Audi, Risk and Assurance Commitee

Thursday 22 October 2026, 13:45 - 15:15

Agenda

13:45 - 13:45
0 min

1. Preliminary Matters

Agenda_ARAC_ 22Oct2026.pdf (3 pages)

1.1. Welcome and Apologies

Chair

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

ARA_1.2_August 2026_Board Members Declaration Of Interests summary 2026-27.pdf (3 pages)

13:45 - 13:45
0 min

2. Consent Agenda Business

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

13:45 - 13:45
0 min

3. Items for Approval / Decision / Ratification

3.1. Minutes of previous meeting held on 07 July 2026

Chair

ARA_3.1_Unconfirmed Minutes_07July2026.pdf (10 pages)

3.2. Committee Action Log

Chair

ARA_3.2_Committee Action Log 2026-27.pdf (1 pages)

13:45 - 13:45
0 min

4. Escalated Items

There are no items for inclusion within this section.

13:45 - 13:45
0 min

5. Items for Assurance

5.1. Internal Audit Progress Report

Head of Internal Audit

ARA_5.1_Internal Audit Progress Report October 26 Cover.pdf (2 pages)
ARA_5.1a_Internal Audit Progress Report October 26.pdf (13 pages)

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5.2. Internal Audit Reports: Vaccine Storage (Reasonable Assurance), Escalation Status Governance & Actions (Reasonable Assurance), Digital Systems Follow-up (Assurance Not applicable)

Head of Internal Audit

- ARA_5.2a_Vaccine Storage Final Internal Audit Report.pdf (12 pages)
- ARA_5.2b_Escalation Status Final Internal Audit Report.pdf (9 pages)
- ARA_5.2c_Digital Systems Uptake Follow-up Final Internal Audit Report.pdf (8 pages)

5.3. External Audit Progress Report

External Audit

- ARA_5.3_Audit Wales_External Audit Progress Report.pdf (11 pages)

5.4. External Audit Report: Arrangements for Managing Agency Staff

External Audit

- ARA_5.4_Powys THB Review of Agency Staffing Report (FT).pdf (27 pages)

5.5. Counter Fraud Update and Reports

Acting Executive Director of Finance

- ARA_5.5_Counter Fraud Update Report October 2026 Cover.pdf (2 pages)
- ARA_5.5a - Counter Fraud Update Report October 2026.pdf (5 pages)
- ARA_5.5b - Appendix 1 - PTHB Counter Fraud Work Plan 2026-27.pdf (14 pages)
- ARA_5.5c - Appendix 2 - Counter Fraud Risk Report.pdf (3 pages)
- ARA_5.5d - Appendix 3 - Resident Doctors and Dentists Wales.pdf (95 pages)

5.6. Policy Management Assurance Report

Director of Corporate Governance

- ARA_5.6_Policy & Written Control Documents Summary Report as of 07-09-2026.pdf (11 pages)

5.7. Single Tender Waivers (including extensions to contracts)

Acting Executive Director of Finance

- ARA_5.7_Single Tender Waiver Report Oct 26.pdf (2 pages)

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0 min

6. Items for Discussion

There are no items for inclusion within this section.

13:45 - 13:45
0 min

7. Consent Agenda

7.1. Audit Handbook

Director of Corporate Governance

- ARA_7.1_Cover Paper_Audit Process and Reporting Handbook_2026.pdf (2 pages)
- ARA_7.1a_Audit Process and Reporting Handbook_March 2026 Redraft.pdf (19 pages)

7.2. Losses and Special Payments

Acting Executive Director of Finance

- ARA_7.2_Losses and Special Payment interim report Oct 2026.pdf (6 pages)

7.3. Internal Audit Reports: Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (Substantial Assurance)

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Head of Internal Audit

- ARA_7.3_Learning Disabilities Final Internal Audit Report.pdf (10 pages)

7.4. Committee Work Programme 2026/2027

Director of Corporate Governance

ARA_7.4_Committee Work Programme 2026-27.pdf (1 pages)

7.5. PTHB Glossary

Director of Corporate Governance

ARA_7.5_PTHB Glossary.pdf (7 pages)

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0 min

8. Other Matters

8.1. Any other urgent business

Chair

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

Chair

8.3. Committee Reflections

Chair

8.4. Date of the next meeting: 12 January 2027 via Microsoft Teams

8.5. Confidential Matters

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

Jones,Bethan
16/10/2026 09:57:45

AUDIT, RISK AND ASSURANCE COMMITTEE
TUESDAY 22 OCTOBER 2026
13:45-15:15
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT

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

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
13:45	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest • Board Members Register of Interests 2026/27	Verbal/ Attached	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
	3.1	Minutes of previous meeting held on 07 July 2026	Attached	Chair
5Min	3.2	Committee Action Log	Attached	Chair
	4	**ESCALATED ITEMS**		
There are no items for inclusion within this section				
	5	**ITEMS FOR ASSURANCE**		
13:50	5.1	Internal Audit Progress Report	Attached	Head of Internal Audit
14:00	5.2	Internal Audit Reports: • Vaccine Storage (Reasonable Assurance) • Escalation Status Governance & Actions (Reasonable Assurance) • Digital Systems Follow-up (Assurance Not Applicable)	Attached	Head of Internal Audit
14:10	5.3	External Audit Progress Report	Attached	Audit Wales
14:20	5.4	External Audit Reports: • Arrangements for managing Agency Staff	Attached	Audit Wales
14:30	5.5	Counter Fraud Update and Reports	Attached	Acting Executive Director of Finance
14:40	5.6	Policy Management Assurance Report	Attached	Director of Corporate Governance

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14:45	5.7	Single Tender Waivers (including extensions to contracts)	Attached	Acting Executive Director of Finance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Audit Handbook	Attached	Director of Corporate Governance
	7.2	Losses and Special Payments	Attached	Acting Executive Director of Finance
	7.3	Internal Audit Reports: • Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (Substantial Assurance)	Attached	Head of Internal Audit
	7.4	Committee Work Programme 2026/2027 **Purpose:** For Information	Attached	Director of Corporate Governance
	7.5	PTHB Glossary **Purpose:** For Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 12 January 2027 via Microsoft Teams		
	8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Committee is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: <u>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</u> ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***			
14:55	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declarations of Interest	Verbal	All

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	8.8	Minutes of the previous In-committee meeting held on 07 July 2026	Attached	Chair
15:05	8.9	Digital First 6 monthly monitoring report (including cyber security)	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital
15:15	8.10	WCCIS (Connected Care Programme) Replacement Update	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital

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

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

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

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

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

Updated: August 2026

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
INDEPENDENT MEMBERS							
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	02-Feb-25	Current	Sole Trader, Mandy Williams Consulting, The Wellbeing Coach	NIL
		Indirect Interests	Loyalty Interests	02-Apr-25	Current	Family member is an employee of Cardiff & Value University Health Board (non Director).	NIL
Vice Chair	**Rhiannon Beaumont-Wood**	Indirect Interests	Outside Employment	Jun-23	Current	Director and Owner of RBW Executive and Professional Coaching	NIL
		Non Financial professional interests	Loyalty Interests	01-Jan-08	Current	Royal College of Nursing	NIL
		Indirect Interests	Outside Employment	07-Apr-23	31-May-26	Dorset ICB (NHS Dorset) Non-Executive Member	NIL
		Indirect Interests	Outside Employment	01-Mar-24	31-Mar-27	Registrant Council Member - Nursing and Midwifery Countil (NMC)	Renumerated as per Registrant Council Member Terms and Conditions
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	17-Nov-21	Current	Chair NPTC Group of Colleges	NIL
		Indirect Interests	Outside Employment	01-Jan-20	Current	External member Cross-party STEMM Group Welsh Government	NIL
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL
Independent Member (finance)	**Stephen Elliot**	Non Financial professional interests	Loyalty Interests	17-Apr-24	Current	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	NIL
		Non Financial professional interests	Outside Employment	17-Apr-24	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	2012	Current	Partner Director of RA and CJ Consulting Limited	Dividend Payment only
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only
Independent Member (University)	**Simon Wright**	Non Financial professional interests	Loyalty Interests	01-Mar-15	28-Feb-29	Personal: Senior Professional Fellow, Cardiff University-Various Healthcare Programmes	Honoury Role
		Indirect Interests	Loyalty Interests	18-Jun-25	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment
		Indirect Interests	Loyalty Interests	18-Jun-25	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment
		Non Financial professional interests	Loyalty Interests	02-Jan-20	Current	Labour Party member	NIL
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	Salaried Employment
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	01-Jun-16	10-Jun-27	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	NIL
		Non Financial professional interests	Loyalty Interests	01-Sep-24	01-Jun-28	Coopted Member of PAVO	NIL
		Non Financial professional interests	Loyalty Interests	01-Apr-24	01-Apr-27	Chair Public Services Board Scrutiny Committee	NIL
		Non Financial professional interests	Loyalty Interests	01-Jun-10	Current	Member of Community Speed Watch Group	NIL
				01-Jan-19	Current	Member of Society Genealogists	
				08-May-22	Current	Associate Member of the Association of Genealogists and Registered Archivists	
		Financial Interests	Shareholdings and other ownership interests	01-Jun-03 01-Jun-22 01-Jun-88	Current	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL

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Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests	01-Jul-22 05-May-22 10-Aug-95 22-May-17 25-Sep-17 01-Jun-10	Current	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel •Member of the Community Speed Watch Group	NIL
		Non Financial professional interests	Loyalty Interests	01-Jan-86 31-Mar-88	Current	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL
		Non Financial professional interests	Loyalty Interests	01-Dec-88	Current	Labour Party member	NIL
Independent Member (Capital)	**Michael Giannasi**	Indirect Interests	Loyalty Interests	2019	Jul-26	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated
Independent Member	**Ian Thomas**	Non Financial professional interests	Loyalty Interests	01-Jun-26	Current	Trustee of a UK Charity - Family Fund that provides financial support to families with disabled and seriously ill children	NIL
		Indirect Interests	Outside Employment	01-Apr-23	31-Mar-24	Previous work as an associate for HICO Consultancy	Self Employed
		Non Financial professional interests	Outside Employment	10-May-26	Current	Sit as an NED on the charity's subsidiary company - Family Fund Business Services.	NIL
EXECUTIVE MEMBERS							
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of Finance, Capital and Support Services (Acting CEO 13 Jul 26 -	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18-Jun-18	Current	Partner is Finance Manager working in SBUHB	Not Relevant
Deputy Director of Finance (Acting Executive Director of Finance 13 Jul 26 -	**Hywel Pullen**	Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation has a share in the ownership of St Joseph's Hospital and also works at the Hospital	NIL
		Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation works as a consultant at Aneurin Bevan UHB and is currently a clinical director and the south-east regional lead for orthopaedics.	NIL
		Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation works in a clinical role at CTM UHB and St Joseph's Hospital.	NIL
		Non Financial professional interests	Outside Employment	01-May-25	Current	I volunteer as the Treasurer of the Monmouth Churches Together Housing Group	NIL
		Non Financial professional interests	Outside Employment	01-Apr-25	Current	I am the Vice President of Cymru CIPFA Wales, the regional branch of the Chartered Institute of Public Finance and Accountancy (CIPFA)	NIL
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07-Jan-19	01-Apr-28	Occasional Lecturer for University of West of England.	Hourly rate
		Non Financial professional interests	Loyalty Interests	01-Apr-26	01-Mar-28	Member of the The Chartered Society of Physiotherapy	NIL
Executive Medical Director (Acting Deputy Chief Executive 13 Jul 26 -	**Kate Wright**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of People and Culture and Transformation	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01-Nov-24	01-Nov-27	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated
			Outside Employment	01-Oct-24	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL

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Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	14-May-25	Current	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date).
		Financial Interest	Shareholdings and other Ownership interests	14-May-25	Current	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	01-Nov-23	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated
		Indirect Interests	Outside Employment	01-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	01-Jun-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	01-May-25	Current	Partner - Associate for Practice Solutions	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	NIL	NIL	NIL	NIL	NIL
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	01-Apr-24	Current	Independent Member – ateb - housing Association	Remunerated
		Non Financial professional interests	Outside Employment	01-Nov-19	Current	Chair of the Board - West Wales Care and Repair	Voluntary
		Indirect Interests	Outside Employment	02-Jun-25	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	NIL
		Indirect Interests	Outside Employment	01-Aug-23	15-May-26	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	NIL
Executive Director of Nursing, Quality, Women and Family Health	**Paul Hooton**	Non Financial Professional Interests	Loyalty Interests	2018	Current	Member of the Royal College of Nursing	25/10/2025 Started with PTHB October 2025

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AUDIT, RISK AND ASSURANCE COMMITTEE (ARAC)

UNCONFIRMED MINUTES OF THE MEETING HELD ON 07 JULY 2026 HELD VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ronnie Alexander	RA	Independent Member (General)
Mick Giannasi	MG	Independent Member (General) (Vice Chair)
Ian Thomas	IT	Independent Members (General)
IN ATTENDANCE		
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Andrea Calise	AC	Internal Audit
Bethan Hopkins	BH	Audit Wales
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Neil Jones	NJ	Counter Fraud
Beth Jones	BJ	Corporate Governance Officer
Beth Powell	BP	Corporate Governance, Risk and Assurance Officer
Sarah Pritchard	SP	Assistant Director of Finance
Matthew King	MK	Deputy Director of Therapies and Health Sciences
Hywel Pullen	HP	Deputy Director of Finance (Deputising for Pete Hopgood)
Ian Virgil	IV	Head of Internal Audit
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	PTHB Chair
Vicki Cooper	VC	Chef Digital Data Officer
Amanda Legge	AL	Post Payment Verification Manager
Rhobert Lewis	RL	Independent Member (General)
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Hayley Thomas	HT	Chief Executive

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/26/041)
Attendees were welcomed and apologies for absence were received and recorded as noted above.
1.2 DECLARATIONS OF INTEREST (ARA/26/042)
No declarations of interests were received in addition to those already recorded on the register.
2. CONSENT AGENDA BUSINESS
The Chair asked Members if they wished to bring forward any items from the Consent agenda to the main agenda. It was highlighted that the Internal Audit Report on

Jonas Bertran 18/10/2026 09:51:45

Standards of Behaviour, that a number of Declarations of Interest had not been completed, particularly by staff with budgetary responsibilities.
It was agreed that further discussion would be considered under the Declarations of Interests, Gifts and Hospitality Report item on the agenda

The Committee **NOTED** the reports contained within the Consent agenda.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (ARA/26/043)

The minutes of the meeting held on the 23 June 2026 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (ARA/26/044)

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

HB confirmed that the Annual Accounts had been submitted and signed by the Auditor General following the previous meeting of Audit, Risk and Assurance and the Board meeting held on 24 June 2026.

ARA/25/090: Internal Audit Annual Plan- A map was shared with members regarding audit related assurance activity and would be incorporated into the Audit Handbook. The action was AGREED for closure.

ARA/26/004: Action Log criteria for closure- Action due for completion in October 2026.

ARA/26/019: Risks associated with overdue Policies and Written Controlled Documents- Action due for completion in October 2026.

ARA/26/017: Single Tender Waiver contract specification and formal tender process update- SP provided an update that three Single Tender Waivers (STW) had been approved for the secure transport of patients with complex mental health needs while a formal procurement process was underway. Although relevant frameworks existed, no framework providers were located in close proximity to Powys. The use of three providers ensured cost-effective and timely transport across North, Mid and South Powys and provided sufficient capacity and resilience where multiple patient transfers were required.

Members discussed broader governance considerations relating to single tender waivers, procurement arrangements, conflicts of interest, and lessons arising from issues reported elsewhere in NHS Wales. RA sought assurance that appropriate controls, oversight, and declarations of interest processes were in place, and that there were no comparable risks within the Health Board.

HB acknowledged the concerns raised and advised that further assurance would be sought to confirm that appropriate procurement, review and oversight processes were in place and that no similar issues existed within the Health Board.
Action: Assistant Director of Finance

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The Committee requested that actions be progressed and discharged as promptly as possible, with completion reported to the Committee in a timely manner rather than

waiting for the next meeting. The action log would continue to record and track the closure of actions.

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

4. ESCALATED ITEMS

There were no items for inclusion in this section.

5. ITEMS FOR ASSURANCE

5.1 INTERNAL AUDIT PROGRESS REPORT 2026/2027 (ARA/26/045)

IV presented the Internal Audit Progress Report for 2026/27, including the completion of one audit which had been given a Substantial Assurance Rating, with a further two audits in progress. Two audits from the 2025/26 plan were resubmitted for consideration. Minor timetable revisions to two planned audits were noted and were not considered a significant risk to delivery. The Committee also received assurance that completed actions recorded on the Health Board's recommendation tracker had been appropriately evidenced and implemented.

SE sought assurance that the Planned Core Financial Systems audit would consider actions arising from Audit Wales' previous findings related to capital systems. It was confirmed that Internal Audit would take account of agreed management actions and review progress made in addressing the recommendations.

MG welcomed the validation work undertaken on completed audit actions and sought clarification on the process. IV confirmed that annual sample testing was routinely undertaken to verify that actions recorded as complete have been fully implemented and supported by appropriate evidence, providing assurance within the Health Board's recommendation tracker.

