for the approval of projects under the Accelerated Cluster Development Programme, and these are subject to continual review and revision with Cluster members. This has led in particular to the development of the plan-on-a page document which is credited with speeding up the process for approval as it provides a quicker initial decision which if approved leads to a more detailed proposal being completed. The one-page plan should align with and reference:

- The Cluster’s IMTP priorities;
- The locality’s population needs analysis; and
- Have recorded support from the sponsoring collaborative before being presented to the Cluster.

All projects are subject to a formal voting process and the outcome of this is formally recorded and issued to all members of the relevant cluster. Testing of a sample of projects from different clusters and at different stages of maturity identified no concerns but did illustrate the changing and improving requirements and documentation for their identification and approval. There is however a need to clarify the number of votes needed to approve a project in the Clusters’ Terms of Reference as the current wording does not reflect the reality of the actual position.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Terms of Reference - Voting Requirements</b></p> <p>The terms of reference for the North Cluster state that:  <i>For decisions where there is a financial implication, no less than 75% of members will secure a decision (12 representatives).</i></p> <p>However, testing of a number of projects identified approvals being based on numbers that were frequently less than 12 and which were as low as eight approving members. The reason for this is due to the following:</p> <ul style="list-style-type: none"> <li>• The Cluster having less than 16 members:               <ul style="list-style-type: none"> <li>• Members being ineligible to vote due to declared conflicts of interest; and</li> <li>• Members not responding to the request to vote (which is done virtually).</li> </ul> </li> </ul>	<p>Project approvals are not consistent with the wording of the requirements set out in the Cluster Terms of Reference.</p>	<p><b>Agreed Action:</b></p> <p>The wording of the Terms of Reference for each of the Clusters will be amended to remove the reference to a specific number of representatives and to include the word eligible – i.e. therefore excluding any member with a declared conflict of interest but not excluding those that have just not responded to the request to vote.</p>

<p>Similarly, the terms of reference state that: <i>For decisions where there is NO financial implication, a core member vote of 50% plus 1 will secure the decision. (9 representatives)</i></p>		<p><b>Expected Evidence of Implementation:</b> Updated Terms of Reference</p>
<p><b>Theme:</b> Governance</p>	<p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Officer: Amanda Walters, Head of Primary Care</b> <b>Target Implementation Date: 31<sup>st</sup> January 2026</b></p>

**Objective 2:** There are standardised, documented project management arrangements in place to ensure the effective implementation of the approved developments. The arrangements are proportionate to the respective value of projects and include identification of project leads, development of project plans and allocation of resources

**Substantial**

### Overview / Summary of Observations

The progress of projects is managed through a Project Monitoring Sheet which is maintained centrally by the Cluster Development Manager. Projects are monitored using the following headings:

- Project Overview;
- Project Plan;
- Resources;
- GANTT chart;
- Action Log;
- Risks and Issues;
- Spend against budget.

Project Monitoring Sheets are kept up to date through regular project meetings, and these are led by the Cluster Development Manager.

The approach to monitoring the progress with implementation of approved projects is therefore robust, albeit that it is very dependent on the role of the Primary Care Cluster Development Manager. The approach has been updated over recent times and as projects are often multi-year in length, audit testing of a sample of projects identified some differences in approach from current requirements, but nothing that caused any particular concern.

A proposal has been drawn up to have a more minimal approach for projects up to £10k in value - this is due to be taken forward for discussion by the Head of Primary Care at the Cluster Business Meeting in February. We would be generally supportive of this development, however the detail of what might and might not be required, and how this might fit with procurement regulations, remains to be thought through.

### **Overview / Summary of Observations**

Regular reporting is undertaken to both the Regional Partnership Board (RPB) Executive Committee and the Cluster Business meeting.

The reports to the RPB Executive Committee are prepared by the Cluster Development Manager and are drawn from the individual Project Monitoring Sheets which are informed by the regular team meetings with the Project Leads. The report covers for each project:

- Description of the project;
- Traffic Light Status;
- Funding Amount and Source;
- Delivery Timescales;
- Project Update;
- Any major risks;
- Next Steps;
- Forecast Financial Outturn.

Reporting to the Cluster Business Meeting is undertaken by the Project Lead and previously could be a verbal update but now requires a written report using a standard template. The report includes the following:

- Headline details – e.g. Project Title, Lead, Cluster, Collaboratives, Start Date and Expected Duration;
- Update Summary;
- Project Status;
- Project Finance:
- Quantitative Measures: and
- Qualitative Indicators.

Testing of a sample of projects identified that reports were being produced for both the Cluster and the RPB Executive as required.

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**Objective 4:** Robust governance arrangements are in place to ensure that overall progress with the developments is effectively monitored and reported both locally and via appropriate escalation through the Health Board where required.

Reasonable

### Overview / Summary of Observations

There are currently three clusters in place across Powys – North, South and Mid. Each should have a Cluster Lead, who is usually a GP, but this does not have to be the case. There is currently no Cluster Lead for both South and Mid-Powys, and the decision has been taken to merge these Clusters with effect from April 2026, which will result in a cluster size that is more representative of clusters across Wales as a whole. The Clusters have a wider membership than when first established, including a number of specialisms other than GPs, and also including the third sector but not currently Local Authorities. Local Authorities do however sit on the RPB Executive.

The Cluster Lead is usually employed for one day or two sessions a week. Under each cluster is a number of collaboratives which are not all fully formed as yet but which cover:

- General Medical Services;
- Optometry;
- Community Pharmacy;
- General Dental Services;
- Allied Health Professionals; and
- Professional Nursing.

Clusters have detailed terms of reference covering their operation. Formal reporting is to the Regional Partnership Board Executive Committee on which the Health Board is represented by the Assistant Director of Primary Care Services, who additionally takes a detailed annual report on the Accelerated Cluster Development Programme to the Health Board Planning, Partnerships and Population Health Committee.

Although not raising a separate finding here, we have attributed a rating of reasonable to this objective in recognition of the need to update the Cluster Terms of Reference for the numbers required for voting (As detailed within Key Finding 1 above).

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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

## Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

## Public Sector Internal Audit Standards

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# Staff Development Programme

## Final Internal Audit Report

2025/26

Powys Teaching Health Board



Substantial Assurance

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### Review Reference

#### Fieldwork

#### Executive Sign Off

#### Audit Committee

#### Executive Lead

#### Audit Team

PTHB-2526-16

August - September 2025

October 2025

January 2026

Debra Wood-Lawson, Executive Director of Workforce and Organisational Development

Ian Virgill, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit

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# Executive Summary

## Purpose

To review the processes for developing and delivering the staff development programme, linked into the Management Charter (the BTHB Manager) / Compassionate Leadership.

## Overview

A competent, committed and motivated workforce is crucial to any organisation. The Health Board's Integrated plan for 2024- 2029<sup>1</sup>, extract from A Great Place to Work (Theme 2 of Workforce Futures) states, 'It is crucial that PTHB is able to be competitive by being a great place to work. Excellence in leadership remains fundamental to employee experience, with a compassionate culture where staff have a high-quality experience and can innovate and transform.'

The Health Board's staff development programme includes a significant number of individual elements. Our review was primarily focussed on the following key programmes:

- The PTHB Manager's Programme - This includes four modules of the Compassionate Leader programme and six modules covering essential Health Board's Managerial information<sup>2</sup>; and
- The Clinical leadership Immersive Programme (CLIP)- This programme has three tiers, with tiers one and two currently in place and the introduction of tier three on hold.<sup>3</sup>

We have concluded **substantial** assurance on this area reflecting that there are currently robust processes in place to ensure the effective delivery of the staff development programme. However, there is a risk (as already identified in the workforce and OD risk register) that the current reliance on fixed term funded posts may affect the future delivery. The Head of Organisational Development is the only permanent staff member within the team, supported by two fixed term contract staff with an end date of March 2026 and one vacancy. The funding for the fixed term contracts is subject to annual review by the Regional Partnership Board.