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

5.2 INTERNAL AUDIT REPORTS: BUDGET SETTING, MORTALITY REVIEWS (ARA/26/046)

Budget Setting:

The Committee noted the **Reasonable Assurance** opinion for the Budget Setting and Financial Planning Audit. While governance and budget-setting arrangements were found to be effective overall, four improvement actions were identified relating to budgetary control procedures, monitoring of budget-holder training, accountability letters, and the timely development of savings schemes.

PH outlined improvements introduced through the Financial Recovery Board and savings management processes. It was confirmed that budget-holder training arrangements would be reviewed and strengthened, with consideration given to implementing improvements earlier than the proposed target date.

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Mortality Review:

IV presented the Internal Audit Report on Mortality Reviews, which received an overall Reasonable Assurance rating. It was noted that appropriate mortality review processes were in place, although Limited Assurance was provided for one audit objective due to

staffing vacancies affecting the timely review and recording of cases referred by the Medical Examiner. One high-priority and six medium-priority recommendations were identified and accepted by management.

The Committee discussed the importance of ensuring that mortality reviews were completed promptly and that learning from deaths was effectively captured and acted upon. Clarification was sought regarding the management of Medical Examiner referrals, learning from deaths occurring outside Powys, and arrangements for monitoring implementation of actions.

It was agreed that the specific issues raised regarding the scope of mortality reviews and assurance on the management of Medical Examiner referrals would be referred to the Patient Experience, Quality and Safety (PEQS) Committee for further consideration and assurance.
Action: Director of Corporate Governance

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

5.3 EXTERNAL AUDIT PROGRESS REPORT (ARA/26/047)

BH presented the Audit Wales Progress Report and provided an update on current and planned audit work.

The Committee noted that reports relating to Agency Staff, Urgent and Emergency Care and Managing Estates were expected to be presented later in the year, alongside ongoing Structured Assessment work, a follow-up review of Workforce Planning, and the planned All-Wales review of Diabetes Management and Prevention.

The Committee discussed the volume and timing of forthcoming audit reports and the importance of receiving reports as early as possible to support effective scrutiny.

The Committee highlighted the potential resource implications arising from the substantial number of recommendations expected from forthcoming internal and external audit reviews. HB acknowledged the challenge and advised that work continued with auditors to ensure recommendations were clear, proportionate and focused on key improvement priorities.

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

5.4 EXTERNAL AUDIT REPORTS: URGENT AND EMERGENCY CARE: ARRANGEMENTS FOR MANAGING DEMAND (ARA/26/048)

The Committee received the Audit Wales report on Urgent and Emergency Care: Managing Demand. It was noted that the audit formed part of a wider programme of work on urgent and emergency care and focused on the Health Board's arrangements for managing demand and reducing unnecessary pressure on the system.

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The audit found that the Health Board utilised comprehensive data to inform decision-making and planning. However, further action was required to improve access to alternative care pathways, strengthen patient and staff engagement, and clarify

resource requirements. Nine recommendations were made, and the associated management responses were presented within the report.

The Committee commented that a number of the management responses appeared too high level and did not provide sufficient confidence regarding the breadth, depth or impact of the proposed actions. Particular reference was made to recommendations 1 and 8, which related to the six goals, noting that one response appeared dependent on recurrent funding. The Committee sought assurance that management responses were robust, meaningful and capable of delivering tangible improvements, and requested clarification on whether reporting arrangements relating to the six goals would be reviewed.

Audit Wales welcomed the feedback and confirmed that it would continue to work with the Health Board to ensure recommendations and management responses were clear.

The Committee **RECIEVED** the External Audit reports.

5.5 AUDIT FINDINGS TRACKER (ARA/26/049)

HB presented the revised Internal and External Audit Recommendations Tracker and outlined enhancements made following previous Committee feedback, including improved analysis of overdue actions, revised deadlines and progress against recommendations.

The Committee noted that 51% of internal audit actions had been completed since the previous report. Updates were provided on outstanding high-priority actions, including mental health recommendations which were expected to be completed by the end of August 2026. HB explained that the report also provided greater visibility of high-priority and limited assurance recommendations, together with the reasons for delays and progress against actions. The Committee noted that 54% of external audit recommendations had been completed and welcomed the continued development of the reporting format to support effective scrutiny and assurance.

Members welcomed the improvements made to the report and suggested that future versions place greater emphasis on residual risk. It was recognised that while the enhanced analysis within the report was helpful, the detailed tracker spreadsheet was difficult to review and was primarily useful for checking the underlying detail. It was suggested that the tracker be provided separately as background information, allowing reports to focus on key findings, trends and risk analysis. Management welcomed the feedback and agreed to consider providing the detailed tracker separately to support more focused committee reporting.

The Committee:

- **DISCUSSED** the current position of Internal and External audit findings that remained overdue and findings that have had their deadlines revised;
- **CONSIDERED** the current position of all Internal and External Overdue audit findings given High Priority ratings and;
- Took **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit findings.

Jones, Bethan
16/10/2026 09:12:45

5.6 INFORMATION GOVERNANCE AND RECORDS MANAGEMENT ANNUAL REPORT (ARA/26/050)

HB presented the Information Governance and Records Management Annual Report, highlighting continued growth in demand across Freedom of Information (FOI) requests, Subject Access Requests (SARs), Data Protection Impact Assessments (DPIAs) and other information governance activities. Performance remained strong, including compliance rates of 92% for FOI requests and 98% for SARs.

The Committee noted improvements in mandatory Information Governance training compliance, increasing from 77% to 81%. Members also noted the increased complexity in requests and the impact of artificial intelligence on Information Governance processes.

Independent Members sought assurance by asking the following questions:

How was the Health Board addressing emerging information governance risks, including those associated with the increasing use of artificial intelligence (AI), and were there opportunities to use technology more proactively to strengthen governance and risk management arrangements?
HB advised the Committee that the Information Governance team was currently at full establishment, although a number of posts remained on fixed-term contracts. In light of ongoing financial pressures, the focus was on maintaining capacity to deliver key compliance requirements and prioritising resources effectively, rather than expanding the team.

AS explained that the increased use of AI was creating challenges in managing information requests, and that an AI policy, together with supporting guidance and training for staff, was under development to support compliance and consistent handling of AI-related requests.

What additional measures were being taken to improve mandatory information governance training compliance?
AS responded that actions were underway to improve information governance training compliance and that ongoing awareness and training activities were being used to strengthen Datix incident reporting compliance.

What further actions were planned to strengthen compliance with incident reporting requirements and reduce the number of unreported incidents?
AS explained that delays in incident reporting were largely due to service capacity pressures and that regular reminders were issues to promote timely reporting to the Organisation.

The Committee commended the work of the Information Governance team and recognised the significant progress made in maintaining compliance and supporting organisational governance.

Ymes Bethan
18/10/2026 09:37:43

The Committee:

- **DISCUSSED** the actions identified to improve compliance

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

5.7 COUNTER FRAUD UPDATE (ARA/26/051)

NJ presented the Counter Fraud Progress Report and advised that, whilst the service continued to experience capacity challenges, arrangements were in place to provide ongoing Counter Fraud support and assurance to the Health Board.

The Committee noted progress against the NHS Counter Fraud Standards, including completion and submission of the Counter Fraud Functional Standards Return, ongoing fraud awareness activity, staff engagement through training and communication campaigns, and continued delivery of the Counter Fraud work plan. It was also noted that there were 15 live investigations and one case had been closed during the reporting period.

Members discussed the impact of service capacity constraints, staff awareness of Counter Fraud arrangements, the potential benefits of mandatory Counter Fraud training, and the length of time some investigations remained open. Assurance was provided that reports and referrals continued to be received and investigated, although progression of some cases had been affected by resource limitations.

The Committee noted that appropriate Counter Fraud systems and processes were in place, however recognised that capacity challenges were impacting the pace of delivery and progression of some aspects of the work programme.

The Committee **NOTED** and **APPROVED** the Counter Fraud Work Plan 2026/27 and **NOTED** that, whilst appropriate systems and processes were in place, capacity challenges had impacted the pace of delivery against elements of the work programme.

5.8 WELSH HEALTH CIRCULAR AND MINISTERIAL DIRECTIONS REPORT (ARA/26/052)

HB presented the Welsh Health Circulars and Ministerial Directions Compliance Report and advised that, whilst further development of the report was planned, current effort had been prioritised towards strengthening Audit Recommendation reporting.

The report provided an overview of compliance status, including completed, partially completed and outstanding actions.

EL provided an update against three actions where no progress had been reported:

- The Primary Medical Services minor surgery requirements had been fully implemented.
- The Outpatient Waiting List Appointment Scheme (OWLAS) pilot had been completed and evaluated, with further consideration being given to future arrangements.
- The Mental Health Quality Statement was being delivered through existing quality and safety arrangements and was expected to be fully implemented.

Jones, Bethan
16/10/2026 09:47:45

Members discussed opportunities to further develop the report, including greater visibility of risks, differentiation between actions within and outside the Health Board's control, and learning from good practice across other Health Boards.

The Committee noted that the next routine update report was scheduled for March 2027. Members acknowledged the resource implications of producing interim reports and agreed that routine reporting should continue, with management bringing forward an exception report, should any significant issues or delays be identified.

The Committee **CONSIDERED** and **RECEIVED** the report in recognition that the position would be reported to Audit Wales, Internal Audit and Welsh Government for scrutiny and reviewed as part of the Annual Report 2025/26.

The meeting adjourned for a ten-minute comfort break at 11:35.

5.9 ORGANISATIONAL REGISTER OF INTERESTS, GIFTS AND HOSPITALITY (ARA/26/053)

HB presented the Declarations of Interest and Gifts and Hospitality Report, noting that following changes to the Standards of Behaviour Policy in May 2025, the requirement to submit declarations had been extended to Budgetary Approvers.

The Committee noted that 770 declarations had been received and that compliance amongst budget approvers had improved, reducing the gap identified through Internal Audit from 23% to 16%. It was acknowledged that further work was required to achieve full compliance.

IV confirmed that Internal Audit had recognised the progress made in implementing declarations for budget holders and that this had contributed to the Substantial Assurance rating, with the remaining gap assessed as a medium-priority issue.

HB also provided an update on the Gifts and Hospitality Register, noting ongoing work to improve staff awareness and reporting. Members were advised that many enquiries were resolved appropriately before requiring formal registration.

The Committee noted that enquiries relating to declarations of interest and gifts and hospitality were occasionally received through Freedom of Information requests and were managed through established processes.

The Committee **RECEIVED** the contents of the Declarations of Interests and Gifts and Hospitality Register; and took **ASSURANCE** that the organisation has appropriate processes to support the collection, management and reporting in line with the Standards of Behaviour Policy.

5.10 COMMITTEE GOVERNANCE ACTION PLAN (ARA/26/054)

HB presented the Committee Governance Action Plan and reminded members of the revised approach to committee effectiveness reviews, whereby formal effectiveness assessments are undertaken biennially, supported by interim workshops and Board development sessions.

Jones, Bethan
08/10/2026 09:57:45

The Committee noted progress against the actions within the plan and received assurance that a further update on delivery and outcomes would be provided later in the year.

RA emphasised the importance of ongoing Board member financial training and sought assurance regarding delivery arrangements. HB confirmed that a finance development session would be held during the summer and that arrangements would be made for members unable to attend to access the training.

Members discussed the value of independent external review of governance and committee effectiveness. HB advised that assurance was currently provided through Structured Assessment and Internal Audit reviews, and that options for external peer review at Board level were being explored.

The Committee **NOTED** and **RECEIVED** the Committee Governance Action Plan.

6 ITEMS FOR DISCUSSION (ARA/26/055)

There were no items for discussion.

7 CONSENT AGENDA (ARA/26/056)

The following reports were **RECEIVED** as part of the consent agenda:

- Committee Risk Register Update
- Confirmation of Clinical Audit Programme
- Single Tender Waivers
- Committee Work Programme 2026/2027
- PTHB Glossary
- Internal Audit Reports: (Substantial Assurance) Standard of Behaviour

The Committee **NOTED** the reports contained within the Consent Agenda. Members had previously highlighted specific issues arising from a small number of reports during earlier agenda items; however, no reports were requested to be moved for detailed discussion.

The Committee **RECEIVED** and **NOTED** the update that the next Committee Risk Register will be presented at the next meeting in October 2026.

8 OTHER MATTERS

8.1 ANY OTHER BUSINESS (ARA/26/057)

No other business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (ARA/26/058)

It was agreed that issues arising from the Internal Audit of Mortality Reviews, specifically regarding Medical Examiner processes and associated assurance arrangements, would be referred to the Patient Experience, Quality and Safety (PEQS) Committee for further consideration and assurance.

The Committee **NOTED** the referral.

8.3 COMMITTEE REFLECTIONS (ARA/26/059)

The Committee reflected positively on the meeting and the opportunity to explore a number of issues in greater depth.

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IT noted the significant volume of audit and assurance work expected later in the year and highlighted the importance of preparing for future Committee business.

MG reflected that the Health Board generally had strong governance arrangements, controls and processes in place, with the ongoing challenge being organisational capacity, prioritisation, timeliness and consistent implementation. He suggested that continued focus was needed on how resources, technology and scrutiny processes could be optimised.

HB agreed that prioritisation remained a key organisational challenge and advised that further discussion would take place through Board Development sessions and Executive Team discussions. HB thanked members for the constructive challenge and positive working environment that supported open and honest discussion.

The Chair thanked members and officers for their contributions and reflected positively on the conduct of the meeting.

8.4 DATE OF NEXT MEETING (ARA/26/060)

06 October 2026 via Microsoft Teams

8.5 CONFIDENTIAL MATTERS

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

Meeting closed at 12:39.

Jones,Bethan
16/10/2026 09:57:45

Beth Jones

Audit and Risk Assurance Committee

RAG Status:	
At risk	Red - action date passed or revised date needed
On track	Yellow - action on target to be completed by agreed/revised date
Completed	Green - action complete
No longer needed	Blue - action to be removed and/or replaced by new action
Transferred	Grey - Transferred to another group

Audit and Risk Assurance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW- (22 OCTOBER 2026)								
07-Jul-26	ARA/26/044	DCG	Action Log: Single Tender Waiver	To provide further assurance on: - The effectiveness of conflict of interest and declaration of interest processes within procurement activities. - The governance and review arrangements relating to contracts, research agreements, and memoranda of understanding. - and any potential actual or perceived conflicts of interest associated with appointments linked to contractual arrangements.	**22.10.26 update -** DCG to provide verbal update.	Oct-26		On track
OPEN ACTIONS - NOT YET DUE (22 OCTOBER 2026)								
ACTIONS RECOMMENDED FOR CLOSURE (22 October 2026)								
07-Jul-26	ARA/26/046	DCG	Internal Audit Report: Mortality Reviews	To share the Mortality Review Internal Audit Report with PEQS.	**07.07.26 Update -** Internal Audit Reort: Mortality Review shared with PEQS to be added to their forthcoming agenda for information.	Oct-26		Completed
12-May-26	ARA/26/017	DoFC&SS	Single Tender Waiver	To confirm why was a contract specification and formal tender process not utilised, particularly if it was a recurring requirement	**23.06.26 update -** Currently awaiting a response from the Service. An update will be provided at the July meeting. **07.07.26 update** - verbal update will be produced during the meeting. **22.10.26 update -** Recommened for closure as superseeded by ARA/26/044.	Jul-26		Completed
12-May-26	ARA/26/004	DCG	Action Log	To discuss criteria for closure of actions within committee action logs at a Chairs Forum meeting	**23.06.26 update** - Item has been added to the next Chair's Forum agenda in September, feedback will be provided following that meeting. **07.07.26 update** - Action on track **22.10.26 update -** Item was discussed at The Chair's Forum held on 09.09.2026.	Oct-26		Completed
12-May-26	ARA/26/019	DCG	Policies and Written Controlled Documents	Executive Committee to review whether timescales for policy updates reflect the assessed level of risk due to higher-risk policies were not clearly prioritised within the current timelines, including the overdue Missing Persons Policy.	**23.06.26 update** - All lead Execuitve Directors have received follow up communciation on overdue policies for action, Executive Committee will review the position in September and report to ARAC in October 2026. **07.07.26 update** - Action in place as above, next report will be produced in readiness for October Committee meeting to reflect actions. **22.10.26 update -** An updated report was presented to the Executive Committee on 16 September 2026 and consequently the Missing Persons Policy review has been completed and the new iteration published. All remaining outstanding policies are medium or low priority with appropriate updated timescales provided within the detail of item 5.6.	Oct-26		Completed
CLOSED ACTIONS								

Jones,Bethan
16/10/2026 09:57:45

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

Agenda Item: 5.1

Audit, Risk and Assurance Committee	**22 October 2026**
Subject:	**Internal Audit Progress Report 2026/27**
Approved and presented by:	Director of Corporate Governance / Board Secretary Head of Internal Audit
Prepared by:	Head of Internal Audit
Other Committees and meetings considered at:	N/A

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Note** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
- **Approve** the proposed adjustments to the 2026/27 plan.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

James.Bethan
16/10/2026 09:57:45

EXECUTIVE SUMMARY:

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

One audit that informed the 2025/26 Opinion and two that will inform the 2026/27 Opinion have been finalised, as follows:

- Vaccine Storage (Reasonable Assurance) (2025/26 Opinion)
- Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (Substantial Assurance) (2026/27 Opinion)
- Escalation Status Governance & Actions (Reasonable Assurance) (2026/27 Opinion)
- Digital Systems Uptake Follow-up (Assurance Not Applicable) (2026/27 plan)

The full copies of the reports are included as separate items within the agenda.