- The only key matter requiring management attention relates to the absence of a structured feedback loop and action tracking mechanism to enhance the effectiveness of the Staff Development Programme.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The below opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- In order to reflect the current practise, management should consider updating the wording of the Induction Policy regarding the mandatory requirement to undertake the manager's programme.

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<sup>1</sup> [pthb.nhs.wales/about-us/key-documents/strategies-and-plans/powys-teaching-health-board-integrated-plan-2024-2029/11/](https://pthb.nhs.wales/about-us/key-documents/strategies-and-plans/powys-teaching-health-board-integrated-plan-2024-2029/11/)

<sup>2</sup> [The PTHB Managers Programme](#)

<sup>3</sup> [Clinical Leadership Immersive Programme \(CLIP\)](#)

## 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

	Objectives	Related Findings	Assurance
1	There is a clear process in place for developing the Staff Development Programme with reference to the principles of Compassionate Leadership and the Manager's Charter	-	<b>Substantial</b>
2	Robust mechanisms are in place for communicating and promoting the Staff Development Programme to relevant staff groups across the Health Board, ensuring appropriate levels of engagement and enrolment	-	<b>Substantial</b>
3	There are suitable processes and resources in place to manage the delivery of the Staff Development Programme in terms of recording the attendees and the outcomes/ feedback from the programmes	1	<b>Reasonable</b>
4	There are governance arrangements in place which allow for the effective monitoring of delivery, reporting of outcomes and evaluation of the impact of the Staff Development Programme	-	<b>Substantial</b>

### Management Actions



1

Medium Priority

### Themes



■ Performance monitoring

### Risk Types

Quality or Safety Issues

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# Findings & Agreed Action Plan

**Objective 1:** There is a clear process in place for developing the Staff Development Programme with reference to the principles of Compassionate Leadership and the Manager's Charter

**Substantial**

## Overview

The development of the Staff Development Programmes within the Health Board has been guided by an iterative, needs-driven process, closely aligned with the principles of Compassionate Leadership. Programmes are initiated in response to organisational needs, executive requests, and staff feedback. Proposals and changes are presented to the Executive Committee for approval, ensuring oversight and alignment with strategic priorities.

The two main staff development programmes in the Health Board are the PTHB Manager's Programme and the Clinical Leadership Immersive Programme (CLIP). Both programmes are evaluated and refined ensuring continuous improvement and relevance.

The Manager's Programme was initially launched in 2019. This programme focuses on operational management and leadership for Bands three to seven based on five core themes. This includes modules on compassionate leadership, team effectiveness, and wellbeing. It incorporates compassionate leadership as a core theme and is regularly updated to reflect evolving requirements, such as equality and organisational risk. In 2024 a manager's charter 'The PTHB Manager' was developed for managers to sign up to. The PTHB Manager is framed around the five themes of the Manager's Programme and communicates to managers what is expected of them in their role and what support is available.

The Clinical Leadership Immersive Programme (CLIP) is an experiential, non-assessed programme for clinical staff, structured in three tiers for different staff bands. Tier one is new and recently piloted, tier two is ongoing and fully established while tier three has been put on hold because of work with HEIW and resource availability. CLIP emphasises compassionate leadership and practical experience, with participants presenting outcomes to senior clinicians.

Compassionate Leadership is embedded in both programmes, with a pledge signed by the CEO and Chair in 2024. Over 500 staff have completed the introductory course.

Bespoke and complementary courses are developed as needed, maintaining flexibility while upholding the core values of compassionate leadership and the expectations set out in The PTHB Manager.

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## Overview

Robust mechanisms are in place to communicate and promote the Staff Development Programme across the Health Board, ensuring staff engagement and enrolment. The CLIP programme piloted in November/December 2023. It currently runs bi-monthly with around ten participants per cohort, totalling eighty-seven so far. In response to attendance levels, the Manager's Programme moved from modular to cohort-based delivery, hosting thirty-six staff last year and twenty so far this year, with nine more booked for October 2025.

Programmes such as the Manager's Programme and CLIP are supported by a range of facilitators and subject matter experts. Digital promotion is led by the Technician Support Officer via SharePoint, which serves as the central hub for training information. Weekly "Training Tuesday" emails consolidate all training updates and link staff to course details. Posters, leaflets, and video adverts further enhance visibility.

Facilitators promote programmes during course sessions, corporate induction, and direct engagement with ward managers. Well-being roadshows and committee meetings also serve as promotional platforms, with staff stories shared to highlight programme impact. HR Business Partners and clinical educators also help cascade information to relevant teams. When enrolment is low, direct messaging to managers is used, along with further communication with relevant directors if required.

The Health Board's Induction Policy outlines the Manager's Programme as mandatory, though participation is currently only encouraged voluntarily to accommodate operational pressures. Award nominations and collaboration with HEIW to scale CLIP across Wales further raises awareness.

These integrated communication strategies ensure that relevant staff groups are informed, engaged, and supported to enrol in development opportunities.

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**Objective 3:** There are suitable processes and resources in place to manage the delivery of the Staff Development Programme in terms of recording the attendees and the outcomes/ feedback from the programmes

**Reasonable**

**Overview**

There are suitable processes and resources in place to manage the delivery of the Staff Development Programme, including mechanisms for recording attendance and capturing outcomes and feedback.

The Manager’s Programme and Clinical Leadership Immersive Programme (CLIP) are self-selecting but guided by internal criteria to ensure appropriate participation. Attendance is recorded via ESR for the Manager’s Programme and through spreadsheets for CLIP, with plans to integrate CLIP into ESR for improved reporting.

Study materials, lesson plans, and handbooks are provided to participants, and SharePoint pages support access to programme information. While physical space and staff availability can be challenging, facilitators adapt delivery accordingly.

Feedback is collected using structured evaluation forms aligned to the Kirkpatrick model, assessing reaction, learning, behaviour change, and impact. Feedback for both the CLIP and manager’s programme are conducted at module level and post-programme. However, evidence could not be provided on how feedback is used to refine content or how feedback results can inform thematic improvements.

The programme is supported by robust processes for delivery, tracking, and evaluation, ensuring continuous improvement and alignment with staff development needs. Whilst we acknowledge resources include a dedicated Organisational Development team and externally funded staff, reliance on fixed-term funding poses sustainability risks which has been highlighted in the People and Culture Directorate Risk Register and Workforce Futures Programme Risk Register.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Monitoring of feedback</b></p> <p>Whilst we acknowledge that feedback is collected following the participation in the Managers Programme and CLIP there is currently no evidence that this feedback is formally shared or discussed at any governance forum. Although the Head of Organisational Development indicated that the feedback would be presented at team meetings and the People and Culture Committee, this has not yet occurred.</p> <p>There is no documented process to monitor or action issues raised through staff feedback. There are no formal plans in place to address recurring themes or issues, meaning that opportunities for programme improvement may be missed.</p> <p><b>Theme:</b> Performance Monitoring</p>	<p>Limitation of the programme’s ability to drive continuous improvement and inform thematic changes.</p> <p>The programme may not fully meet staff development needs</p> <p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Suggested Action:</b></p> <p>Management will agree on the forums through which staff feedback is presented.</p> <p>Management will establish a formal medium through which key concerns are captured with actions put in place to strengthen, improve the programme, and further aid staff’s development.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Presentation of feedback at a governance forum.</p> <p>Implement action plans for staff feedback.</p> <p><b>Officer:</b> Rhys Brown, Head of Organisational Development</p> <p><b>Target Implementation Date:</b> 31<sup>st</sup> March 2026</p>

**Objective 4:** There are governance arrangements in place which allow for the effective monitoring of delivery, reporting of outcomes and evaluation of the impact of the Staff Development Programme

**Substantial**

### **Overview**

Governance arrangements for the Staff Development Programme are established in a way which enables effective monitoring, reporting, and evaluation of its delivery and impact.