The progress report also includes details of proposed adjustments to the 2026/27 plan.

Progress with the delivery of the 2026/27 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 2026/27 plan was formally approved by the Audit, Risk and Assurance Committee at its March 26 meeting.

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

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

NEXT STEPS:

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

Jones,Bethan
16/10/2026 09:57:45

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
October 2026

NWSSP Audit and Assurance Services

Jones,Bethan
16/10/2026 09:17:43

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau 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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3.Outcomes from Completed Audit Reviews *3*
4.Delivery of the 2026/27 Internal Audit Plan *4*
5.Changes to the 2026/27 Plan *4*

Appendix A Assignment Status Schedule
Appendix B Report Response Times
Appendix C Key Performance Indicators
Appendix D Assurance Opinions

Jones,Bethan
16/10/2026 09:57:45

1. Introduction

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

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

The plan for 2026/27 was agreed by the Audit, Risk & Assurance Committee in March 2026 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
Care at Home Services	Draft Report	Reasonable	Delay in agreeing draft report due to lead manager being on leave.
Primary Care Point of Care Testing	Work in Progress		Delay in completion of fieldwork due to linking in with GP practices.

3. Outcomes from Completed Audit Reviews

One audit report from the 2025/26 plan was not finalised in time for submission to the Audit Committee in May 26, although the outcome was included within the Head of Internal Audit Opinion and Annual Report for 2025/26. The report has now been finalised, as detailed in the table below.

A further three assignments that will inform the 2026/27 Opinion have been finalised since the previous meeting of the committee and are also 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 separate items.

Jones,Bethan
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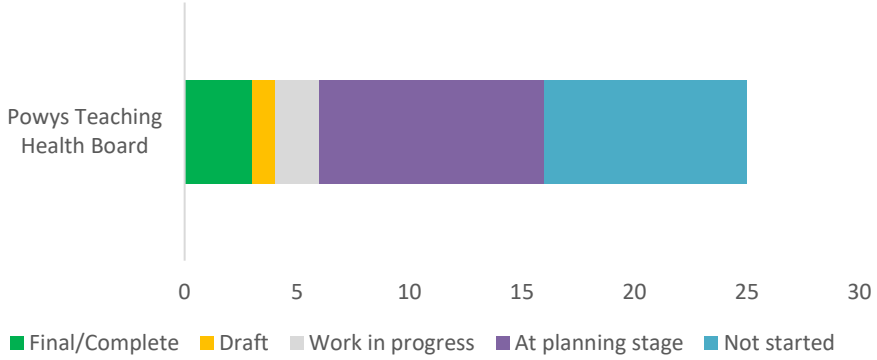
FINALISED AUDIT REPORTS	ASSURANCE RATING	
2025/26 Opinion		
Vaccine Storage	Reasonable	
2026/27 Opinion		
Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (From 25/26 plan)	Substantial	
Escalation Status Governance & Actions	Reasonable	
Digital Systems Uptake Follow-up	N/A	

4. Delivery of the 2026/27 Internal Audit Plan

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



The illustration shows that three audits have been finalised so far this year and one more is at the draft report stage. Two audits are currently work in progress, with a further ten at the planning stage.

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

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

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5. Changes to the 2026/27 Plan

- Population Health Framework – This audit is proposed for deferral from the 2026/27 plan as the scope was linked to the Annual Planning process which is now being reviewed by Audit Wales via their 2026 Structured Assessment. The deferral has been agreed by the Executive Director of Public Health.
- Grip & Control Self-Assessment – This audit is proposed for addition to the 26/27 plan as the review is being undertaken across all NHS Wales organisations. The addition is supported by the Director of Corporate Governance.

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ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2025/26 Plan								
Learning Disabilities Eligibility Assessment & Care Co-ordination Processes	Review of the eligibility assessment and care co-ordination processes operating within the Learning Disabilities service.		Primary, Community Care and Mental Health	1		Final Report	Substantial	October
2026/27 Plan								
Standards of Behaviour (Declarations of Interests, Gifts and Hospitality)	Review the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour, including declarations of interest and declarations of gifts, hospitality and sponsorship.	2	Corporate Governance	1		Final Report	Substantial	July
Escalation Status Governance / Actions	Review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation action plan.	5	Finance, Capital & Support Services / Planning, Performance & Commissioning	2		Final Report	Reasonable	October
Digital Systems Uptake Follow-up	Follow-up of 2025/26 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	16	Allied Health Professions, Health Sciences & Digital	1		Final Report	N/A	October
Care at Home Services	Review of the plans and processes in place to provide care within patient's homes to avoid admission to hospital. Covering the work of GPs, Primary Care Team, Community Care Teams and virtual wards, targeting high risk patients.	17	Primary, Community Care & Mental Health	1		Draft Report	Reasonable	January
Primary Care Point of Care Testing	Review the arrangements in place for point of care testing within GP Practices and how the Health Board is receiving oversight and assurance on these.	15	Allied Health Professions, Health Sciences & Digital	1		Work in Progress		January

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Service Level Business Continuity Plans	Review of the quality and robustness of plans in place within individual service areas to ensure continuity of service in the event of a loss of critical services.	14	Allied Health Professions, Health Sciences & Digital	2		Work in Progress		January
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22. To include review of Security Services.	10	Finance, Capital & Support Services	~~1~~	3	Planning – Final brief issued		January
Core Financial Systems	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	6	Finance, Capital & Support Services	3		Planning – final brief issued		January
Regional Partnership Board Funding	Review of how the Health Board is managing the risks associated with projects and posts that are funded via the RPB on a non-recurrent basis.	12	Public Health	~~2~~	3	Planning – Draft brief issued		January
Better Together Transformation Programme	Review of the first phase engagement, lessons learned and how they have informed planning for the second phase.	21	People & Culture	3		Planning – Draft brief issued		January
Internal Escalation Process	Review of the Health Board's Internal Escalation process to establish if the policy is fit for purpose and if it has been applied effectively.	25	Planning, Performance & Commissioning	3				March
Capital Systems (Targeted Estates Fund)	To obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated funds.	8	Finance, Capital & Support Services	~~1~~	3	Planning – Final brief issued		March
Themes from Internal Audit Work	Potential advisory engagement providing analysis of the themes from Internal audits undertaken for the Health Board over previous years.	3	Corporate Governance	3				March
Agency Staff Usage	Review of controls in place around the use of non-ward based agency staff for AHPs, Medics and community nursing.	19	Primary, Community Care & Mental Health	3		Planning – Final brief issued		March

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Grip & Control Self-Assessment	To provide assurance that the Health Board's self-assessment is complete, accurate and evidence-based; reflective of actual practice; and demonstrates robust financial governance and control.	26	Corporate Governance	3		Planning		March
Management of Medical Staff	Review of the processes around management of medical staff. Potentially covering medical staff induction / In-reach medical staff / consultant contract / Medical staff rostering / medical staff sickness, annual leave or study leave management.	11	Medical	3		Planning		March
Neuro Diversity Action Plan	Review of the Neuro Diversity service and the implementation of the action plan developed following the service being in local escalation. Potentially include review of the ongoing arrangements for monitoring and reporting of service delivery around waiting time targets and wider quality indicators.	23	Nursing, Quality, Women & Family Health	3				March
Estates Assurance – Control of Contractors	Evaluate the processes and procedures that support the management and control of contractors working for the Health Board. Ensuring compliance with Right to Work requirements, Health & Safety Executive (HSE) and other associated legislation.	7	Finance, Capital & Support Services	3		Planning – Final brief agreed		March
Llandrindod Hospital Capital Project	To consider the governance, management and control arrangements being applied at the project with particular emphasis on the delivery of the project in accordance with the approved Business Justification Case requirements.	9	Finance, Capital & Support Services	3		Planning – Final brief agreed		March
Delivery of actions from the External Review	Review of the processes for the development, delivery and reporting of the actions arising from the external review completed by Grant Thornton.	4	Finance, Capital & Support Services / Planning, Performance & Commissioning	4				March

Jones Bethan
16/10/2019 09:57:45

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
MH and LD Triage and Assessment Process	Review phase 2 of the project covering the assessment of patients. Following on from audit of the phase 1 SPOA service in 25/26.	18	Primary, Community Care & Mental Health	4				March
Health & Safety	Review of the governance and oversight arrangements for Health & Safety following recent changes to arrangements, sub-committee structure and Executive responsibility.	20	People & Culture	4				March
Risk Management / Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance	4				May
Transition from Child to Adult Services	Review of the processes and controls around the transition from child into adult services, following completion of the Health Board's Transition Improvement Programme.	22	Nursing, Quality, Women & Family Health	4				May
Quality & Safety Governance	Review of the appropriateness and effectiveness of the Quality and Safety Governance arrangements within the Health Board, to ensure compliance with the Duty of Quality and Duty of Candour.	24	Nursing, Quality, Women & Family Health	4				May
Reviews removed from the plan								
Population Health Framework	Review how plans included within the Framework are integrated into the Health Board's Annual Planning process for 26/27 to support the shift to health promotion.	13	Public health	Proposed for deferral from the 2026/27 plan as the scope was linked to the Annual Planning process which is now being reviewed by Audit Wales via their 2026 Structured Assessment. To be approved by October 26 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
Standards of Behaviour	Substantial	Final	10/06/26	01/07/26	17/06/26	17/06/26	G
Learning Disabilities Eligibility Assessment & Care Co-ordination Processes (From 25/26 plan)	Substantial	Final	13/08/26	04/09/26	27/08/26	27/08/26	G
Escalation Status Governance / Actions	Reasonable	Final	05/08/26	26/08/26	01/09/26	01/09/26	R
Digital Systems Uptake Follow-up	N/A	Final	01/09/26	22/09/26	04/09/26	08/09/26	G

Jones,Bethan
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KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2026/27	G	March 2026	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	A	67% 4 from 6	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 5 from 5	95%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	75% 3 from 4	85%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 4 from 4	95%	v>20%	10%<v< 20%	v<10%

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16/10/2026 09:57:45

Assurance Opinions

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

Jones,Bethan
16/10/2026 09:57:45

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16/10/2026 09:45

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Vaccine Storage

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

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Review Reference	PTH-2526-25
Fieldwork	March - May 2026
Executive Sign Off	August 2026
Audit Committee	June 2026
Executive Lead	Mererid Bowley, Executive Director of Public Health
Audit Team	Ian Virgill, Head of Internal Audit Ken Hughes, Audit Manager

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

Executive Summary

Purpose

Our review of Vaccine Storage arrangements was completed in line with the 2025/26 Internal Audit Plan and focused on the arrangements for the transportation and storage of vaccines.

Overview

Immunisation is a highly effective way of protecting individuals and communities from infectious disease. To remain potent, vaccines must be stored within the manufacturers' recommended storage temperatures. Failure to store vaccines correctly can reduce vaccine effectiveness and cause vaccine failure in addition to being wasteful and costly to the NHS.

We have concluded reasonable assurance on this area. The following matters require management attention:

- Central pharmacy vaccine storage arrangements may not always meet minimum standards;
- Manual stock records were sometimes incomplete or inaccurate;
- The recording of cold chain disruptions due to temperature excursions needs improvement;
- Investigations of temperature excursions are not always being carried out within reasonable timescales; and
- Vaccine waste is not currently being fully reported within the Health Board.

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:

- At the time of our review, Policies and procedures needed to be updated to reflect changes to procedures such as the move away from using vaccine porters.

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There are clearly defined standards for the safe storage and transportation of vaccines and accurate stock records of vaccines in storage are kept.	1, 2	**Reasonable**
2	Refrigerator temperatures are regularly and accurately recorded to provide assurance that vaccines are stored within the manufacturers recommended temperature range.	-	**Substantial**
3	Procedures to be used when refrigerated vaccines are stored outside of the manufacturers recommended range or in the event of a fridge temperature excursion outside of the cold chain range of +2°C to +8°C have been established and are adhered to.	3, 4	**Reasonable**
4	Incidents are recorded in Datix on a timely basis when vaccines have to be destroyed.	5	**Reasonable**
5	The collection and transportation of vaccines complies with applicable guidance and procedures.	-	**Reasonable**

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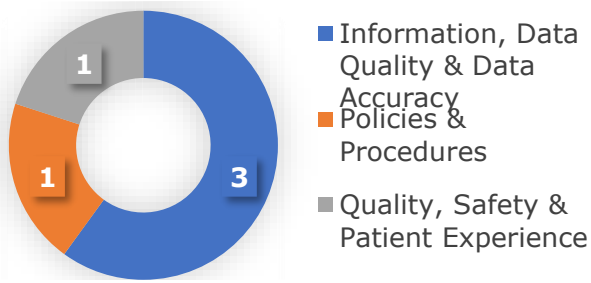
10/10/2026 09:57:45

Management Actions

0	5
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

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Findings & Agreed Action Plan

Objective 1: There are clearly defined standards for the safe storage and transportation of vaccines and accurate stock records of vaccines in storage are kept.	**Reasonable**

Overview / Summary of Observations

Historically the primary guidance for the safe storage and transportation of vaccines issued by the Welsh Government was their Advisory Document on the Ordering, Storage and Handling of Vaccines. This document set the standards required and recommended it should be used by all Health Boards in Wales to inform their local policies and guidance. This document is the 7th revision and was last updated in September 2017, although we note that it is currently under review. Until the review and during the interim period, guidance on the safe storage and transportation of vaccines is provided within local Standard Operating Procedures (SOPs), including reference to the Green Book.

There are a range of guidance documents for staff on the Pharmacy SharePoint page relating to the safe storage and transportation of vaccines. All the guidance documents were in date with review dates in 2027 or 2029. Section 5 of the WG Advisory Document covers the storage of vaccines and section 7 covers transportation. The local guidance was reviewed and found to be in line with the WG guidance.

The conditions under which vaccines are being stored are in line with the WG guidance, for example vaccines are stored in their original packaging retaining batch numbers and expiry dates and are stored within the manufacturers specified rang of +2C to +8C and are protected from natural light in specialist vaccine refrigerators. Each vaccine refrigerator has a glass front and a digital temperature display so the contents can be seen, and the temperature taken without opening the fridge door.

We were informed that the vaccine store is connected to an emergency generator that would be used to maintain the electricity supply to the fridges in the event of a power cut. The guidance also states that refrigerators need to meet storage needs and can be stored in a cold room or specialist vaccine refrigerators, but we were informed by the Pharmacy Technician that the current arrangements do not always meet storage needs.

Manual stock records are kept on individual Excel spreadsheets at the Pharmacy stores, with each vaccine having its own spreadsheet. However, our review of the spreadsheets identified some issues.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Bronllys Pharmacy Store** Welsh Government guidance states that vaccines can be stored in a cold room or specialist vaccine refrigerators, but there should be sufficient space around the vaccines for air to circulate. There should also be sufficient capacity to meet seasonal demands such as flu vaccine stocks. At the time of our visit there was sufficient capacity for the vaccines being stored, with only 5 of the 11 fridges being used to store vaccines. The remaining 6 fridges were storing cool packs used in the transportation of vaccines.	The storage of vaccines may not always meet the minimum storage standards.	**Agreed Action:** A paper was presented to the Vaccination Service highlighting challenges related to fridge capacity and cold chain assurance across both the Pharmacy Store and the Vaccination Centres. The paper identified limitations in current storage arrangements and distribution process and the potential impact on maintaining optimal temperature control and service resilience. As part of the recommendations, the vaccination service was asked to consider investment in a cold room facility to enhance overall storage capacity and strengthen the efficiency and reliability of vaccine distribution processes.