Updates are provided quarterly through summary reports prepared by the Executive Director of People and Culture, which are shared with the Executive Team, People and Culture Committee, and Local Partnership Forum (LPF).

The Board is presented with the Integrated Plan Progress quarterly report which includes the Workforce Futures section alongside progress against integrated plan milestones, BRAG ratings, and update of key deliverables from the Manager's, CLIP and Compassionate Leadership programmes.

Governance is supported by a structured reporting cycle, with papers reviewed sequentially by the Executive Committee, Workforce & Culture Committee (now People and Culture Committee), and LPF.

The same core data is circulated across forums to maintain consistency, with updates delivered via reports and presentations. The integrated plan includes specific actions related to leadership and management development, and progress is tracked quarterly.

The governance framework ensures transparency, accountability, and continuous improvement in the Staff Development Programme.

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# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	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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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
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Powys Teaching  
Health Board

**Agenda item: 7.2**

<b>Audit, Risk and Assurance Committee</b>	<b>Date: 13 January 2026</b>
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<b>Subject:</b>	Information Governance and Records Management Performance and Assurance Monitoring Report
<b>Approved and presented by:</b>	Helen Bushell, Director of Corporate Governance/Board Secretary
<b>Prepared by:</b>	Head of Information Governance, Records and Data Protection Officer, Corporate & Health Records Manager and Information Governance Manager
<b>Other Committees and meetings considered at:</b>	Executive Committee - 07 January 2026

**PURPOSE:**

To provide assurance of the arrangements in place to ensure the health board complies with its statutory obligations in relation to key legislation such as Data Protection Act and Freedom of Information Act, national frameworks, and good practice.

**RECOMMENDATION(S):**

The Committee are asked to:

- **RECEIVE** the report and take **ASSURANCE** appropriate performance monitoring is in place across information governance and records management.
- **NOTE** areas of poor or non-compliance (specifically training and information asset register completion) and take **ASSURANCE** a programme of work is in place to improve compliance.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

**ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:**

1. Focus on Wellbeing	Y	Information governance and records management is relevant to every service across 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	

**EXECUTIVE SUMMARY QUARTERLY SUMMARY:**

This reporting period covers Quarter 2 July – September 2025/26, with a high-level overview of performance listed below, with breakdown provided in the detailed background and assessment section.

**Freedom of Information (FOI) & Environmental Information Regulations (EIR) Requests:**

- Total Requests Received: **144** – 27.43% increase in the number of requests received since the last quarter
- Compliance Rate: **91%** overall for the quarter (above ICO target of 90%) however, performance in September dipped to **89%** falling below ICO compliance target
- Breaches: **13** (longest breach: **44** days due to service-related issues and annual leave due to summer holiday season; statutory timeframe: 20 working days).
- Quarterly Comparison: Figures remain consistent with the previous quarter
- Internal Reviews: **1** received; no further action taken by the requester
- EIR Requests: **0** received
- Update – The team is actively collaborating with selected services to identify key information for inclusion in the Health Board’s Publication Scheme. This proactive initiative is designed to improve transparency and reduce repeat Freedom of Information (FOI) requests, delivering time and resource efficiencies. The initial focus will be on Finance and People and Culture data, with implementation planning scheduled to commence April 2026.

**Requests for Personal Information:**

- Total Requests Received: **230** (living and deceased)
- Compliance:
  - UK GDPR: **96%** overall for the quarter; three extensions applied due to complexity, **2** met within revised deadline. **1** request was jointly responded to under the Freedom of Information Act and the deadline was missed. Compliance remains consistent with previous quarter.
  - Request for Erasure/Rectification: **2** erasure requests were received, both relating to the Health Board’s online SilverCloud service. **1** request was closed as no records were held, and the other was successfully completed.
  - Access to Health Records Act (deceased): **100%**
  - Medical Examiner (ME) Service: **3** disclosures exceeded the 72-hour target due to weekend staffing delays
- Request volumes in Q2 has increased compared to Q1 (171 requests) and Q4 2024/25 (188 requests).
- Operational Impact: Since implementing the Radiology IEP system (RISP Project) at Newtown, Welshpool, and Llandrindod Wells, challenges have arisen in retrieving historical images from the former DGH system. This caused delays

in SAR responses, with two disclosures missing legislative deadlines in Q2. The issue is expected to continue as the RISP project progresses and has been added to the project risk register.

### **Datix Incidents (Breach Reporting):**

- **57** IG-related incidents reported
- **13** incidents missed the UK GDPR 72-hour reporting window, mainly due to service delays
- **1** incident reported to the ICO due to repeat nature; no further action taken
- **49** non-IG incidents logged due to incorrect categorization (down from 56 last quarter)
- **Operational Impact:** Slight improvement in timely logging, but delays remain a concern. Continued reminders issued to services

The top four themes identified during this reporting period:

- **7 incidents** – Information Governance: Unintended external recipient (via letter or email).
- **5 incidents** – Records Management: Wrong attachment containing personal identifiable information (PII) sent to an external recipient (via letter or email).
- **4 incidents** – Physical Security - Insecure premises
- **4 incidents** – Information Governance: Breach of sensitive data.

Physical Security Incidents – increase in physical security incidents during the last 2 quarters, with a further **4** logged this quarter, specifically relating to insecure premises. Staff reminder on physical security will feature in next quarter's news feeds.

### **Audit and Monitoring:**

#### Information Asset Register:

- **73** new assets added since Q1.
- Research, Innovation & Improvement submitted entries for the first time.
- Targeted engagement remains essential as some directorates have yet to submit, posing compliance risks (breakdown in Q3). Continued support will ensure full representation and clear asset ownership.
- Operationally, asset approvals remain labour-intensive, and a backlog is forming.

#### The National Intelligent Integrated Audit Solution (NIIAS):

- **2** notifications of staff potentially accessing their own record (1<sup>st</sup> offence).
- **1** notification of staff potentially accessing their own record (2<sup>nd</sup> offence).
- **2** notifications of staff potentially accessing a family member's record (Home relations First offence) one incident was found to be inappropriate, and the staff member was required to retake mandatory Information Governance training via ESR.

- **0** incidents reported to the ICO

#### NHS Wales IG Toolkit Update:

- Ongoing Action – The team continues to progress actions from the previous IG Toolkit submission with service leads. Next quarter, we will publish our first local low-level DPIA in line with Action 6 of the IG Toolkit Out-turn Report and Improvement Plan 2025–26.
- 2025–26 Submission – The latest assessment opened in Q2, and work is underway on updated requirements. The team is engaging with key services to prepare PTHB responses

#### **Training & Awareness:**

- Mandatory IG E-Learning (NHS Wales):
- Compliance rate: **78.54%**, slight decrease from last quarter (78.63%) (this includes hosted organisations)
  - Now **below** the national target of 85%
  - the team have issued reminder emails to all non-compliant staff during quarter 2
  - Bank staff remain the lowest for IG training compliance (61.21%). A meeting with the Temporary Staffing Unit addressed assurance and improvement actions:
    - Agency Workers – Confirming if IG training is part of onboarding and how to capture this for assurance.
    - Locum Doctors – Reviewing current assurance, training undertaken, and how to record compliance.
- New Starters:
  - **99** of **134** did not complete mandatory IG training within the required 6 weeks
  - A targeted process introduced by the Team to chase non-compliant starters, seems to have received positive response – to date no individual has required more than two reminders.
  - Pro-active consideration still required how staff are targeted upon start date to complete their training within the 6 weeks.
- Internal IG Training Delivered:
  - **7** bespoke sessions provided, covering:
    - Information Asset Register
    - Refreshers for Personal Data Breaches x 3
    - UK GDPR & use of CCTV
    - Secure use of SharePoint for Planned Care - Business Continuity

Three Health Board staff successfully completed IHRIM Certification in Records Management in 2025 and received their results in Q2. All staff passed, two with distinction, which further demonstrates organisational commitment to professional development and competency in records management.