Logs Section 30 - 16/12/2025 09:51:44

	However, we were informed by the Senior Pharmacy Technician that during peak periods all available refrigerators may be fully utilised to store vaccines and associated cool packs required for vaccination teams for the forthcoming week. This can result in refrigerators operating at maximum capacity, limiting appropriate air circulation and reducing overall storage resilience. Consequently, there is limited flexibility to accommodate any additional stock if required, which may pose a risk to maintaining optimal storage conditions and effective cold chain management.		A further appraisal of the options available to ensure sufficient capacity to safely store vaccines throughout the year will be undertaken and submitted to the Health Board for consideration. **Expected Evidence of Implementation:** The HB has sufficient capacity to safely store sufficient quantities of vaccine to meet demand throughout the year.
		Medium Priority	**Officer:** Nikki Mathers, Senior Pharmacy Technician **Target Implementation Date:** 31st December 2027
	Theme: Quality, Safety & Patient Experience	Control Design	
2	**Manual Stock Records** The Excel spreadsheets used to record stock levels for Covid, Flu and RSV vaccines were reviewed and the following issues were identified: • The spreadsheets have a formula to record balances, but these are often overwritten. Consequently, some of the balances were incorrect. • There is no column to record where stock has been supplied to, the name of the stock checker or to make notes, so Excel 'Comments' function is being used for this.	Vaccine stock records may not be accurate.	**Agreed Action:** A review of the format and accuracy of the stock management spreadsheet was undertaken in May. The revised version is scheduled for implementation from 1 September, aligning with the commencement of the Autumn/Winter vaccination programme. Enhancements to the updated spreadsheet include the restriction of the stock balance column to prevent manual overwriting, thereby improving data integrity. In addition, new fields have been incorporated to record the destination of supplied stock and to capture the name of the individual responsible for checking entries, supporting improved accountability and traceability within the process. This process will be reviewed, and scoping of suitable digital dashboards and software to be explored. **Expected Evidence of Implementation:** Improvements to the format of spreadsheets and accuracy of data held.
		Medium Priority	**Officer:** Nikki Mathers, Senior Pharmacy Technician **Target Implementation Date:** 1st September 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Jones,Bethan
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Objective 2: Refrigerator temperatures are regularly and accurately recorded to provide assurance that vaccines are stored within the manufacturers recommended temperature range.	**Substantial**

Overview / Summary of Observations

Health Board procedures require staff to check and record the temperature in each fridge at least once each day and record the temperature in the Welsh Immunisation System (WIS), but this can only be done when the pharmacy store is manned. Although the WIS retains all data input, users can only display data from the last 3 months. A review of the daily temperature recordings in the WIS for the period 31st March 2026 to the 5th May 2026 identified that a daily temperature was not recorded for 12 of the 26 working days in the period (excluding weekends). However, fridge temperatures are automatically recorded and retained until the fridge thermometer is reset and data logger information would be available to download and be assessed if a deviation is found. Local Standard Operating Procedures (SOPs) for the management of refrigerated medicines and vaccines recognise that some teams may not be present on site daily to record fridge temperatures. In such cases, a risk assessment is recommended to evaluate any potential impact on vaccine integrity. Mitigation measures are in place for the pharmacy store, including the use of maximum temperature readings to identify any deviations occurring between readings. These alerts prompt staff to review data logger records, providing a more comprehensive assessment of temperature stability over time.

It is however, recognised that the above provides retrospective information, therefore a digital initiative request has recently been submitted to support the implementation of Wi-Fi-enabled data loggers across the Vaccination Service, including use within community vaccination settings. Subject to approval, these devices would enable remote, real-time temperature monitoring, allowing for earlier identification and resolution of any temperature excursions and improving compliance with cold chain requirements. The introduction of this technology would also remove the need for manual downloading of temperature data, as records would be automatically captured, stored, and accessible within the system, providing a robust audit trail for assurance purposes. Overall, this approach would enhance the reliability of temperature monitoring, reduce workload pressures on vaccination and pharmacy teams, and provide increased assurance in maintaining the integrity of the vaccine cold chain.

Each vaccine fridge has an external display showing the current temperature, and an alarm sounds in the event of a temperature excursion. Each fridge also has a portable data logger inside that records the temperature at 5-minute intervals. The data can be downloaded via USB to computer and a temperature log created that records the fridge number, start date, finish date and temperature every 5 minutes. During our visit it was confirmed that all fridges had a functioning external temperature display, and all fridges with vaccines had a data logger within.

The data loggers can operate for up to two months after which time they must be downloaded, otherwise the data is overwritten and lost. We were informed by the Senior Pharmacy Technician that data loggers used within Pharmacy Store refrigerators and Vaccination Centres are downloaded on a weekly basis, reflecting the high frequency of fridge access and use within the service. However, outside the pharmacy store, they are normally left in place for up to one month if there are no fridge alarms before being downloaded and checked. If no temperature excursions are identified the logs are then deleted and are only retained if there has been a temperature excursion. They are then used to determine if the vaccines can be used in line with their expiry date, used within a reduced timescale or must be destroyed.

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Objective 3: Procedures to be used when refrigerated vaccines are stored outside of the manufacturers recommended range or in the event of a fridge temperature excursion outside of the cold chain range of +2°C to +8°C have been established and are adhered to.	**Reasonable**

Overview / Summary of Observations

Sections 9 and 10 of the Standard Operating Procedure MMP 427 (Safe and Secure Management of Refrigerated Medicines and Vaccines) cover the actions to be taken when a temperature excursion or disruption to the cold chain occurs. The SOP requires all temperature excursions outside of the range of +2°C to +8°C to be acted on immediately, regardless of duration. Once vaccines are exposed to temperatures outside of this range, they must be quarantined in a separate fridge and clearly labelled 'quarantined - do not use'. The fridge should then be re-set, and the temperature re-checked after one hour. A 'Disruption of Cold Chain' form should then be completed and the incident recorded on the 'Cold Chain Disruption' log. The Medicines Management Team should then be notified and forwarded the 'Disruption of Cold Chain form'. The Medicines Management Team will then contact the vaccine manufacturers for advice and decide if the vaccine is safe to use, should be used within a shortened expiry date or destroyed. In accordance with the internal procedures, instances of cold chain disruption should also be recorded on Datix.

All the entries on the 2025/26 'Cold Chain Disruption Log' were checked to ensure a 'Cold Chain Disruption' report had been completed and that all entries were consistent and accurate, and action taken was timely and in line with the SOP. A number of issues were identified, as highlighted in the finding below.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Cold Chain Disruption Log** The cold chain disruption log shows 25 instances of temperature excursions for 2025/26. A copy of the cold chain disruption report was requested for each entry in the log for 2025/26. Our testing identified that: • There was no Cold Chain Disruption Report on file for 3/25 entries in the 2025/26 Cold Chain Disruption Log. • 7 Cold Chain Disruption Reports or notifications of a temperature excursion on file were not recorded in the Cold Chain Disruption Log. • The Cold Chain Disruption Reports are not cross referenced to the Log (i.e. no unique identifier such as a reference number). • The value of lost stock was not recorded on the log for 4/23 occurrences in 2025/26 where stock was destroyed. • A number of the Cold Chain Disruption reports were not initially available for review.	Inaccurate records and investigations not carried out resulting in additional wastage. **Medium Priority**	**Agreed Action:** The respective responsible individuals within each of the areas covering the Vaccination Team, wards and Primary Care will review the way cold chain disruption reports are completed and collected to ensure consistent compliance with the Standard Operating Procedure. **Expected Evidence of Implementation:** Each entry on the cold chain disruption log has a corresponding cold chain disruption report. **Officer:** Nikki Mathers / Kath Harries / Jade Bell **Target Implementation Date:** 31st August 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

James Bethell 16/07/2026 09:57:45

4	**Temperature Excursion Investigations** When a temperature excursion occurs, it must be recorded on the cold chain disruption log. A cold chain disruption report must also be completed and submitted to the medicines management team so that an investigation can be carried out to determine whether the vaccine can still be used. Affected vaccines are quarantined at +2°C to +8°C. Where quarantined vaccines are required for a scheduled vaccination clinic, and to avoid service disruption, new vaccine stock is supplied in the interim. Our review of the 23 instances of temperature excursions recorded on the log for 2025/26 identified that the average time taken to complete investigations was 10 days (excluding an outlier), with some investigations taking up to 90 days to complete. We were informed that Vaccines supplied from the pharmacy store should be investigated immediately and completed within 2-5 days. However, there is no target time set for completion of investigations in other areas.	Vaccines that could have been used may have to be destroyed.	**Agreed Action:** Responsible individuals will be reminded of the requirement to ensure that all Pharmacy store investigations are completed within the stated 2 to 5 days. Other areas will ensure that all investigations are completed within a reasonable timescale.
			Expected Evidence of Implementation: Future investigations consistently completed within the required timescales.
		Medium Priority	**Officer:** Nikki Mathers, Senior Pharmacy Technician **Target Implementation Date:** 31st August 2026
	Theme: Policies & Procedures	Control Design	

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Objective 4: Incidents are recorded in Datix on a timely basis when vaccines have to be destroyed.	**Reasonable**

Overview / Summary of Observations

The main reasons vaccines are destroyed are due to temperature excursions or vaccines exceeding their expiry date. We were informed during the audit that teams reporting fridge temp excursions are requested to submit a Datix report, if vaccines/medicines have to be disposed of then it would be noted on the Datix report. Also, any wastage relating to vaccines ordered through the UKHSA ImmForm platform is recorded directly within that system. We were provided with waste data for 2025/26, but this includes mainly vaccine disposals from GP practices, whose stock PTHB does not manage. In addition, RSV/Covid-19/Flu vaccine waste is captured via the Welsh Immunisation Service (WIS) platform, however data more than 3 months old is not readily available, although we understand that a request may be made to DHCW for this.

We were informed that VPW monitor HB vaccine waste related to stock ordered and managed via the Pharmacy Store for COVID-19, and we were provided with their waste assessment and comparison for 2024/25 and 2025/26. This showed that the Health Board's assumed waste percentage for the Autumn 2025/26 campaign was 3.97% against an All-Wales figure of 12.57%, although we note that this was 13.36% for Spring 2025 against an All-Wales figure of 14.23%.

The disposal of vaccines is also recorded on the Cold Chain Disruption Log. This records all instances of temperature excursions notified to the team, and whether the vaccine has been destroyed together with the cost. A separate Waste Log is also maintained that records all waste across the Health Board on a month-by-month basis. The waste log for 2025/26 was reviewed, and this raised a number of issues.

Vaccines deemed no longer fit for purpose are disposed of via the pharmacy waste medicines bin. All waste medicines are collected by the nominated contractor (there is an All-Wales contract in place for this) and disposed of safely, normally through incineration.

	Key Findings	Risk & Impact	Agreed Management Action
5	**Waste Recording** A Waste log is maintained that mostly contains details of vaccines destroyed due to going out of date. It does however also contain some entries of vaccines destroyed due to temperature excursions which should also be recorded on the Cold Chain Disruption Log. Our review of the Waste Log and Cold Chain Disruption Log identified several omissions from the Cold Chain Disruption Log of vaccines destroyed due to temperature excursions. There were also many examples of wastage due to temperature excursions recorded in the Cold Chain Disruption Log that were not recorded in the Waste Log.	The HB is unable to effectively monitor vaccine waste or provide assurance that wastage for all vaccines is at a reasonable level.	**Agreed Action:** A review of all vaccine wastage reporting will be undertaken to ensure there is overall monitoring and reporting of Health Board waste to an appropriate group or committee. There are currently waste reports for vaccines inputted into the WIS system including flu, RSV and Covid-19. This is presented and reviewed through the Vaccine Programme Wales structure and reposts issued to the Vaccination Service. The gap in other programmes that order stock via ImmForm will be explored to develop a summary of waste to be reported through the Powys Vaccination Group on a Quarterly basis.

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	Wastage is also input to the WIS, however, the data extracted for 2025/26 does not provide a monetary value, just a percentage value. There are currently no KPI's relating to vaccine waste and a lack of comprehensive reporting of all wastage within the Health Board.		**Expected Evidence of Implementation:** More detailed and comprehensive monitoring and reporting of wider vaccine waste levels in place.
		Medium Priority	**Officer:** Sarah Barnes, Head of Service: Public Health Programmes and Projects
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30th September 2026

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Objective 5: The collection and transportation of vaccines complies with applicable guidance and procedures.	**Reasonable**

Overview / Summary of Observations

There are two Standard Operating Procedures (SOPs) covering the transportation of vaccines. These are SOP MMP428 - Use of Labcold Vaccine Carriers and MMP432 - Use and Management of Helapet Vaccine Carrier Systems. Both documents had been approved by the PTHB Vaccination and Immunisation Operational Development Group in April 2024 and were not due for review until 2027.

Prior to our audit, vaccines were distributed using specialised vaccine carriers which the Health Board has in a variety of sizes. Vaccination distributions reflect known appointments scheduled at the vaccination centres (Bronllys and Newtown), to whose records Pharmacy Stores has access, or requests from District Nurses, Maternity Services or School Nurses.

The basic details for each distribution are recorded on the relevant vaccine log and a more detailed vaccination Delivery Note template is completed for each distribution from the pharmacy store. The delivery note accompanies the vaccination distribution and is signed by the driver and vaccine recipient. Following sign off by the recipient, the completed version should be returned to Pharmacy Stores for retention. A random sample of 26 distributions was selected from the three main vaccine spreadsheets for reconciliation to a completed distribution template, however only 16 delivery notes could be found and a small number of these had not been signed by both the driver and recipient.

However, we were informed in discussions with the Medicines Management team that the vaccine delivery process was updated at the start of the Spring Vaccination Programme. Health Courier Service Wales (HCSW) now deliver the vaccines using vehicles equipped with validated temperature-controlled units, removing the need for vaccines to be packed into individual vaccine porters. The entire delivery journey, from collection through to receipt, is fully tracked and documented digitally. Orders are entered onto the Cleric system by HCSW, and temperature conditions are continuously monitored throughout transport to ensure compliance with cold chain requirements. Full traceability is maintained, and journey details can be retrieved if required using the pharmacy store reference number and the corresponding Cleric order number assigned by HCSW. This approach aligns with the standard HCSW delivery model implemented across Wales, ensuring consistency, reliability, and adherence to best practice.

We have not raised an issue under this objective as the system has recently changed and the testing we carried out retrospectively covered the old system. However, we are only able to provide Reasonable assurance for this objective as it was too early for us to carry out any substantive testing on the new process.

Jones,Bethan
16/10/2026 09:57:45

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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.

Prioritisation of Findings

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

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Public Sector Internal Audit Standards

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

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

Escalation Status Governance & Actions

Final Internal Audit Report

2026/27

Powys Teaching Health Board

Reasonable Assurance

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Review Reference	PTH-2627-05
Fieldwork	June/July 2026
Executive Sign Off	01 September 2026
Audit Committee	October 2026
Executive Leads	Hywel Pullen, Acting Executive Director of Finance & Nicola Johnson, Executive Director of Planning
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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Executive Summary

Purpose

The purpose of our audit was to review the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and the de-escalation plan.

Overview

The Health Board is, since November 2024, under Targeted Intervention (Level 4) escalation status for finance, strategy and planning under the NHS Wales Oversight and Escalation Framework. This is due to a deteriorating financial position and an Annual Plan for 2026/27 which includes a planned deficit of £44.7m and is not therefore approved or supported by Welsh Government. For all other domains of the escalation framework the Health Board is in routine monitoring. In March 2026 Welsh Government published a revised accountability framework for all organisations which was intended to simplify current reporting processes, and which focuses on the four pillars of quality, finance, workforce and delivery & performance, with a foundation domain of leadership. Interactions with Welsh Government are now through the lens of these four pillars and we understand that the impact on the existing de-escalation criteria is still to be confirmed.

There are continuing financial pressures on the Health Board which if not addressed are likely to lead to further deterioration in future leading to concerns about the Board's ability to achieve financial sustainability. The reported position for M3 2026/27 is a £12.991m overspend against a forecast deficit of £11.163m giving the Health Board an overspend of £1.827m compared to plan. The overspend is being caused by issues with commissioning from English providers, continuing healthcare, and non-achievement of savings in the private and voluntary sectors. As at M3, £21.3m of green and amber savings plans have been identified against the target of £22.9m. However, only £12m of these are recurring and therefore the remainder is not positively benefitting the underlying deficit.

Our review has however found that the governance arrangements and response within the Health Board appear appropriate and are instrumental in ensuring that the approach to financial recovery has sufficient momentum to help achieve some very challenging targets. Interviews with Board members as part of our audit indicated that the initial feedback from Welsh Government following the first Escalation Board has apparently been positive and the support from both NHS Performance & Improvement (NHS P&I) and Grant Thornton and their partners has been welcomed. The Financial Recovery Board has helped to ensure that all directors understand their role and responsibilities in meeting the financial agenda and the focus on short-term goals and actions injects the necessary pace to give the greatest chance of achieving the desired results. Turning this into sustainable long-term actions however is going to be extremely challenging for the Health Board, particularly when the external support is withdrawn.

We have concluded **reasonable** assurance on this area. The matters requiring management attention, the majority of which are recognised within the Health Board and for which there were already intentions to address, are:

- Management information reported to the Board and Finance and Performance Committee could be further developed to provide more detail on specific actions and savings schemes.
- The detailed finance plan, agreed recently between the Health Board Finance Team and NHS P&I, has not been shared in its entirety with the Board; and
- The Health Board has identified that more needs to be done in terms of training and communication in finance for its staff and has made good progress in terms of staff briefings and more recently in undertaking training needs analyses but needs to implement a regular programme of training and communications for board members and staff.

Agenda Pack 10/12/2026 09:15 - 12:45

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:

- Although the other domains are largely covered by current performance reporting, there is no specific read-across to the criteria underpinning each domain, and a periodic review to ensure that the requirements of the other domains are fully assured may be helpful.

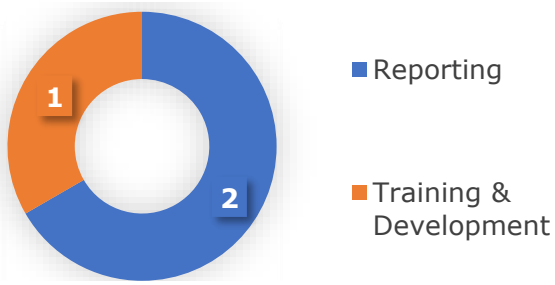
Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Appropriate governance arrangements have been established to manage the six domains of the NHS Wales Escalation and Oversight Framework.	1	**Reasonable**
2	The Health Board has effective arrangements in place to respond to its escalation to Level 4 Targeted Intervention for Planning, Strategy and Finance, including planned actions towards the achievement of de-escalation.	2,3	**Reasonable**

Management Actions

0	3
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

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Three-Year Financial Strategy

Year	Focus	Objective
2026/27	Stabilise & Change	Establish control and deliver plan
2027/28	Embed	Deliver recurring improvements
2028/29	Transform	Achieve target control total

All information on this page taken from slide pack submitted to Welsh Government for Escalation Board meeting June 2026.