### **Records Storage:**

Storage Requests: **6** archive storage requests were received this quarter (up from four last quarter). **4** have been completed; one is on hold pending work on O Ward, and **1** awaits additional information from the service.

New Developments: To support ongoing health records archiving refurbishment of O Ward at Bronllys began in September 2025 and is scheduled for completion by mid-Q3. An *Archiving of Records Procedure* was drafted and approved during Q3.

### **Data Protection Impact Assessments (DPIAs)**

The team have been providing advice and support during Quarter 2 for the following new DPIAs:

- National DPIAs – **3**
- Local DPIAs – **15**

Alongside supporting the new DPIAs, the team have completed work on the following from previous quarters:

- **1** National DPIAs
- **4** local DPIAs

### **Information Sharing Agreements**

The team have been providing advice and support for **13** Information Sharing Agreements which include Information Sharing Protocols (ISP) and Data Sharing Agreements (DSA):

- National – **1** ISP completed, **2** DSAs not yet started
- Local – **1** ISP in progress, **5** DSAs in progress, **3** DSAs completed.
- Regional – **1** ISP completed.

### **Data Processing Agreements (DPA)/Contracts/Service Level Agreements (SLA) Reviews**

The team have been asked to provide support with **5** DPAs/contracts/SLAs **4** have been reviewed, with **1** on hold. All 5 are local contracts.

### **Research and Service Evaluation Support**

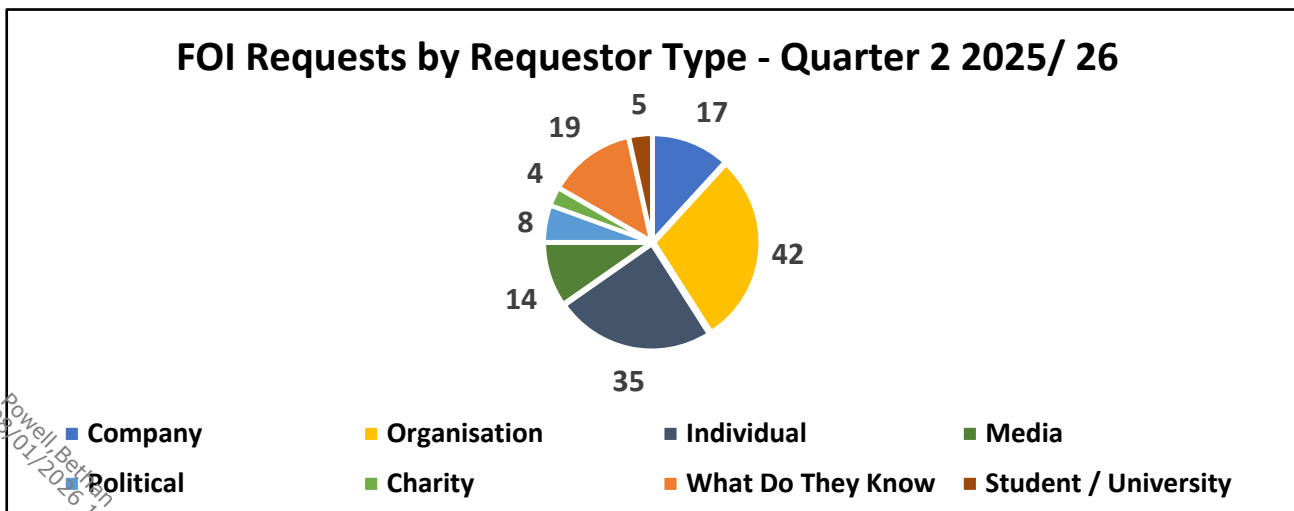
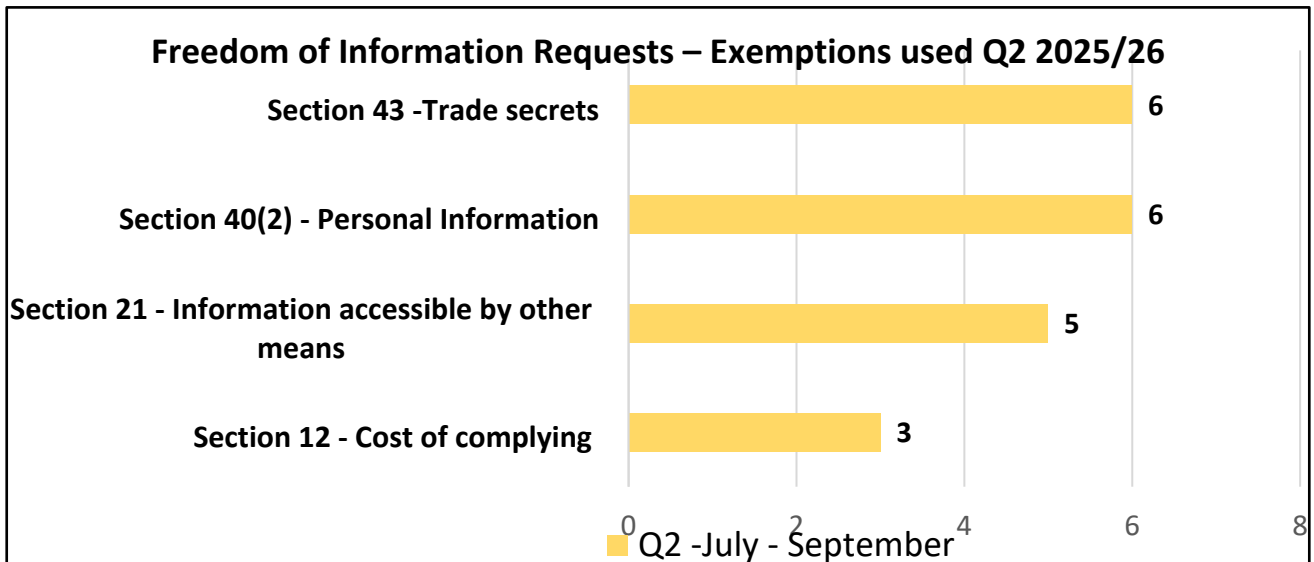
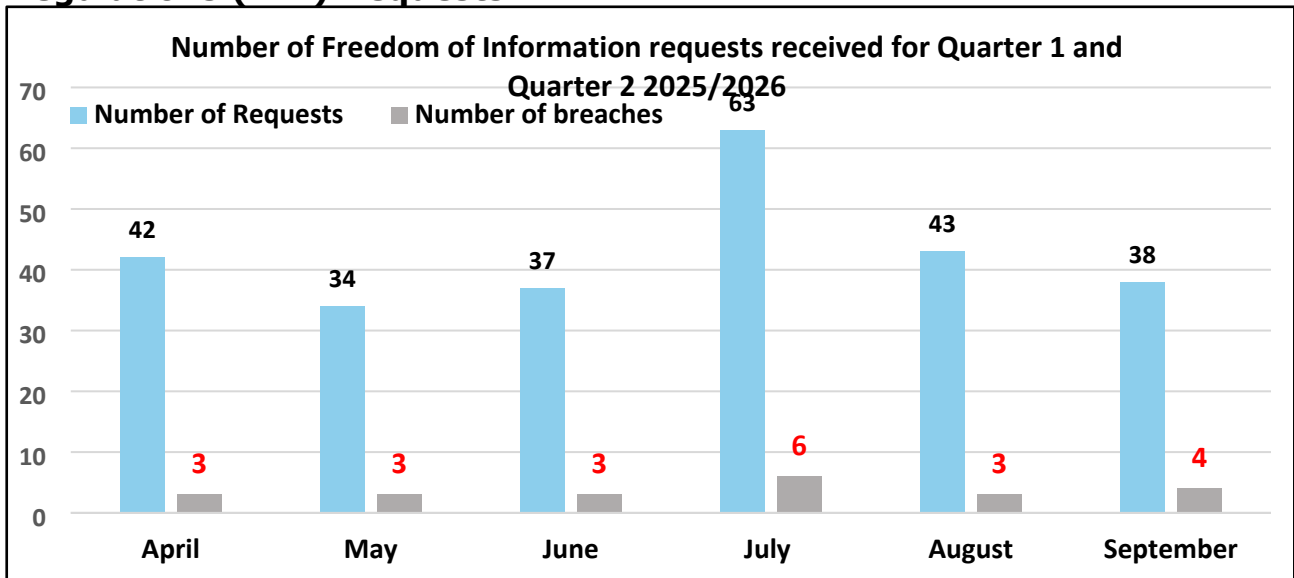
The team have been providing advice and support for **6** Research projects/service evaluations (Research – **4** and Service Evaluations – **2**). The team closed **5** of the above research projects/service evaluations for this quarter