Financial Recovery Route Map

Area	2026/27 £m	2027/28 £m	2028/29 £m
Underlying Deficit	44.70	44.67	23.19
Growth & Inflation	24.10	12.05	12.05
Funding	(1.20)	(5.00)	(5.00)
2% Savings	Included Below	Included Below	(7.05)
1% Savings	(3.93)	(3.93)	(3.93)
Grant Thornton Opportunities	(11.40)	(11.70)	(3.70)
Better Together Opportunities	(2.50)	(5.50)	(4.00)
GRFT and Other Opportunities	(5.10)	(7.40)	(2.00)
Total	**44.67**	**23.19**	**9.56**

Jones,Bethan
16/10/2026 09:57:45

Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements have been established to manage the six domains of the NHS Wales Escalation and Oversight Framework.	Reasonable

Overview / Summary of Observations

The governance arrangements within the Health Board to oversee the response to the targeted intervention status are as follows:

- Executive Committee – day-to-day leadership and overview of finance, delivery and performance and progress against the de-escalation plan reported monthly.
- Financial Recovery Board – this is a sub-group to the Executive Committee which meets fortnightly. All Executive Directors attend this Board.
- Finance and Performance Committee – seeks assurance on financial performance and progress against the Level 4 de-escalation plan – reported to every meeting;
- Audit, Risk and Assurance Committee – gains assurance through oversight of the financial controls – reported to every meeting;
- Planning, Partnerships and Population Health Committee – gains assurance through measuring progress against the Maturity Matrix and over planning and strategy governed by the NHS Planning Framework – reported to every meeting.

At the strategic level, the Board have ownership of escalation and in addition to their normal responsibility for culture, strategy, performance and risk they also need to regularly report against the Level 4 de-escalation criteria and plan. In this the Chief Executive and Chair both have specific responsibilities with the Chief Executive engaging with and reporting to both the Health Board Chair and the Director General, and the Chair having similar responsibilities to the Cabinet Secretary. The Board receive formal reports bi-annually with reports from the Chief Executive in-between, and directors attend quarterly Escalation Boards with Welsh Government

The establishment of the Financial Recovery Board has helped to ensure that all directors understand their role and responsibilities in meeting the financial agenda and the focus on short-term goals and actions injects the necessary pace to give the greatest chance of achieving the desired results. There is an acknowledgement that the Financial Recovery Board, which only met for the first time in April 2026, needs to move on from the identification of savings schemes to monitoring their delivery and ensuring that there is appropriate and proportionate governance over individual schemes, and recent minutes demonstrate that this transition in approach is now occurring. There is further recognition that relevant reports, particularly to the Finance & Performance Committee, require development to provide more detail on progress, albeit that the scope of what can be reported is limited by the bulk of reports being in the public domain.

Inevitably the current focus within the Health Board is on Finance, Strategy and Planning due to its Level 4 status. The other domains of the NHS Oversight and Escalation Framework are largely covered through internal performance reporting but there is no explicit link to them, or the criteria that sit under each domain. We are also aware that Welsh Government have recently amended their approach to simplify reporting and focus on four pillars of Quality, Workforce, Finance and Delivery & Performance, and a foundation domain of leadership, but that it is currently not clear on the resulting impact on the de-escalation criteria.

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	Key Findings	Risk & Impact	Agreed Management Action
1	**Management Information** Although updates on the Escalation status are provided to the bi-monthly Finance and Performance Committee and elsewhere, to date much of the information is repeated from meeting to meeting and recaps the journey to escalation and the structural arrangements that have been put into place to respond to it. Interviews with Independent Members and key staff demonstrate that there is both a desire and willingness for more detailed information to be provided in terms of specific progress against both the recommendations in the Grant Thornton report and the development of savings schemes to address the underlying financial deficit.	Board members and senior management are not provided with a sufficient level of detail to give assurance over the progress being made by the Health Board in responding to the escalation measures.	**Agreed Action:** The update reports to the Finance and Performance Committee, and other Board and Committee meetings will demonstrate the links to the Finance Report which includes more specific detail on delivering the Grant Thornton report through the delivery of the savings schemes; and also, through the reports on the development of the Plan 2027/28, describe the further actions the Health Board is taking through its planning processes in response to the escalation status & development of the future pipeline of opportunities.
			Expected Evidence of Implementation: Updated reporting formats.
		Medium Priority	**Officer:** Executive Director of Planning/Acting Executive Director of Finance
	Theme: Reporting	Control Design	**Target Implementation Date:** 30 September 2026

Jones,Bethan
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Objective 2: The Health Board has effective arrangements in place to respond to its escalation to Level 4 Targeted Intervention for Planning, Strategy and Finance, including planned actions towards the achievement of de-escalation.	Reasonable

Overview / Summary of Observations

The response required to achieve de-escalation from Level 4 for Finance, Strategy and Planning does not have a specific action plan attached to it but is instead incorporated into the Annual Plan which reduces duplication, but which can make it harder to isolate the specific actions required for financial recovery. However, in response to the escalation to Level 4, the Health Board has undertaken the following actions:

- Initial review by Grant Thornton and Partners focused on financial sustainability, commissioning and continuing health care.
- Financial Recovery & Turnaround Director appointed, reporting to CEO.
- Establishment of financial recovery programme team to implement effective programme management and drive delivery of savings schemes and related enabling productivity and transformation programmes.
- Targeted follow-on support from Grant Thornton and Clarity Consulting partners in place to provide capacity and supporting expertise to drive pace in key areas (commissioning and contracting, CHC, workforce)]
- Fortnightly drumbeat established with CEO-chaired, whole Executive Team, Financial Recovery Board.
- Series of sprints in place to accelerate planning and delivery, de-risk the plan and remove barriers.
- Enhanced Independent Member oversight in place, maximising skills and experience.
- A specific and detailed finance action plan agreed with NHS Performance & Improvement.
- Deep dives on variable pay, commissioning, mental health placements and continuing health care at the Finance and Performance Committee.
- Completion of the Financial Grip and Control Assessment Tool.
- Establishment of a Strategic Commissioning Framework.

The response thus far seems appropriate with actions taken to date and monitored in the Financial Recovery Board having deliberately very short timescales for completion to ensure that the necessary pace and momentum is maintained.

Jones,Bethan
16/10/2026 09:57:45

	Key Findings	Risk & Impact	Agreed Management Action
2	**Finance Action Plan** As part of the relationship between the Health Board Finance Team and NHSP&I, a detailed Level 4 Finance Action Plan was drafted with the original version dating from April 2025. We understand that although elements of this plan have been reported within the Health Board it has never been shared in its entirety. The Health Board has recently agreed updates to the plan which are shortly to be signed off by NHSP&I, and this would seem an opportune time to ensure that the plan is shared more widely within the Health Board.	The detail of the finance action plan agreed with NHSP&I is not widely known outside of the finance department which reduces the overall accountability within the Health Board.	**Agreed Action:** More detailed updates against the finance specific action plan agreed between the Health Board Finance Team and NHS P&I will be provided to the Finance & Performance Committee.
			Expected Evidence of Implementation: Agenda and minutes of Finance & Performance Committee meetings.
		Medium Priority	**Officer:** Deputy Director of Finance **Target Implementation Date:** 30 November 2026
	Theme: Reporting	Control Operation	
3	**Training and Communications** As part of its response to the Level 4 escalation the Health Board completed two financial grip and control assessment tools – one that was aimed at workforce and one which covers everything apart from workforce. The workforce assessment produced several recommendations for which action has already been completed or will shortly be complete. The non-workforce assessment noted that there was more to do in terms of formal training and communications. Communication plans are in place with regular written and verbal briefings to managers and staff to help embed understanding and ownership of the need for financial recovery at all levels The capacity limitations of a small finance team, and the need to focus on financial recovery has led to some delays in undertaking finance training but we are aware that all board members and budget holders have recently been contacted to complete either a training needs analysis for the former and a short questionnaire for the latter, to understand the recent training that they have received and the areas that they would most value receiving help with.	Health Board staff are not fully aware, trained and engaged in addressing the financial challenges resulting in it being less likely that financial targets will be achieved.	**Agreed Action:** The Health Board will build on the communication plans already in place, and the information gained from the questionnaires and training needs analysis to budget holders to inform a regular programme of training and communication for budget holders.
			Expected Evidence of Implementation: Analysis of the responses, resulting training programme and materials. Evidence of delivery of training.
		Medium Priority	**Officer:** Assistant Director of Finance **Target Implementation Date:** 31 December 2026
	Theme: Training & Development	Control Design	

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Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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.

Prioritisation of Findings

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

Jones, Bethan
30/10/2026 09:57:45

Public Sector Internal Audit Standards

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

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

Digital Systems Uptake Follow-up

Final Internal Audit Report

2026/27

Powys Teaching Health Board

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Review Reference	PTH-2627-16
Fieldwork	July - August 2026
Executive Sign Off	4th September 2026
Audit Committee	October 2026
Executive Lead	Claire Madsen, Executive Director of Allied Health Professions, Health Sciences and Digital
Audit Team	Ian Virgil, Head of Internal Audit
	Martyn Lewis, IT Audit Manager
	Kevin Bridgman, IT Audit Manager

Jones Bethan
16/10/2026 09:57:45

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

Executive Summary

Purpose

We have completed a follow-up review of Digital Systems Uptake.

Our original Digital System Uptake audit was reported in October 2025 and identified five issues, resulting in an overall assurance rating of 'Limited Assurance'.

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

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

We note that progress against these actions has been monitored through the Health Board audit action tracker, with an update reported to the Executive Committee in March 2026 and the Audit, Risk & Assurance Committee in July 2026.

Overview

Our follow-up review has confirmed that four of the five agreed actions have been implemented. One action remains ongoing, with further action required, as follows:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	1	1	0	0
Medium	4	3	1	0
Total	5	4	1	0

As part of our follow-up review, we discussed progress with management and reviewed supporting evidence. The project milestone tracker supplied by management contained ten projects.

We found that the benefits realisation, training, change management and low uptake/lessons learned actions have been implemented, although some arrangements are still bedding in. The agreed benefits template, training documentation and milestones, trainer posts and final Change Management Framework are in place, with change-support activity evident in the projects reviewed.

Finding 4 remains ongoing. The corporate tracker provides benefits and selected training information but does not include utilisation, uptake or adoption data, so it does not yet provide the integrated uptake view required by the original action. The other actions are closed because management has put in place what was agreed; current projects will continue to bed these arrangements in.

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

James Bethan
16/07/2026 09:57:45

Appendix A: Progress of Agreed Actions

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 1	**Benefits Realisation.** Finding: Not all projects sampled fully complied with good practice in terms of all benefits defined by stakeholders and having a formal benefits realisation plan. We also note that levels of user engagement vary with some projects lacking ongoing user involvement, which can lead to a loss of service ownership of the digital product. Agreed Action: 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 strategic benefits framework. Digital Services project managers will utilise this template, which will be defined in collaboration with stakeholders ensuring operational service teams take ownership and accountability of their benefit realisation logs. The Digital project will oversee that benefits data is collected and tracked against an agreed stakeholder map for up to six months following implementation (Go Live), after which responsibility for ongoing benefits realisation will be transferred to the agreed service leads. Original Responsibility & Timescale: Head of Digital Programmes, 31 December 2025	**Medium Priority**	**Action Status: Implemented** A standardised benefits register template and central project milestone tracker have been produced. The tracker reviewed contained ten projects and links to benefits information for eight. Benefits registers were also identified within DMC, ePMA and Digital Eyecare. The tracker includes existing and current projects. Our review confirmed that the agreed benefits process has been introduced and is operating across the projects reviewed, with a standard template for benefits capture in place and identified leads within the service. We note that the arrangements will continue to bed in as current projects progress through their post-go-live monitoring period.

Jones,Bethan
16/10/2026 09:57:45

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 2	**Training.** Finding: Not all projects contained a defined training stage within the plan and have relied on early stakeholder engagement and ad hoc training sessions. Agreed Action: At the time of the Audit an interim arrangement was already in place with the recently recruited Training Function. To support this, training documentation will be prepared and will be incorporated into the project framework suite of templates, providing guidance for project managers during the implementation of new projects. Where training is deprioritised, this will be reported by the project board, in the Risks and Issues Logs. Training schedules will be added as a clearly defined milestone, against the project, and will record the method of training that will be provided based on each project requirements and workforce considerations. Some training will have to be cascade training due to the size of the training team and the demand and this will be the responsibility of the operations team. Original Responsibility & Timescale: Head of Digital Programmes & Chief Nurse Informatics Lead, 28 February 2026	**Medium Priority**	**Action Status: Implemented** Three substantive Band 5 Digital Support Trainer posts were approved by the Executive Committee on 4 March 2026. Our review noted training documentation and defined training milestones within the projects sampled. The projects demonstrated planning of training delivery methods and completed training activity. The agreed action to introduce training documentation and milestones has therefore been completed. The action is implemented and the arrangements will continue to bed in as the training function supports further projects.

Jones,Bethan
16/10/2026 09:57:45

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 3	**Change Management.** <u>Finding:</u> 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. <u>Agreed Action:</u> A Change Management Framework was started in draft as part of the EPMA programme, where an interim Change Manager was appointed on a fixed term basis up until March 2025. This is a known area for improvement, and we accept this is a role that is essential, however due to how digital projects are funded, there is not a permanent Change Manager in post. The size of the organisation, the rurality of PTHB and the funding available is often a challenge to recruit the required change management roles with experience. That said it is an identified gap and so where resources are defined, this will include Change leads or Change Champions. <u>Original Responsibility & Timescale:</u> Head of Digital Programmes and Assistant Directors of Operational Services, 31 March 2026	**High Priority**	**Action Status: Implemented** A final Change Management Framework v1.0 dated 21 July 2026 has been produced, together with supporting processes for identifying change leads and change champions. Our review noted evidence of change-support roles and activity in practice along with adoption-risk management. As such the action to complete the framework and identify change-support roles where resources allow is therefore implemented with the ongoing inclusion within future projects continuing to be resource dependant.

Jones,Bethan
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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 4	**Monitoring of Uptake.** Finding: 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. Agreed Action: At the time of the audit, there was a Clinical Digital Systems group implemented, that has a focus for reviewing system uptake and usage. This will be an important governance hierarchy led by Clinicians and in collaboration with Finance and digital leads. There is currently not a project management system tracking tool in place to ensure that a method of tracking utilisation is embedded in all future projects. This will be reviewed to support the outcome for a dashboard reporting and performance. Original Responsibility & Timescale: Head of Digital Programmes and Chief Nurse Informatics Lead, 31 March 2026	**Medium Priority**	**Action Status: Ongoing** A central project milestone tracker has been introduced. The tracker reviewed contained ten projects and records project status, completion, RAG, key risks and links to benefits and selected training information. We also identified project-level utilisation within DMC, ePMA and Digital Eyecare. The Digital Eyecare OPERAi dashboard records referral activity and shows that the system is being used. However, the corporate tracker itself does not include utilisation, uptake or adoption information and therefore does not provide the integrated view across live projects required by the agreed action. The action remains ongoing. We note that this action was recorded as complete within the Health Board's Audit Findings Tracker Report submitted to the Audit, Risk and Assurance Committee in July 2026. Management will need to contact the Corporate Governance team to ensure that the status of the action within the Audit Findings Tracker is adjusted to 'Partially Complete' so that it can be effectively monitored and reported through to full completion.

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Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 5	**Low Uptake and Lessons Learned.** Finding: 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. Agreed Action: 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. Original Responsibility & Timescale: Head of Digital Programmes and Assistant Directors of Operational Services, 31 March 2026	**Medium Priority**	**Action Status: Implemented** We identified lessons learned, monitoring of adoption risks and corrective action across the projects reviewed. In Digital Eyecare, the RAID log records an end-user uptake risk and a specific issue where referral guidance could reduce adoption; corrective action was taken and the issue was subsequently closed. The lessons-learned log also records adoption and implementation learning with actions and owners. DMC and ePMA provide further monitoring and post-go-live learning evidence. The evidence shows that low uptake is being identified, the reasons considered and action taken, which addresses the original finding. The action is implemented. Post-go-live evaluation arrangements will continue to bed in as current projects complete their lifecycle.

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Appendix B

Disclaimer

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Prioritisation of Findings

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

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Jones,Bethan
16/10/2026 09:57:45

Archwilio Cymru
Audit Wales

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

Date issued: October 2026

Jones,Bethan
16/10/2026 09:57:45

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16/10/2026 09:57:45

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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.

Jones,Bethan
16/10/2026 09:57:45

Introduction

This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board (the Health Board). We presented our most recent Audit Plan to the committee in May 2026.