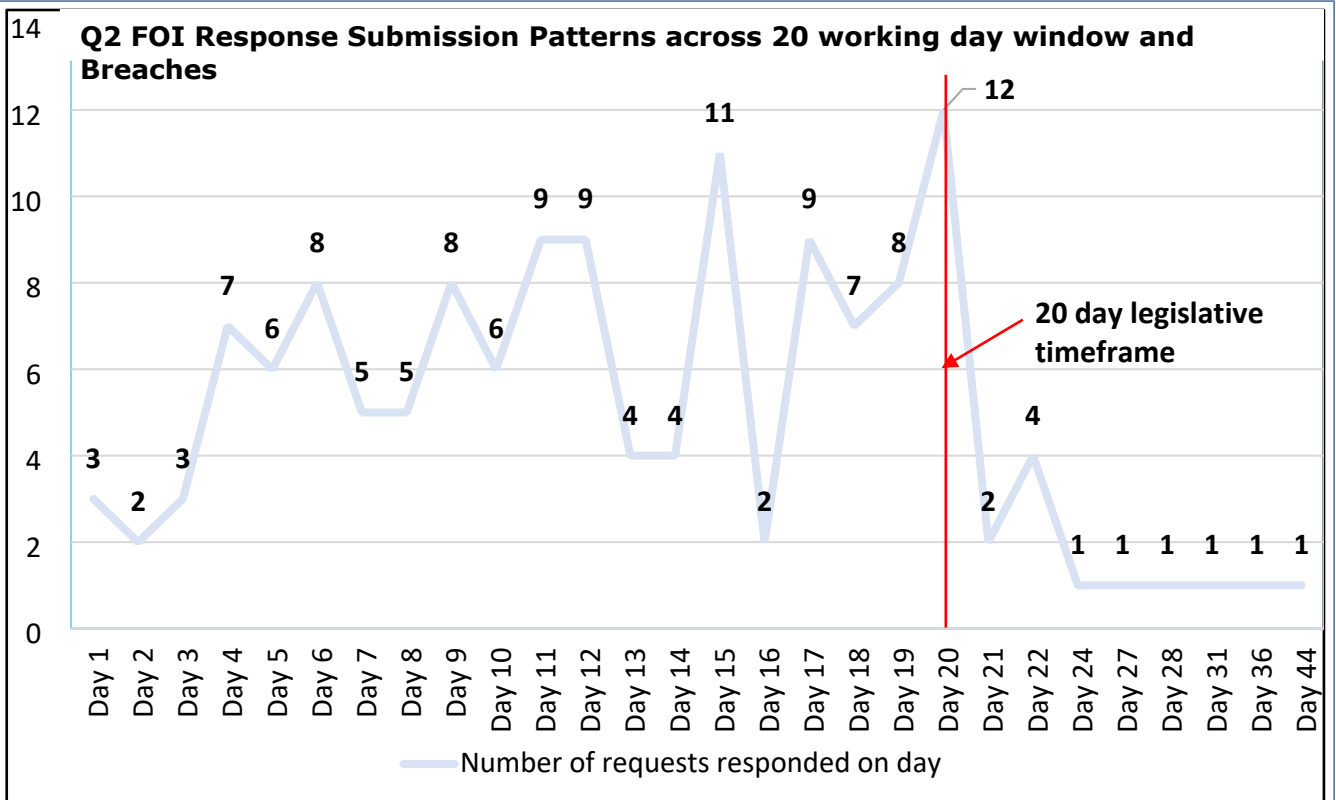
- **3** Service Evaluations
- **2** Research projects.

**Records Management update:** An embargo has been implemented from the 1 December 2025 on the destruction of records following instruction by Welsh Government in support of the Infected Blood Compensation Authority (IBCA). This was reported to Execs and an action taken to submit an Impact Analysis report for consideration in February 2026.

### **DETAILED BACKGROUND AND ASSESSMENT QUARTERLY SUMMARY:**

## Freedom of Information (FOI) & Environmental Information Regulations (EIR) Requests:





Note: Response rates have improved since last quarter, with most replies now peaking around day 10 rather than days 17–20, following IG team reminders on day 6 about the 20-day deadline.

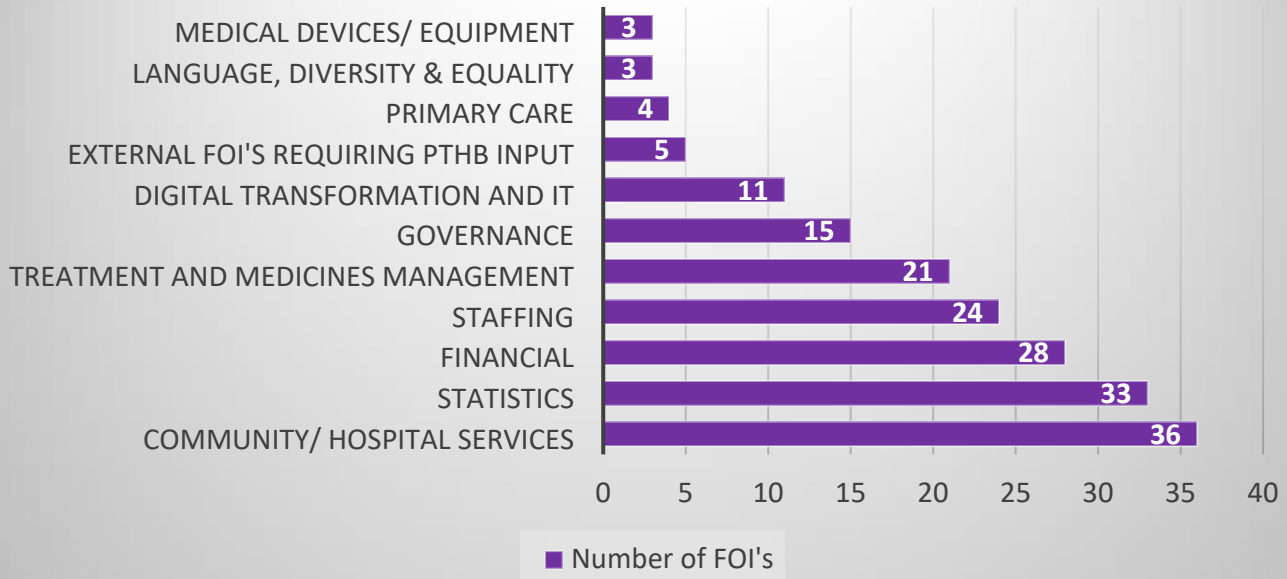
#### Service Areas that breached and reason:

No of days	Services involved	Reason for breach
44	Digital & Finance	Service.
36	People and Culture & Finance	Service.
31	Digital	Service.
28	Digital & Finance	Service.
27	Digital	Service.
24	W&C	Service.
22	Digital	QA approval.
22	Radiology	Service.
22	Digital	QA approval.
22	Therapies, People & Culture, Finance	Service.
21	Planned care, Finance & Powys Information Services	Service.
21	Digital	Service.