We also provide additional information on:

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

Jones,Bethan
16/10/2026 09:57:45

Accounts audit update

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

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

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

- **Executive Lead:** Executive Director of Finance, Capital and Support Services and Deputy Chief Executive.
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Audit has been completed and final accounts submitted.
- **Committee date:** June 2026

Jones,Bethan
16/10/2026 09:57:45

Performance audit update

Review of arrangements for managing agency staff

- **Executive Lead:** Executive Director of People, Culture and Transformation
- **Focus of the work:** This work will review the Health Board's arrangements to manage agency staff use within mental health and learning disability settings. The exact scope of the work is still to be developed.
- **Status**: Final
- **Expected committee date:** October 2026

Review of urgent and emergency care

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

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

  We have also reviewed progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).
- **Status:** Part 1 – Reporting
- **Expected committee date:** Part 1 – January 2027, Part 2 reported at July 2026

Jones,Bethan
16/10/2026 09:57:45

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:** Draft report with the Health Board for clearance
- **Expected committee date:** January 2027

Structured Assessment 2026

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

Local work 2026 - Review of Workforce Planning Arrangements Follow Up

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

Jones,Bethan
16/10/2026 08:37:45

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

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

Jones,Bethan
16/10/2026 09:57:45

Other relevant publications

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

NHS digital: delivery not matching ambition | Audit Wales	September 2026

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

The Code of Audit Practice of the Auditor General for Wales | Audit Wales	July 2026
Annual Report and Accounts 2025-26 | Audit Wales	June 2026

There are no relevant Audit Wales consultations currently underway.

Jones Bethan
16/10/2026 09:57:45

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.

Jones Bethan
16/10/2026 09:57:45

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We welcome correspondence and telephone calls in Welsh and English.

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

James Reynan
16/10/2025 09:57:45

Archwilio Cymru
Audit Wales

Managing Agency Use – Powys Teaching Health Board

February 2026

Jones,Bethan
16/10/2026 09:57:45

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Audit snapshot

What we looked at

1 Our review has looked at whether the Health Board understands the factors driving demand for agency staffing. It has also looked at whether the Health Board is taking effective action to reduce agency staffing use and expenditure, particularly in high-cost areas.

Why this is important

2 NHS organisations rely on flexible staffing approaches, including temporary agency staff, to manage fluctuations in demand and staff availability. When effectively managed, agency staffing supports service continuity and offers flexibility for NHS workers. However, excessive reliance on agency staff can be costly and may compromise service quality, patient safety, and staff morale.

3 The Health Board's agency pay spend is an outlier in NHS Wales, with agency costs making up 8.5% of total pay in 2024-25, well above the national average of 2.4%. Continued reliance on agency staff (particularly by the Mental Health Directorate), including off-contract suppliers, is a major cost pressure and contributed to the Health Board's financial deficit of £15.8 million in 2024-25.

4 Agency spend continues to be a major cost pressure in 2025-26, with the Health Board's 2025-26 Annual Plan including a target to reduce agency expenditure by 30%, supporting broader goals for workforce sustainability and financial recovery.

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What we have found

5 The Health Board has a good understanding of the main factors driving its demand for agency staff. These include vacancies, sickness, high patient needs, rurality, recruitment challenges, and small-ward models. Its Mental Health Directorate faces the greatest pressure.

6 It regularly reviews data to see where agency use is highest. But data quality in e-rostering codes, and limited measurement of the impact of recruitment initiatives and other actions to reduce agency use continue to restrict insight.

7 Finance teams are good at tracking direct agency costs well, but the Health Board does not routinely measure indirect costs, and workforce and financial data are not fully integrated.

8 The Health Board has a clear plan to reduce agency use by strengthening recruitment, improving rostering, and redesigning services. Its use of international recruitment, targeted programmes, and new staffing models is having some positive success in reducing agency spend. But progress varies and high sickness, especially in its Mental Health Directorate, continues to drive agency use.

9 Oversight is strong, with regular reporting and challenge from committees and a director-led oversight group. Despite this, the Health Board has not yet achieved sustained reductions in its highest-cost areas.

10 The Health Board has strengthened procurement controls, reduced off-contract use, and is phasing out high-cost suppliers like Thornbury. However, agency use in the Mental Health Directorate is still high.

11 The Health Board has processes to manage agency risks and safeguard patients, but risks are not recorded consistently, and safety processes such as induction, supervision and incident analysis vary in quality. As a result, the Board lacks a full picture of risks and cannot always judge whether its actions are reducing agency demand or improving safety.

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What we recommend

12 We have made four recommendations which focus on:

- Improving the recording of agency risks.
- Introducing a programme of audits.
- Analysing agency related incidents.

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Key facts and figures

33.6% decrease in agency spend to £7.5 million in 2025-26, compared to £11.1 million in 2024-25.

5.3% of the total pay spend on agency staffing in 2025-26, compared to 8.5% in 2024-25, and 2.0% across Welsh health boards.

59.1% of agency use due to vacancies in 2025-26, with a further 22.9% due to activity pressures.

20.1% vacancies in medical establishment[1] (8.7% across Wales), 11.5% in registered nursing (3.0% across Wales), and 4.0% in unregistered nursing (8.8% across Wales) at the end of December 2025.

6.7% sickness absence in registered nursing, compared to 8.5% across Wales for October to December 2025.

105 vacancies in the Mental Health Directorate in April 2026, accounting for 19.9% of establishment, and 6.7% sickness absence for the rolling 12-month period.

64.5% of total agency use in April 2026 deployed in the Mental Health Directorate.

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[1] Based on a total medical establishment of 38.4 whole time equivalent

£6.9 million overspend in the Mental Health Directorate by the end of 2025-26 with agency costs a significant contributory factor.

19.2% increase in the use of bank staff in 2025-26, compared to 2024-25.

49.8% reduction in off contract use in 2025-26, compared to 2024-25.

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Our findings

Understanding agency demand and costs

The Health Board understands what drives agency use and costs, but inconsistent data and gaps in analysis restrict its ability to plan and respond effectively

Understanding factors driving agency use

13 The Health Board has a clear understanding of the main reasons driving its reliance on agency staff. Operational, workforce, and finance teams consistently identify the same structural and service-specific pressures that contribute to staffing gaps. These include persistent vacancies, sickness absence, high patient acuity, rurality, recruitment challenges in specialist areas, and the fragility of small ward models.

14 Reports and committee papers clearly describe these drivers, especially in the Mental Health Directorate. This service area faces the greatest and most persistent pressures because of long-standing workforce shortages and the high level of enhanced observations needed for patients. As a result, it uses agency staff more heavily than other services (64.5% of all agency use in April 2026).

15 The Health Board routinely analyses data to understand where and why services rely on agency staffing. Workforce dashboards, e-rostering information, and workforce and finance reports highlight patterns in vacancies, sickness, agency use, and bank fill rates. This helps the Health Board spot the wards most dependent on agency staff and track how pressures change over time.

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16 E-rostering reason codes (such as vacancy, sickness, and acuity) offer further insight by linking agency use to specific causes. Although coding quality varies between departments, improvements are underway and are beginning to support better analysis.

17 Regular workforce and finance reports also highlight high-cost areas and explain changes in demand. They give a clear picture of how staffing pressures drive agency use. These findings are shared with key committees, including the People and Culture Committee, Finance and Performance Committee, and Patient Experience, Quality and Safety Committee. This ensures the Health Board discusses and monitors the drivers of agency demand consistently.

18 However, the Health Board could improve how it links and maximises the use of its workforce, finance, acuity, and activity data. As these datasets are analysed separately, the Health Board does not always see how factors interact. For example, how changes in acuity or patient flow affect staffing needs. However, inconsistent data quality, particularly in e-rostering codes, reduces the accuracy of demand analysis. We discuss this further in paragraph 25.

19 While recruitment initiatives and improvements in sickness rates aim to reduce pressures that drive agency use, their impact is not routinely measured. Reports could also be strengthened by measuring and analysing the impact of specific actions and initiatives on reducing agency demand, both across the Health Board and within high-cost areas. We discuss this further in paragraph 34.

Understanding agency costs

20 The Health Board has a clear system for identifying and tracking the direct costs of agency staffing. Finance teams check pay rates, agency fees, enhancements, and other charges through monthly financial reports, giving the Health Board good visibility of agency spend.

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21 The Health Board analyses agency spending in detail, breaking it down by department, site, staff group, grade, specialty, and ward. This helps identify high-cost areas and understand where reliance on agency staffing is most significant. Mental health services consistently appear as the highest-cost area because of vacancies, sickness, and high patient acuity.

22 The Health Board also reviews short-, medium-, and long-term agency placements to understand whether costs stem from temporary pressures or longer-term workforce gaps. Overspends are routinely highlighted and explained in finance reports, which are escalated through the Finance and Performance Committee. The committee challenges cost trends and seeks assurance on actions being taken.

23 Finance and workforce teams link cost data with information on sickness, vacancies, acuity, and activity. This helps explain why agency staffing is rising or falling. E-rostering reason codes support this analysis, although inconsistent coding means the data is not always reliable.

24 However, the Health Board's understanding of agency costs has gaps. It does not routinely measure indirect costs, such as the impact on continuity of care, productivity, or supervisory workload. These issues are recognised but not quantified, limiting the organisation's ability to fully understand the wider financial impact of agency use.

25 As noted earlier, financial and workforce data is aligned, but not fully integrated. Reports are often presented separately, and combined analysis is limited. A more joined-up approach would give a clearer picture of how operational pressures drive agency costs. We were told that the new Financial Recovery Board set up in April 2026 would address this.

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Reducing reliance and spend on agency staff

The Health Board is reducing agency use through strengthened controls, but persistent pressures in some service areas prevent sustained improvements

Reducing reliance on agency staff

26 The Health Board has a clear plan to reduce its use of agency staff in line with its 2025-26 Annual Plan commitments. This plan includes workforce strategies, variable pay programmes, and service-specific action plans that set out how the organisation intends to lower agency use.

27 The plan focuses on strengthening recruitment, improving rostering, building a positive workforce culture, and redesigning services so they run more efficiently and rely less on temporary staff. High-cost areas, such as the Mental Health Directorate, receive particular attention because they depend heavily on agency staff.

28 The Health Board is trying to improve recruitment through international campaigns, the Aspiring Nurses programme, and targeted efforts for difficult-to-fill roles. It has also streamlined recruitment to reduce delays and improve the candidates' experience. Workforce reports cover vacancies and time-to-fill rates, so the Board can monitor and identify problem areas and prioritise recruitment. However national shortages, local labour pressures, and the complexity of specialist roles continue to make recruitment difficult, especially in the Mental Health Directorate, with the directorate reporting 19.9% vacancies in April 2026.

29 The Health Board has also tried alternative staffing approaches. This includes reconfiguring services, changing observation models, adjusting shift patterns, and redesigning roles to create more flexible teams. These actions aim to reduce reliance on agency workers, although their impact varies across departments.

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30 High sickness absence is also a reason for agency use, particularly in the Mental Health Directorate. The Health Board monitors sickness through dashboards and reports and offers occupational health and well-being services to improve attendance, reduce stress, and promote resilience. Although sickness has improved in some areas, it is still high in the Mental Health Directorate (6.7% in April 2026) and continues to increase demand for agency cover.

31 Governance for monitoring agency-reduction progress is strong. The Board and relevant committees receive regular updates on agency usage and workforce pressures. Reports provide detailed data on trends, and the director-led Variable Pay/Agency Oversight Group challenges progress against agreed milestones. Despite this oversight, the organisation has not yet achieved sustained reductions in its highest-cost areas.

32 Overall, the Health Board has made positive improvements in reducing its use of agency staff (achieving a 33.6% decrease in agency spend in 2025-26, compared to 2024-25) and increasing its use of bank staff. However, progress is uneven across service areas, such as the Mental Health Directorate, which continues to rely heavily on agency staff due to major workforce pressures, including vacancies, high sickness, and the need for enhanced observations.

33 The Health Board could strengthen how it evaluates and reports the impact of its actions. While reports analyse agency use, they do not always assess whether specific interventions, such as recruitment pipelines or service redesign, are reducing demand. A more structured approach would help identify what works and improve assurance provided to the Board.

34 In our 2025 structured assessment, we recommended that the Health Board should ensure it regularly reports more explicitly on the activity and impact of working groups which have been set up to mitigate financial pressures. This includes the director-led Variable Pay Working Group.

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Controlling agency use

35 The Health Board has recently strengthened its rules for using agency staff. It has a clear process for when agency staff can be booked, which requires staff to consider lower-cost options first, such as bank staff, redeployment, or changing the skill-mix.

36 Roles and responsibilities for approving agency use are clear. Every request requires executive approval, a completed form and escalation criteria, giving the Health Board a structured and auditable process. Clinical oversight is needed for out-of-hours decisions, providing an extra layer of control. Evidence from forms and authorisation emails shows these controls are working in practice. Work is underway to standardise forms and criteria across physical and mental health service areas.

37 At the time of our work, the Health Board had introduced a Standard Operating Procedure (SOP) which covers Health Care Support Worker (HCSW) agency staff. The SOP sets out several steps which wards should take before requesting the use of HCSW agency staff. This includes considering the redeployment of staff from other wards and the use of bank staff.

38 The Health Board tracks agency use centrally through e-rostering, monthly workforce reports, and finance checks. Finance business partners add enhanced scrutiny through invoice checks and detailed cost reports. This central oversight helps the Health Board check compliance, identify areas of concern, and challenge any unnecessary use of agency staff. The Variable Pay/Agency Oversight Group, Finance and Performance Committee, and Board-level finance reports regularly review agency use trends. Deep dives and exception reports provide added assurance to the Finance and Performance Committee.

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39 Despite these arrangements, agency use is still high and volatile in the Mental Health Directorate, where structural workforce pressures and high acuity often lead to rapid decision-making and reliance on agency staff. While high-cost areas are consistently identified, there is limited evidence of routine audits of compliance with the SOP or targeted interventions where controls are not being applied consistently.

Procuring and managing agency staff

40 The Health Board has strengthened its controls on agency procurement by introducing on- and off-contract rules, setting cut-off dates, and reducing the use of unqualified or off-contract agency staff. These steps form part of its wider financial control framework, which is regularly reported to the Audit, Risk and Assurance Committee and discussed by the Finance and Performance Committee and Executive Committee.

41 The Health Board manages its agency suppliers strategically. It uses national frameworks wherever possible and continues to reduce off-contract usage (it achieved a 46.3% reduction in 2025-26, compared to 2024-25). The Health Board has historically relied on high-cost suppliers such as Thornbury, largely due to rurality and remote service locations. This reliance is now being phased out through agreed deadlines and clear exception rules. Actions are already in place to cut Thornbury use except where there is an unavoidable clinical need.

42 The Health Board currently uses a mix of framework agencies and Thornbury. Although Thornbury is expensive, it is reliable, can fill shifts at short notice, and has not generated any safeguarding concerns. In contrast, some lower-cost framework agencies have caused more quality and safety issues, including Section 5 incidents[2]. This reinforces the need to select suppliers based on overall value and safety, not cost alone.

[2] Section 5 incidents generally refer to a category within the National Patient Safety Incident Reporting Policy that focuses on specific, serious, and often systemic issues requiring high-level oversight and investigation.

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Managing risks and patient safety

The Health Board has processes to manage agency risks and safeguard patients, but inconsistent recording, oversight and incident analysis weaken overall assurance

Managing agency staffing risks

43 The Health Board has processes to identify and manage risks linked to agency staffing. These risks include continuity-of-care issues, skill-mix problems, and reliance on temporary workers. Although operational and corporate levels recognise these risks, they are not always recorded consistently in the appropriate risk registers. This inconsistency limits the Health Board's ability to see the full picture of agency-related risks across services and manage them effectively.

44 Some directorates record agency-related risks clearly and keep their entries updated, but others do not. The risks are most significant in high-cost areas, such as the Mental Health Directorate, where high agency usage, high sickness rates, high acuity, and the need for enhanced observations create a complex risk environment. Even though these risks are known, staff are not always reflecting them fully in risk registers.

45 Where risks are recorded, risk registers often describe the required actions, the person accountable and expected completion dates. These actions often relate to recruitment, improved rostering, enhanced supervision, or stronger induction and oversight of agency staff.

46 Where risk management is well embedded, staff update actions regularly, showing that risks are being managed proactively. However, this is not consistent across the Health Board. In high-cost areas, such as the Mental Health Directorate, actions are recorded at a high level without enough detail, or updates are infrequent. This makes it difficult to assess progress or confirm whether risks are under control.

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47 The Health Board has governance arrangements to support oversight of agency-related risks. Relevant committees receive regular updates on workforce pressures, agency use, and associated risks. These reports outline emerging issues and the actions being taken to address them. The Board also receives additional assurance through the Nurse Staffing Act report, which highlights safe staffing risks and temporary staffing levels in areas covered by the Act.

48 However, these reporting arrangements do not always provide a consolidated or thematic overview of risk. As a result, the Board may not get a complete picture of how agency staffing risks are developing across the organisation. This gap reduces the Health Board's ability to monitor risks effectively and ensure that mitigating actions are targeted and proportionate.

Safeguarding patient safety

49 The Health Board has several processes to ensure agency staffing does not put patients at risk. These include mandatory pre-employment checks, local induction, supervision, and clear ways to raise concerns. While these arrangements are generally strong, they are applied less consistently in high-cost areas, such as the Mental Health Directorate, where agency use is highest.

50 The Health Board requires agencies to complete all NHS pre-employment checks before agency staff begin work. These checks cover identity verification, right-to-work, professional registration, employment history, and training compliance. Operational teams report confidence in the reliability of these checks, and the Health Board acts quickly if concerns arise. However, the Health Board relies too heavily on agency assurances and rarely carries out its own spot-checking or audit.