Note: This period included summer holidays, causing some delays due to staff absences and annual leave, alongside an increased number of requests.

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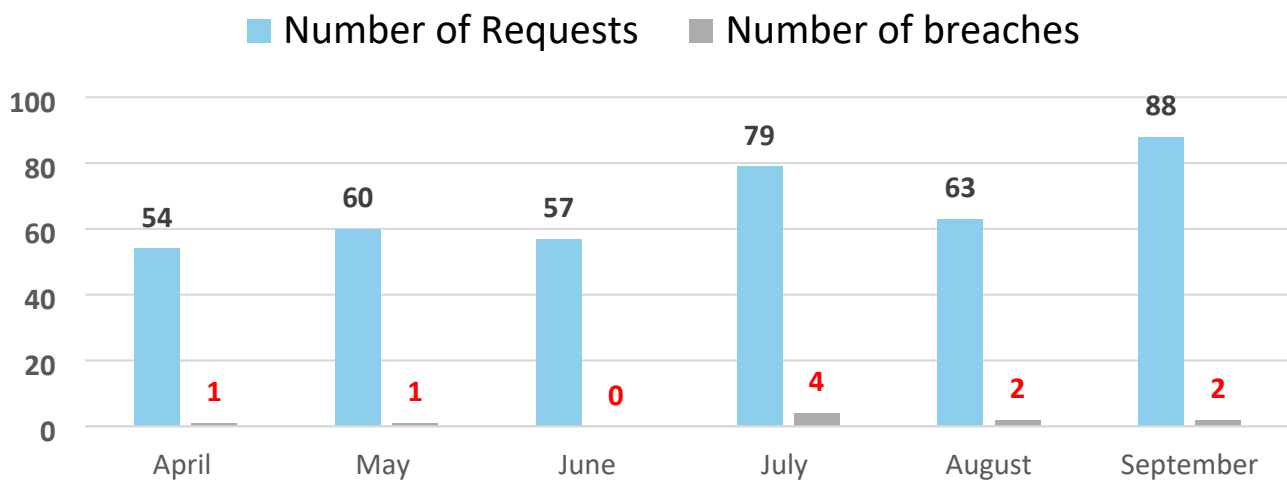
## FOI High Level Theme – Quarter 2 2025/26



Note: Where multiple high-level categories apply to a single record, each category is counted individually, so totals may exceed the number of FOI requests receive.

### Requests for Personal Information:

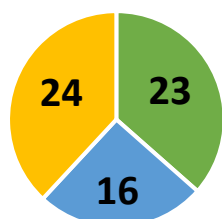
Number of personal information requests received and the number of breaches for Quarter 1 and Quarter 2 2025/2026



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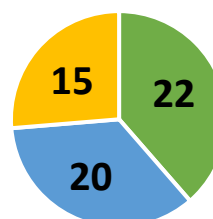
## Datix Incident Notifications (Breach Reporting):

Number of IG/ RM related Datix notifications received - Quarter 1 2025/2026



■ April ■ May ■ June

Number of IG/ RM related Datix notifications received - Quarter 2 2025/2026

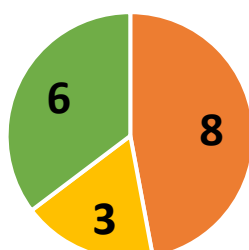


■ July ■ August ■ September

Datix entries previously marked as 'Don't Know' continue to be recorded as 'Yes' for specific incident categories. This targeted approach helps ensure no relevant incidents aren't overlooked. The team has liaised with the Datix Administrator. From Q.3, the team will be able to categorise these for future papers.

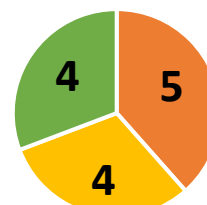
Operational Impact: consistent with the last quarter in the timeliness of services logging incidents within the 72-hour window. However, delays are still proving a challenge. This would, should any of these incidents be reported to the ICO be picked up as a concern. Reminders continue to be issued out via several channels including Datix training sessions to try and reduce the numbers.

Number of incidents NOT reported within 72 hrs (including non PTHB incidents) (Q1)



■ April ■ May ■ June

Number of incidents NOT reported within 72 hrs (including non PTHB incidents) (Q2)



■ July ■ August ■ September

A significant number (**49**) of non-IG related incidents were received again this quarter into the team due to services incorrectly assigning the incident as having IG relevance. This has decreased since the last quarter (**56**):

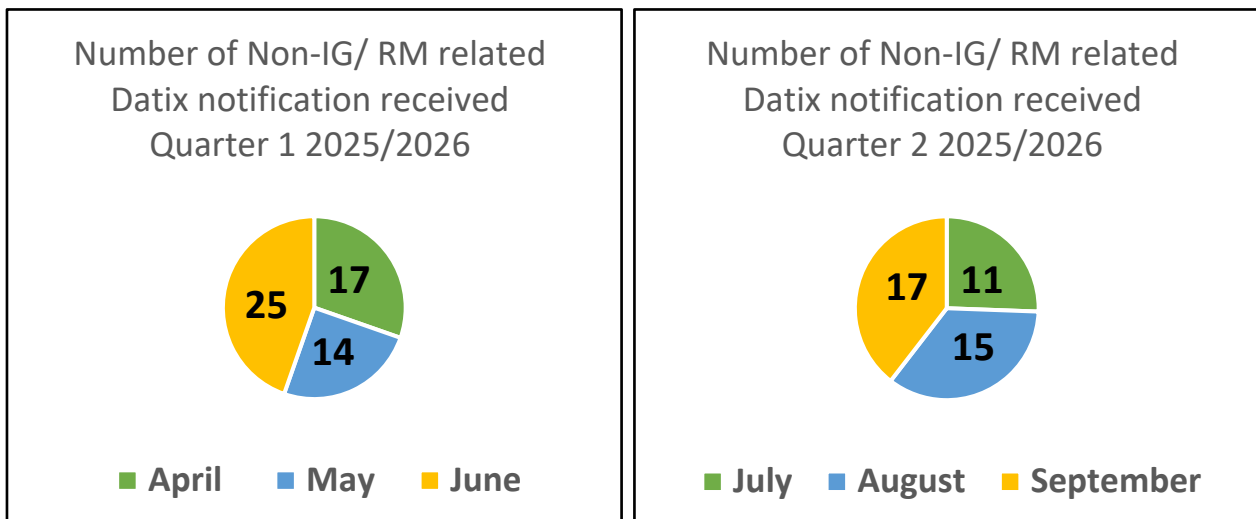
- **July** - Non-IG notifications – **11**
- **August** - Non-IG notifications – **16**
- **September** - Non-IG notifications – **23**

Top 4 Non-IG Incident Themes:

- 6 Incidents - Slip, Trip & Falls
- 6 Incidents – Medication
- 6 Incidents - Pressure Damage, Moisture Damage
- 6 Incidents – Safeguarding

Operational Impact: Correcting these incidents consumes unnecessary team resources. Despite reminders to staff, high volumes persist. National feedback indicates this is a common issue across Wales.

The graphs below show the number of notifications received that do not relate to Information Governance or Records Management:



Breakdown for IG/RM Datix notifications received by Service Area Q2:

Service	Number of incidents
Support Services	4
Community Hospitals/ Nursing Services	2
Mental Health	13
Planned Care	5
Therapies & Health Science Operational	10
Women & Children	8
Primary Care	5
Unscheduled Care	1
Digital	9
<b>Total</b>	<b>57</b>

Q2 Breakdown of Datix Incidents by theme:

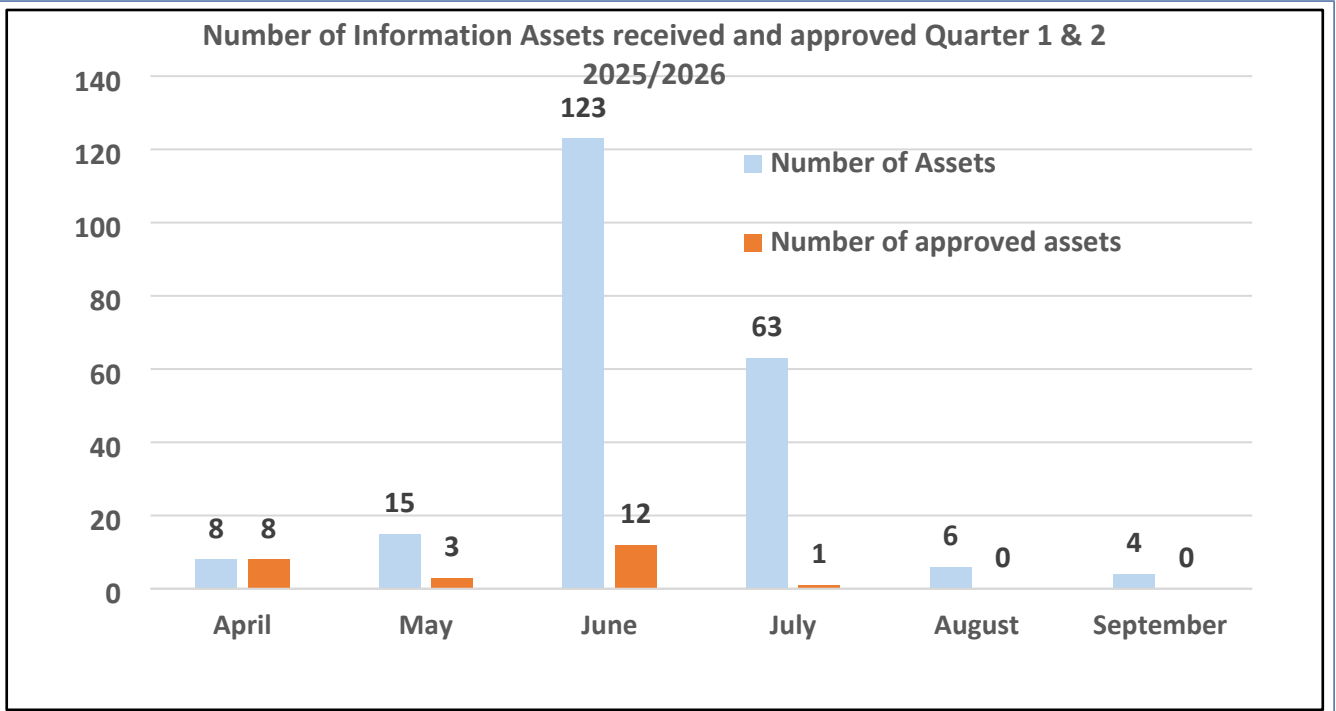
Datix Incidents Theme	No. of incidents
-----------------------	------------------

RM - Wrong attachment/data (containing PII) sent external	5
RM - Wrong attachment /data (containing PII) sent to internal	1
RM - Missing Records / Documentation	3
RM - Records Management - Documentation Lost	1
RM - Wrong information recorded	4
RM - Wrong attachment uploaded	1
RM - Wrong Patient Record Updated	1
RM - Lack of availability of information for clinical care	3
RM - Patient record misfiled	2
IG - Unintended recipient external (letter, email)	7
IG - Unintended recipient medication	1
IG - Breach of sensitive data	4
IG - Inappropriate disclosure (verbal) external	1
IG - Unintended recipient internal (letter, email)	1
IG - Communication issues	2
IG - PTHB Service SOP / Process not followed correctly	2
IT/System Security or Function - Missing laptop / Device	1
IT/System Security or Function - System not functioning as expected	4
IT / System Security or Function - Photocopier - Printer issue	1
IT/System Security or Function issue - No access to Internet/server issues	1
Non-PTHB Records Management - Wrong information recorded	3
Non-PTHB IG - Unintended recipient external (letter, email)	1
Non-PTHB IG - Breach of sensitive data	1
Non-PTHB - Records Management - Lack of availability of information for clinical care	1
Non PTHB Physical Security - Insecure premises	1
Physical Security - Insecure premises	4

**Audit and Monitoring:**

Information Asset Register:

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**NIIAS (National Integrated Intelligent Auditing System)**

Type of incident	Q1 25/26	Q2 25/26
Own Record - 1st offence	0	2
Own Record - repeated	1	1
Home Relations (Family) Record - 1st offence	3	2
Home Relations (Family) Record - repeated	4	0
Both home relations and own record accessed	0	0
Notification for Non-PTHB member of staff	0	0
<b>Grand Total</b>	<b>8</b>	<b>5</b>

NIIAS - Potential Breach Outcome	Q1 25/26	Q2 25/26
Confirmed appropriate - work related (not family member)	5	1
Confirmed inappropriate own record first offence.	0	2
Confirmed inappropriate - line manager reiterated obligations. Mandatory IG training to be retaken.	1	1
Confirmed as part of work - no other staff available	1	1
Confirmed appropriate work related. Accessed in error due to same name	0	0
Confirmed appropriate - work related (family member - legitimate reason)	1	0
Confirmed appropriate - work related (Patient numbers and viewed own account)	0	0
<b>Grand Total</b>	<b>8</b>	<b>5</b>

## Training & Awareness:

New starters Compliance Q2 2025/26:

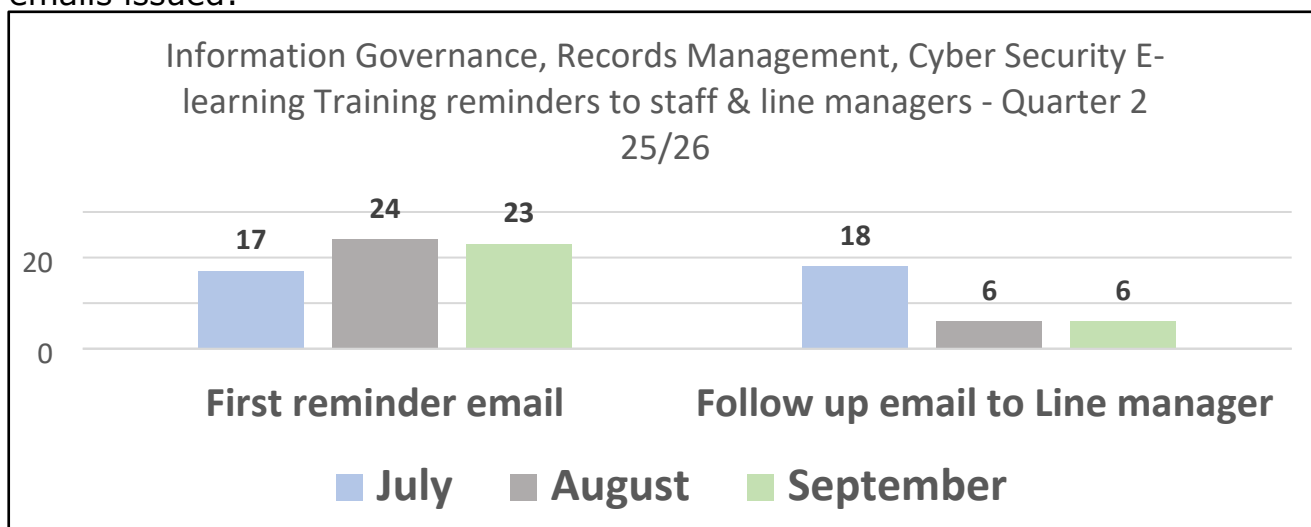
Mandatory IG Module Completion	Q2 2025/2026	
	Headcount	Compliance %
Prior To Joining	10	7%
<b>Not Completed</b>	<b>95</b>	<b>71%</b>
Completed within 6 Weeks	25	19%
Completed after 6 Weeks	4	3%
<b>Grand Total</b>	<b>134</b>	<b>29% compliant</b>