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51 Most services provide agency workers with a local induction that covers the ward, procedures, communication routes, documentation, and key safety expectations. Staff said that agency workers usually receive this induction, but the level of detail varies depending on workload and how often the service uses agency staff. In the Mental Health Directorate, where agency staff can be brought in at short notice to support enhanced observations, induction is brief and focused on immediate safety needs. This approach works in practice but increases the need for strong supervision and clear communication.

52 Ward managers and senior nurses oversee the day-to-day work of agency staff and escalate concerns through established professional concerns processes. Managers provide feedback to longer-term agency workers, especially in the Mental Health Directorate. However, agency workers are not part of formal appraisal processes, and performance oversight is still informal. This limits the Health Board's ability to track performance consistently over time.

53 The Health Board records and reviews incidents involving agency staff using the standard incident reporting system. It escalates concerns through the Professional Concerns Policy and removes agency staff from use when necessary. However, the Health Board does not routinely carry out thematic analysis of these incidents. Without this wider analysis, recurring issues or emerging risks may go unnoticed, especially in high-cost areas such as the Mental Health Directorate, where agency use is high.

54 Committees receive updates on workforce pressures, safe staffing, and quality indicators, but reporting on agency-specific incidents is limited. Reports do not routinely highlight trends or risks linked to agency staff. As a result, the Health Board may not always see the full impact of agency staffing on patient safety. Improving the visibility and analysis of agency-related incidents would strengthen assurance and support better decision-making.

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Recommendations

R1 Ensure all agency related risks are clearly identified and recorded in directorate and corporate risk registers, supported by appropriate controls and mitigating actions, and monitored and reviewed regularly by senior management teams (**paragraphs 43 - 46**).

R2 Introduce a programme of routine audits which checks completion of pre-employment checks by agencies. Findings of the audits should be reported to the relevant operational, executive, and Board-level committees (**paragraphs 49 - 50**).

R3 Strengthen thematic reviews of incidents to include those where the use of agency staff is a contributory factor and report emerging themes to the relevant operational, executive, and Board-level committees (**paragraph 53**).

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Appendices

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1 About our work

Scope of the audit

We have assessed whether the Health Board has effective arrangements in place to understand, manage, and reduce its reliance on agency staffing and the associated costs.

We carried out the work between May and November 2025.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a comprehensive understanding of the factors driving its demand for agency staffing, particularly in high-cost areas?
- Does the Health Board have effective arrangements in place to reduce its reliance and spend on agency staffing, particularly in high-cost areas?
- Does the Health Board have effective arrangements in place to manage risks and maintain quality and safety when using agency staff, particularly in high-cost areas?

Criteria

We shaped our audit questions by:

- previous audits we have undertaken focused on workforce, including reviews of temporary staffing and our 2023 Review of Workforce Planning Arrangements.
- actions set out in the Agency Workforce Reduction Programme and Control Framework 2024-2025.

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Methods

We reviewed a range of documents, including:

- Risk Registers
- Financial Performance Reports
- Nursing Establishment Reports
- Policies, Procedures and Protocols.
- Audit Programmes

We interviewed the following Health Board officers:

- Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
- Executive Director of People and Culture
- Executive Director of Primary, Community Care & Mental Health
- Director of Corporate Governance
- Executive Director of Nursing, Quality, Women and Family Health; and
- Head of Mental Health Nursing, Quality and Safety

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2 Management Response Form

Recommendation		Commentary on planned actions	Completion date	Responsible officer
R1	Ensure all agency related risks are clearly identified and recorded in directorate and corporate risk registers, supported by appropriate controls and mitigating actions, and monitored and reviewed regularly by senior management teams.	Working with Quality & Safety, Nursing and operational directorates, the Health Board will review how agency-related risks are currently identified, recorded, and managed. Material risks will be captured within existing service, directorate or corporate risk arrangements and escalated in line with the Health Board's risk management framework. Standard risk descriptions, controls, and mitigating actions will be developed where helpful. Relevant risks will be reviewed quarterly through existing senior management arrangements, with operational ownership remaining with the relevant directorate.	30 September 2026 Process established; quarterly review thereafter	Heads of Nursing – W&C, CSG & MHLD, Clinical Director MHLD, Head of Therapies - CSG Nursing Directorate / Quality & Safety

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Recommendation		Commentary on planned actions	Completion date	Responsible officer
R2	Introduce a programme of routine audits which checks completion of pre-employment checks by agencies. Findings of the audits should be reported to the relevant operation, executive and Board-level committees.	The Temporary Staffing Unit will establish a quarterly, risk-based audit of a proportionate sample of agency workers recorded on Allocate against the pre-employment requirements of the All-Wales Framework, including right to work, DBS clearance where applicable, professional registration and occupational health clearance. Any exceptions will be followed up with the supplying agency and corrective actions tracked. Findings will be reported through existing governance routes, with significant or recurring non-compliance escalated to the relevant Executive and Board-level committees.	30 September 2026 Audit process established First audit by 31 December 2026	Resourcing Manager
R3	Strengthen thematic reviews of incidents to include those where the use of agency staff is a contributory factor and	The existing agency concerns process will be strengthened with Quality & Safety to ensure relevant Datix incidents and directly reported concerns are consistently identified and brought together for review.	30 September 2026 Review process established	Quality & Safety / Resourcing Manager

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Recommendation	Commentary on planned actions	Completion date	Responsible officer
report emerging themes to the relevant operational, executive, and Board-level committees.	A quarterly thematic review will identify trends, recurring issues, contributory factors, and learning, including where agency deployment may have contributed through factors such as induction, continuity, familiarity with the service, supervision, or skill mix. Material themes and actions will be shared with operational managers and reported through existing governance routes, with significant issues escalated to Executive and Board-level committees.	First thematic review by 31 December 2026	

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

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Agenda item: 5.5

AUDIT RISK AND ASSURANCE COMMITTEE	**22 OCTOBER 2026**
Subject:	Counter Fraud Update Report
Approved and presented by:	Hywel Pullen, Interim Director of Finance / Neil Jones, Interim Head of Counter Fraud
Prepared by:	Head of Counter Fraud (Interim)
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this report is to provide the Audit, Risk and Assurance Committee with assurance regarding the delivery of the Counter Fraud Work Plan 2026/27 (Appendix 1), including progress made, key activities undertaken, and significant counter fraud developments during the reporting period (Quarter 1).

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

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EXECUTIVE SUMMARY:
The Counter Fraud Update Report provides the Committee with an update on key activities and developments delivered against the Counter Fraud Work Plan for 2026/27. The report has been prepared in accordance with the requirements of the NHS Counter Fraud Standards and the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

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Item 5.5

Counter Fraud Update Report

22 October 2026

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1. INTRODUCTION

The purpose of this report is to update the Audit, Risk and Assurance Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists since the last meeting.

2. BACKGROUND

Regular meetings are held with the Director of Finance to provide oversight of progress against the annual Counter Fraud Work Plan, review emerging and significant risks to the Health Board, and monitor the Local Counter Fraud Specialist (LCFS) case workload.

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below.

Strategic Area	Resource Allocated For FY 2026/27	Resource Used from April 2026
Strategic Governance	**45**	**23**
Inform and Involve	**60**	**9**
Prevent and Deter	**103**	**17**
Hold to Account	**100**	**47**
TOTAL	**308**	**96**

4. STRATEGIC GOVERNANCE

The Counter Fraud Functional Standard Report 2025/26 has received formal approval from both the Chair of the Audit, Risk and Assurance Committee (ARAC) and the Director of Finance (DoF). Following approval, the report was submitted to the NHS Counter Fraud Authority (NHSCFA) and has been accepted, providing assurance that the Health Board has met the required reporting obligations.

5. INFORM AND INVOLVE

The Counter Fraud Team has continued to engage proactively with Health Board managers and key partners to deliver face-to-face and Teams fraud awareness training, helping to strengthen understanding of fraud risks and prevention measures across the organisation.

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In addition, the Team has made effective use of the Employee Engagement Platform, Viva Engage, to further promote a positive counter fraud culture within the Health Board. This has included the publication of monthly newsletters, awareness campaigns, and informative blogs designed to keep staff informed of emerging fraud risks and lessons learned from Court cases.

The Team is also exploring opportunities to further develop the use of Artificial Intelligence (AI) as an innovative platform to enhance staff engagement and awareness. This includes carefully assessing how AI can support the delivery of counter fraud messaging, provide accessible learning opportunities, and increase understanding of the impact that fraud has on both the Health Board and the wider NHS. Through these initiatives, the Team aims to strengthen fraud resilience and further encourage a culture in which fraud prevention is everyone's responsibility.

6. PREVENT AND DETER

During a recent presentation delivered by the NHS Counter Fraud Authority (NHSCFA), advice and guidance was provided regarding the utilisation of a Fraud Prevention Figure (FPF) formula. The NHSCFA methodology, which is currently adopted and reported upon by a number of Health Boards across Wales and England, offers a straightforward and consistent approach to performance reporting by converting an identified fraud loss into a quantified estimate of future losses avoided through counter fraud intervention. The underlying principle is that, where an ongoing fraud has been detected and stopped, it is reasonable to assume that the offending would have continued for a further period had it not been identified. Consequently, the formula seeks to demonstrate the value of counter fraud activity by calculating a reported prevention figure, in addition to the actual loss identified.

The formula and accompanying example is set out below:

For a Detected Fraud:
Total detected fraud ÷ duration of offending (months) = **monthly fraud value**
Monthly fraud value × 12 = **fraud prevention figure**

Example of Fraud prevented calculation:

A nurse has submitted false claims for expenses over a **14 month period**. The total value of the false expenses was **£15,000.**

£15,000 ÷ by **14 months** = **£1,071** is the monthly value of the fraud.
£1,071 × by **12 months** = **£12,852** is the preventive figure that can be recorded

Fraud prevention is notoriously difficult to quantify because it involves measuring events that never happen. This formula provides a tangible measure of benefit.

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Work on the Health Board's matched data sets released by the National Fraud Initiative is about to commence. The initial emphasis will is on issues which identify dual employment between the Health Board and other public sector organisations. This has been highlighted previously due to the continuous agile working

opportunities. This is an area of fraud risk, which continues to be emphasised following the Covid-19 pandemic.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised below. A summary of basic investigation KPI data is presented at outset of the appendix.

The case data is presented with the information, which is currently available and accessible. This data displays those cases which are open and active; contained in the Open Cases table.

Reference	Date Commenced	Title	Type
INV/26/01538	11/05/2026	Op Vortex - GP Practice Diversion Fraud (LCFS/CFS/DPP)	AI Banking Fraud
INV/25/03210	30/10/2025	Op Ziggy 2 - Employee working elsewhere during contracted hours (CFS)	Employee
INV/25/03419	18/11/2025	Working whilst sick	Employee
INV/25/01130	01/04/2025	False representation – Volunteer Public member Validation	Non-NHS Staff

Closed Cases Table

Reference	Date Commenced	Title	Type
INV/24/00525	04/03/2024	Working Elsewhere Whilst Sick	Staff
INV/24/03253	17/12/2024	Working Elsewhere	Employee
INV/25/00156	21/01/2025	Prescription Fraud	Patient
INV/25/00902	24/03/2025	Diversion of Practice Funds / Abuse of Position	Contractor
INV/25/01519	02/06/2025	Abuse of Position	Employee
INV/25/01520	02/06/2025	Working Whilst on Sick	Employee
INV/25/01522	20/05/2025	Working Whilst on Sick	Employee
INV/25/01838	30/06/2025	Abuse of Position	Employee
INV/25/02728	16/09/2025	Working Elsewhere Whilst in Receipt of Occupational Sick Pay	Employee
INV/25/03024	14/10/2025	Claiming overtime when no evidence of work completed.	Employee
INV/25/03210	30/10/2025	Consultant working elsewhere during contracted hours	Employee
INV/25/03391	13/11/2025	Over claimed Travel Expenses	Employee
INV/25/03419	18/11/2025	Working whilst sick	Employee
INV/26/00528	16/02/2026	Forged Prescription	Patient
INV/26/00768	02/03/2026	Fraudulently prescribing medication	Employee

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8. GOVERNANCE AND RISK ISSUE

The attached Counter Fraud Risk Report **(Appendix 2)**, together with the new Terms and Conditions for Resident Doctors and Dentists (Wales) **(Appendix 3**), highlights an increased financial risk to the Health Board. The report provides an overview of the identified concerns and the potential impact of this increased level of risk.

These concerns have been escalated to the relevant Health Board senior management teams, as well as the Head of Counter Fraud Services (Wales).

The report and its findings provide reasonable assurance that appropriate processes and controls have been implemented to mitigate the identified risks. In addition, further actions have been discussed to strengthen existing controls and provide enhanced assurance. These proposed actions are currently being considered by the relevant regulatory body.

9. RECOMMENDATION

The Audit Committee is asked to **Note** the Counter Fraud Progress Report.

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Counter Fraud Work Plan 2026/27

R Neil Jones
Interim Head of Counter Fraud Services
May 2026

Jones,Emma
16/10/2026 09:57:45

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Introduction

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

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 208 and reactive days - 100 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.

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INFORM AND INVOLVE			
The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.			
TASK/OBJECTIVE		**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
I&I.1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	GovS 013 component 11	Throughout the Year
I&I.2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	GovS 013 component 11	Throughout the Year
I&I.3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	GovS 013 component 11	Q2 and Q4
I&I.4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	GovS 013 component 11	Throughout the Year
I&I.5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	GovS 013 component 11	Throughout the Year

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The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.			
TASK/OBJECTIVE		**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
I&I.7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other "beware" notices and relevant messages.	GovS 013 component 11	Q2 and Q4
I&I.8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	GovS 013 component 11	Q2
I&I.9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	GovS 013 Components 4, 7 and 12	Throughout the Year
I&I.10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 Components 7 and 12	Throughout the Year
	TOTAL DAYS ALLOCATED	**60**	

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COUNTER FRAUD WORK PLAN 2026/27

PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.1	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 GovS 013 component 10	As Appropriate
P&D.2	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
P&D.3	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year

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COUNTER FRAUD WORK PLAN 2026/27

PREVENT AND DETER

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The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.4	Review existing fraud risk assessments with Risk Owners.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5 FR01, FR02, FR03, FR04, FR05, FR06, FR07, FR25, FR34, FR59	Q2
P&D.5	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010.	GovS 013 component 12	Q2
P&D.6	Utilise National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10	Q2
P&D.7	Finalise fraud risk assessment around identified issue of False International English Language Testing System Certificates (IELTS)	FPN H-005-23	Q2

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COUNTER FRAUD WORK PLAN 2026/27

PREVENT AND DETER

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TASK/OBJECTIVE		RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.8	Finalise fraud risk assessment centred on falsifying timesheets and expense claims	FPN – L-001-25	Q2
P&D.9	Finalise fraud risk assessment in relation to Mental Health Act s.12 Assessments claims	FPN – M-002-25	Q2
P&D.10	Review both FR08 & FR09 around updated issue of Mandate Fraud. Seek to amalgamate both risks into one comprehensive risk assessment to streamline future review of this ever evolving fraud risk	FPN – L002-23	Q1
P&D.11	Review FR22 in response to the identified issue of CEO/Unsolicited Payment Requests	FPN-M001-24	Q1
P&D.12	Review and update information sharing protocols currently in place.	Service level	Q1
P&D.13	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Service level	Throughout the Year
P&D.14	Record and respond to ad-hoc requests for assistance received.	Service level	Throughout the Year

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PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
TASK/OBJECTIVE		**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.15	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
P&D.16	Issue of fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
P&D.17	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level	Throughout the Year
P&D.18	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	GovS 013 component 10	Throughout the Year
P&D.19	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required

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PREVENT AND DETER

The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified.

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.

	TASK/OBJECTIVE	RISK/FPN/STANDARD	PROPOSED DELIVERY
P&D.20	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line.	GovS 013 component 10	Throughout the Year
P&D.21	Membership of Local Intelligence Network and attendance at meetings.	Service level	As Required
	TOTAL DAYS ALLOCATED	**103**	

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HOLD TO ACCOUNT			
The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. **The organisation must have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.** **The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA.**			
TASK/OBJECTIVE		**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
HTA.1	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As Required
HTA.2	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 GovS 013 component 8	As Required
HTA.3	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	GovS 013 component 9	As Required
HTA.4	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	GovS 013 component 6 GovS 013 component 9	As Required
HTA.5	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	GovS 013 component 6 GovS 013 component 8	As Required

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HTA.6	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1
	TOTAL DAYS ALLOCATED	**100**	

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STRATEGIC GOVERNANCE

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation.

The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.1	Attendance at all Fraud Forum meetings held by CFS Wales.	Service Level	As Required
SG.2	Completion and agreement of the annual work plan with Director of Finance.	GovS 013 component 2	Q4
SG.3	Completion and agreement of the annual report with Director of Finance.	GovS 013 component 5	Q1
SG.4	Regular meetings/liaison with Director of Finance.	GovS 013 component 1	Throughout the Year
SG.5	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
SG.6	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service Level	Q4 and As Required
SG.7	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service Level	As Required

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STRATEGIC GOVERNANCE

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The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.