Breakdown of PTHB mandatory IG training compliance by directorate as of 30 September 2025:

Directorate	Assignment Count	Required	Achieved	Compliance %
Bank Staff	1614	1614	988	61.21%
Chief Executive Office	23	23	19	82.61%
Community Care & Therapies	1177	1177	1064	90.40%
Community Dental Service	75	75	66	88.00%
Corporate Governance	28	28	27	96.43%
ESR	24	24	24	100.00%
Estates & Works	51	51	45	88.24%
FID Finance Directorate	36	36	32	88.89%
Facilities & Support Services	198	198	160	80.81%
HCRW	85	85	71	83.53%
MED Medical Directorate	6	6	5	83.33%
MHD Mental Health	498	498	420	84.34%
Medicines Management	42	42	41	97.62%
NUD Nursing Directorate	35	35	35	100.00%
Public Health Directorate	95	95	86	90.53%
PLD Planning Directorate	16	16	15	93.75%
People & Culture Directorate	71	71	60	84.51%
Primary Care	18	18	18	100.00%
THD Therapies & Health Sciences Directorate	70	70	66	94.29%
Transformation Directorate	24	24	18	75.00%
Women and Children Directorate	208	208	191	91.83%
<b>Grand Total</b>	<b>4394</b>	<b>4394</b>	<b>3451</b>	<b>78.54%</b>

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The graph below shows the number of first time and follow-up reminder emails issued:



Internal training provided by team.

- Training Requests Received: **10** internal training requests were received from services during this quarter.
- Training Delivered: **7** sessions were delivered by the IG team, including 1 session originally requested in Q4 2024–25.
- Closed Requests: **1** due to no response from the requesting service.
- Cancelled requests: **1** cancelled by service.
- Forward Planning: **2** sessions requested in Q2 are scheduled for delivery in Q3.

**NEXT STEPS:**

- Continue to enhance organisational IG and Records Management awareness through targeted sessions, digital learning, and ongoing training.
- Collaborate with People & Culture to embed IG training compliance for new starters, exploring options on early engagement.
- Continue working closely with services to identify root causes of delays and breaches in information request processing and implement practical solutions.
- Focus on services yet to upload assets to the Information Asset Register and remind IAOs to keep assets updated.
- Support directorates in improving IG Toolkit compliance with tailored guidance and follow-up.
- Maintain quarterly assurance reporting.

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## IMPACT ASSESSMENT

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

### QUALITY:

	No impact	Negative	Positive	Both	
Safe			X		Strengthens confidentiality, integrity, and availability of records Good compliance around processing access to information requests Standardised processes supports staff in IG and Records Management and ensure compliance with legislation. Consistent handling of requests and access support legislative obligations Ensure Trust is embedded and open and transparency Increase in access requests, embargo and other legislative requirements means addition input requirement from operational staff Dependences across services and systems (digital transformation, archiving of records, estates) can impact consistency.
Timely			X		
Effective			X		
Efficient			X		
Equitable			X		
Person Centred			X		
Workforce		X			
Leadership					
Culture	X				
Information				X	
Learn, Improve, Research					
Whole Systems Approach				X	

### EQUALITY:

	No impact	Negative	Positive	Both	
Age	X				Standardised Accessibility of information and formats; reduced barriers to request processing
Disability			X		
Gender reassignment	X				
Marriage / civil partnership	X				
Pregnancy / maternity	X				
Race	X				
Religion or Belief	X				
Gender	X				
Sexual Orientation	X				
Welsh Language			X		
Socio-economic status	X				
Social exclusion			X		
Carers			X		

### RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	X				Potential of fines if breach or lack of compliance with Uk GDPR. Also recent embargo on destruction of records could result in additional financial requirements. Organisation wide compliance risk if IAR completeness or toolkit scores lag.
Financial			X		
Corporate			X		
Operational			X		
Reputational		X			

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# Audit, Risk and Assurance Committees 2025-26

Item Title	May 13/05/2025	June 17/06/2025 (Annual Accounts)	July 08/07/2025	Oct 7/10/24	Jan 13/01/2026	March 10/03/2026
Minutes of previous meeting	✓		✓	✓	✓	✓
Declaration of Interests	✓		✓	✓	✓	✓
Action Log	✓		✓	✓	✓	✓
Annual Work Programme	✓		✓			
Work Programme (updated through year)			✓	✓	✓	✓
Annual Assessment of Committee Effectiveness	✓					✓
Committee Governance Action Plan			✓	✓		✓
Committee Annual Report	✓					
Audit Recommendation Tracker				✓		✓
WHC Tracker	✓			✓		✓
Organisational Register of Interests				✓		✓
Organisational Register of Gifts and Hospitality				✓		✓
Board Assurance Framework				✓		
Review of Terms of Reference	✓					✓
Review of Standing Orders and Standing Financial Instructions						✓
Confirmation Clinical Audit Programme in place			✓			
Approach to the Annual Accounts						✓
PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	✓					
PTHB Final Accountability Report and Financial Accounts and Letter of Representation		✓				
Head of Internal Audit Opinion Draft	✓					
Head of Internal Audit Opinion Final		✓				✓
Internal Audit Annual Plan						✓
Internal Audit Progress Report 25/26	✓		✓	✓	✓	
Internal Audit Reports (as required)	✓		✓	✓	✓	✓
Internal Audit Trend Report					✓	
Enquiries of Management and Those Charged with Governance		✓				
External Audit Annual Plan						✓
External Audit Progress Report	✓		✓	✓	✓	
External Audit Reports (as required)	✓		✓		✓	✓
Structured Assessment	✓				✓	
Counter Fraud Annual Plan						✓
Counter Fraud Update	✓		✓	✓	✓	
Counter Fraud Reports (as required)	✓		✓		✓	✓
Single Tender Waivers Annual Report	✓					
Single Tender Waivers (including extensions to contracts)	✓		✓	✓	✓	✓
Losses and Special Payments Annual Report	✓					
Losses and Special Payments	✓			✓		✓
Post payment Verification Yr End May, Mid Yr Jan	✓				✓	

Financial Controls				✓		
Review of Risk Management Framework				✓		
Assurance of Risk Management arrangements inc. revised Risk Management Toolkit	✓		✓	✓	✓	
Hosted Body annual report (HCRW)		✓				
IG Annual Report	✓					
IG Performance Report				✓	Q2✓	
IG Toolkit (National Audit replaces Caldicott Principles)			✓	✓		
Information Governance & Records Management report	✓				✓	
Strategic Risk deep dive •Digital Infrastructure (In-Committee)					✓	
Digital First Annual Plan				x	✓	
Digital First Quarterly Monitoring (including cyber security)			✓	✓	✓	✓
WCCIS assurance update					✓	✓
SFI executive financial delegation limits				✓		
<b>Key:</b>						
Date to be confirmed						
Item to be confirmed						
Item deferred						
Item brought forward						
Going to Board						
Find Exec Cttee date						
Added to draft agenda						

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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

## Powys Teaching Health Board Glossary (Last updated December/Januar 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

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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

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GNCC	General Nursing Complex Care Team
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System

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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
OOB	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PMVA	Prevention and Management of Violence and Aggression
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund

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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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