TASK/OBJECTIVE			PROPOSED DELIVERY
SG.8	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	GovS 013 component 8	Throughout the Year
SG.9	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	GovS 013 component 6	Throughout the Year
SG.10	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 GovS 013 component 7	Q2
SG.11	Attendance at Counter Fraud Joint Working Group monthly meetings.	Service Level	Throughout the Year
	TOTAL DAYS ALLOCATED	**45**	

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SUMMARY TOTALS		
	STRATEGIC AREA OF ACTIVITY	**RESOURCE ALLOCATED (in days)**
A	**INFORM AND INVOLVE**	60
B	**PREVENT AND DETER**	103
C	**HOLD TO ACCOUNT**	100
D	**STRATEGIC GOVERNANCE**	45
	TOTAL	**308**

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Appendix 2

Counter Fraud Risk Report

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Powys Teaching Health Board
Counter Fraud Risk Report

There has been an increased level of risk to the Health Board arising from the implementation of the new Terms and Conditions for Resident Doctors and Dentists (Wales), as detailed in Appendix 3.

The attached documentation was reviewed by the Counter Fraud team, following concerns raised by a Health Board Service Director, whereby it appeared that no formal Counter Fraud consultation or fraud risk assessment had been undertaken as part of the development and implementation process. The potential financial implications of the new arrangements, in addition to the possible fraud, bribery and corruption risks, associated with the claiming of unverified and unauthorised additional overtime payments were considered high.

In particular, concerns relate to the governance arrangements surrounding claims for additional pay. Point 42 states:

"It is expected that all submissions for additional pay are accurate and genuine. Whilst the host organisation will have internal governance measures in place and an individual with responsibility for authorising the roster, no separate clinical supervisor sign-off will be required. Therefore, claims will not ordinarily be scrutinised or queried prior to payment. Where the payroll team has concerns regarding whether a claim is genuine, this should be forwarded to the Guardian of Safe and Flexible Working for review, and if required, further investigation."

Whilst the expectation that claims will be accurate and genuine is clearly stated, the absence of a defined verification process or independent assurance mechanism raises concerns regarding the adequacy of controls designed to prevent, detect and deter fraudulent or erroneous claims. It is not clear what governance measures will be consistently applied across the three Health Boards, nor how assurance will be obtained that the hours claimed have actually been worked.

Further concern arises from point 45, which states:

"Deliberately fraudulent claims will be considered a conduct issue and dealt with in accordance with procedures contained in Upholding Professional Standards in Wales."

Whilst disciplinary action may be an appropriate response to proven misconduct, the wording appears to focus on the consequences of fraud rather than the preventative and detective controls required to identify, prevent and mitigate the risk of fraud occurring in the first instance.

Furthermore, the explicit reference to "fraudulent claims" acknowledges the potential for dishonest claims to be submitted. By definition, a fraudulent claim involves an element of dishonesty and may meet the criteria of an offence under the Fraud Act 2006, particularly where an individual knowingly makes a false representation for financial gain.

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Given this recognised risk, it is noted that the Terms and Conditions appear to place greater emphasis on managing cases after a fraudulent act has occurred, other than on establishing robust preventative governance arrangements, assurance mechanisms and verification controls to reduce the likelihood of such claims being submitted and paid in the first place.

With the current financial pressures across NHS Wales, there is a need for clear, consistent and unambiguous governance arrangements that can be applied uniformly across all service groups and divisions within each Health Board. In the absence of such arrangements, there is a risk that managers and other staff responsible for authorising claims may be placed in a vulnerable position and could be exposed to allegations relating to inappropriate authorisation practices, conflicts of interest, or potentially bribery and corruption.

The new *Fighting Fraud* Strategy clearly sets out an ambition to move towards a more preventative and risk-based approach to countering fraud. As a result, a request was submitted seeking clarification as to whether a formal counter fraud consultation and fraud risk assessment had been undertaken during the development of the new Terms and Conditions.

In response, it was confirmed that neither the NHS Counter Fraud Service (Wales) nor the NHS Counter Fraud Authority (NHSCFA) were consulted or involved in fraud-proofing either the Welsh or English versions of the Terms and Conditions.

A meeting was subsequently held between the Head of Counter Fraud (Wales) and senior managers from NWSSP's Single Lead Employer Programme for Resident Doctors to discuss this matter.

The current assessment is that the overall fraud risk associated with the new Terms and Conditions is low. The area identified as presenting the highest relative risk relates to additional hours worked outside the Job Plan, including exception reporting, breach reporting, and any associated overtime payments.

It was confirmed that existing arrangements for managing concerns relating to criminality, fraud, and professional conduct will remain unchanged. Where criminal activity is suspected, matters will continue to be referred directly to the Police. Allegations of suspected fraud will be referred to the relevant Local Counter Fraud Specialist (LCFS) or the NHS Counter Fraud Service (Wales), depending on the scale, value, and nature of the concern. Professional conduct issues will continue to be managed through the appropriate GMC or GDC reporting processes.

In relation to the Terms and Conditions (Appendix 3), existing controls include review of exception reports by the relevant Health Board Guardian, with additional oversight provided by the NWSSP Guardian. This will include review of the pre-agreement and authorisation of overtime claims, while Rota Coordinators will undertake further review prior to sign-off and payment.

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A six-month review point has been proposed, at which time NWSSP will provide an update to enable the fraud risk assessment to be revisited and reviewed in light of any emerging issues, trends, or concerns.

Terms and Conditions of Service

Resident Doctors and Dentists (Wales)

Version 1 – August 2026

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Agreed July 2026

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Definitions

Acting Down	Acting down is where a resident is requested by their employer to cover the duties of a more junior colleague within their contracted working hours, although it may extend to covering the duties of a more junior colleague during unplanned additional hours. This definition does not apply, however, where the resident undertakes duties as part of their normal workload which a more junior resident might be competent to undertake, nor does it apply where a resident agrees to undertake locum work at a more junior level.
Additional NHS responsibilities	Additional NHS Responsibilities means special responsibilities within the employing organisation not undertaken by the generality of residents, which are agreed between the resident and the employer, and which cannot be absorbed by the other activities detailed in the job plan. These could include, being a rota co-ordinator, clinical manager, clinical audit lead or clinical governance lead. These additional responsibilities should be specified in the personalised job plan.
Base Location	The base location is the hospital or training location (for those in a community training environment), during a rotational training programme, which is closest to the resident doctor's or dentist's home address. The residents base location will change when programmes change i.e. moving from foundation to core, and core to specialty. (This should not be confused with work base as defined below).
Caring obligations	Significant responsibilities to care for another person, whether solely or as part of a group (for example of family members). This may include but is not limited to acting as a carer for a child or an ill or disabled family member.
Director of Medical Education (DME)	The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education, ensuring that residents receive a high-quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education and Improvement Wales (HEIW). The

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	DME is responsible for delivering the educational contract. For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME. In some organisations the DME role is carried out by or called an Associate Medical Director or equivalent
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Duty roster	The prospective working pattern and range of duties expected for each individual resident on a rota for that rotation.
Educational review	An educational review is a formative process which enables residents to receive feedback on their performance and to reflect on issues that they have encountered. Residents will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the job plan.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Employment Management Agreement (EMA)	Agreement Relating to the Employment of Foundation Doctors, Foundation Dentists, Trainee Pharmacists, Medical and Dental Core Trainees and Specialty Medical and Dental Training Registrars and Specialty General Practice Registrars in Wales Between Velindre University NHS Trust (On behalf of NHS Wales Shared Services Partnership) as the Single Lead Employer and Health Boards/Trusts.
Employer	The organisation the Resident is employed by, i.e. detailed on the contract of employment.

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Fixed Leave	Fixed leave is residual leave which is allocated to an individual resident after requests for leave have been accommodated as best as possible.
Flexible (Part Time) (FPT)	Resident employed on a contract that is less than full time.
Guardian of safe and flexible working (GOSFW)	A senior appointment made jointly by the employer / host organisation and residents, who ensures that issues of compliance with safe working hours are addressed, flexible working is promoted and provides assurance to the Board of the employing organisation that residents' working hours are safe. This description is not exhaustive.
Gold guide	The Gold Guide as referenced in these TCS, refers to the document entitled A reference guide for postgraduate specialty training in the UK3 as amended from time to time. A separate Gold Guide for dental training entitled A Reference Guide for Postgraduate Dental Specialty Training in the UK (or any successor document) should be referred to with regard to dental training programmes.
Host Organisation	An organisation where a resident is deployed to work in a post for a fixed period of time under a lead employer arrangement. The employer can also be, but is usually not, the host organisation.
Integrated clinical academic pathway	Integrated clinical academic pathway combines both clinical and academic components within one training programme (this includes The Wales Clinical Academic Track, GP academic training and those defined under the auspices of the National Institute for Health and Care Research (NIHR)).
Job Plan	A job plan is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the resident, education and development time, periods of formal study (other than study leave), the number and distribution of hours for which the resident is contracted shift types and minimum staffing levels on each shift.
Job Plan Review	A job plan review is a formal process by which changes to the job plan may be suggested and/or agreed. A job plan review can be triggered by one or more exception reports, or by a request from either the resident or the employer. A job plan review should

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	consider safe working, working hours, educational concerns and/or issues relating to service delivery.
Long shift	For the purposes of these TCS, a long shift is any shift that exceeds 10 hours in duration.
NHS Wales Policy	Policies approved through Medical and Dental Business Group as the body authorised through the Welsh Social Partnership Structure for collective bargaining. NHS Wales Policies approved via this group form part of the National Terms and Conditions unless otherwise stated.
On-call	A resident is on call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A resident carrying an 'on call' bleep whilst already present at their place of work as part of their job planned duties does not meet the definition of on-call working. This is fully defined within the terms and conditions.
On-call period	An on-call period is the time that the resident is required to be on-call (as defined above) by their employer.
Period of grace	6 months of continued employment after a resident has successfully completed their specialist training. Periods of grace are not applicable to GP Registrars.
Placement	For the purposes of these TCS, a placement is a setting into which a resident is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the job plan.
Post	For the purposes of these TCS, a post has approval by the GMC/HEIW for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Predictable on-call work	Routine activities which will occur at specific times during an on-call duty period. This may include, but is not limited to, ward rounds, anticipated duties and clinical handovers. Such activities, along with the expected hours of work required, should be specified within a Job Plan.
Professional leave	Professional leave is leave in relation to professional work.

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Professional work	Professional work is work done outside of the requirements of the curriculum and/or the employer/host organisation for professional bodies such as Royal Colleges, Faculties or the GMC/GDC. Nontrade union activities undertaken by for a recognised trade union, for example work on an Ethics Committee would count as professional work, however trade union duties and activities are covered through the All-Wales Recognition Agreement.
Public holiday	Holidays recognised by the NHS in Wales. Currently, these are: New Year's Day; Easter Friday (also known as Good Friday); Easter Monday; the two May bank holidays; the August bank holiday; Christmas Day and Boxing Day. This will also include additional bank holidays as and when they arise.
Regulator	General Medical Council or General Dental Council (for dental programmes) or any other relevant body.
Resident	Wherever 'resident' is used in these terms and conditions, it is intended to mean (i) a doctor or dentists in an approved postgraduate training programme under the auspices of HEIW, or (ii) or a locally employed doctor or dentist (LED) who has signed a Contract and Statement of Main Particulars for Locally Employed Doctors (Wales) with the exception of any provisions of these Terms and Conditions that exclusively apply to those in an approved postgraduate training programme as these do not apply to an LED.
Rota	The working pattern of an individual resident or group of residents.
Rota cycle	The number of weeks activity set out in a rota, from which the average hours of a resident's work and distribution of those hours is calculated.
Rotation	A rotation is a series of placements made by HEIW into posts with one of more employers or host organisations. These can be at one or more locations.
Shift	The period which the employer schedules the resident to be at the workplace performing their duties, excluding any on-call duty periods.
Single lead employer	The organisation that issues and holds the contract of employment for residents in recognised training programmes throughout their training programme,

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	during which the resident may be deployed into one or more host organisations. This is currently Velindre University NHS Trust.
Study leave	Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum and personalised training objectives. This will include regional educational events where the time is protected.
Training programme	Training programmes and training posts are approved by the GMC or GDC (for dental programmes). Learning environments and posts used for training are recommended for approval by HEIW for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the resident to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).
Unpredictable on-call work	Unscheduled activities that occur at unspecified times during an on-call duty period, including but not limited to telephone calls, actively awaiting urgent results or updates and travel time arising from any such calls.
Work Base	The place of work from which the resident conducts their main duties. Where a resident has a joint contract with more than one employer, the term 'work base' means the place from which the resident conducts their main duties within that joint contract, irrespective of employer. (This should not be confused with base location as defined above).
WTR Reference Period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

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Abbreviations

ACAS	Advisory, Conciliation and Arbitration Service
ARCP	Annual Review of Competence Progression
BMA	British Medical Association
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
DCT	Dental Core Trainee
DST	Dental Speciality Trainee
DME	Director of Medical Education
EDT	Educational Development Time
EMA	Employment Management Agreement
F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
FPT	Flexible (Part-Time)
FPCC	Foundation Programme Certificate of Completion or equivalent
GDC	General Dental Council
GMC	General Medical Council
GOSFW	Guardian of safe and flexible working
GP	General Practitioner
HEIW	Health Education and Improvement Wales
HR	Human Resources
JLNC	Joint Local Negotiating Committee
LED	Locally Employed Doctor
LNC	Local Negotiating Committee
MDBG	Medical and Dental Business Group
MH	Mental Health
NHS	National Health Service
NWSSP	NHS Wales Shared Services Partnership
OMFS	Oral and Maxillofacial Surgery
OOH	Out of Hours
OOP	Out of Programme
PIDA	Public Interest Disclosure Act 1998

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PGME	Postgraduate Medical Education
PP	Pay premium / premia
RDF	Resident Doctor Forum
RRP	Recruitment and Retention Premia
SLE	Single Lead Employer
StR	Speciality Registrar
TCS	Terms and Conditions of Service
TOIL	Time Off In Lieu
TPD	Training Programme Director
UPSW	Upholding Professional Standards Wales
WRDC	Welsh Resident Doctors Committee
WTE	Whole Time Equivalent
WTR	The Working Time Regulations 1998 (as amended)

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Schedule 01
General duties and responsibilities

1. Doctors and Dentists have clinical and professional responsibility for their patients (for doctors in public health medicine, this is for their population) as set out in the General Medical Council (GMC) guidance Good Medical Practice [1]or any successor documents, as amended or substituted from time to time.

   It is the duty of a doctor or dentist:

   a. to maintain professional standards and obligations as set out by the GMC and the General Dental Council (GDC), as appropriate
   b. to keep patients (and/or their carers, if appropriate) informed about their condition
   c. to involve patients (and/or their carers, if appropriate) in decision-making about their treatment
   d. to maintain the required level of skills and knowledge, and
   e. to protect patients and colleagues from any risk posed by their own health or fitness to work.

2. A resident is responsible for carrying out any work related to, or reasonably incidental to, the duties set out in their job plan, such as:

   a. the keeping of records and the provision of reports
   b. the proper delegation of tasks, and
   c. other related duties.

3. Residents will be expected to be flexible and to cooperate with reasonable requests to cover for their colleagues' absences where the resident is competent to do so, and where it is safe and practicable for the resident to do so and the individual is happy to provide cover. Other options for cover which employer/hosts can explore would include locum cover or a senior colleague acting down.

4. Where residents carry out work in accordance with paragraph 3 and such work takes place outside of their contracted hours, they will receive either an equivalent off-duty period in lieu or appropriate remuneration at the rates described in Schedule 02.

5. Subject to paragraph 3 and 4 above, a resident will be prepared to perform duties in occasional emergencies and unforeseen circumstances (for example

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[1] Good medical practice - professional standards - GMC

short-term sickness cover), if they are able and safe to do so, where the employer/host has had less than 48 hours' notice, and the duty is for less than 48 hours' duration of cover. Commitments arising in such circumstances are, however, exceptional and the resident should not be required or expected to undertake work of this kind for prolonged periods or on a regular basis.

6. A resident is expected to engage fully with the training programme.

7. A resident is expected to engage constructively with the employer/host in the design of services, rotas and of safe working patterns to support that service delivery.

8. A resident will make all reasonable efforts to achieve agreed training and service delivery objectives.

9. A resident employed under these TCS must continue to hold a place in an approved postgraduate training programme.

10. A resident must sit such examinations as are required for the completion of training. These must be completed in accordance with the curriculum, including the timetable approved by the regulator (the GMC, GDC or other body, as appropriate). The employer/host will work constructively with the resident on job planning in order to facilitate optimum conditions before examinations.

11. Whilst Residents in general practice (GP registrars and foundation doctors on placement in general practice) are expected to provide valuable clinical services whilst in training, they are not to be considered a part of the workforce in terms of required staffing levels. As such, effective running of the service should not be dependent on their attendance. In practice this means that any gaps in staffing levels will be appropriately covered by locum or other appropriate measures and that all requests for leave will be granted (subject to the Resident providing appropriate notice) in line with their supernumerary status.

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Schedule 02
Pay

Basic Pay

12. Residents shall be paid a basic salary at the rates set out in Medical and Dental Pay Circular, as updated by Welsh Government.

13. The basic salary for a resident employed full time is calculated on an average of 40 hours' work per week.

14. The basic salary for flexible (part time) residents is calculated pro rata on the average hours' work per week across the rota cycle.[2]

Starting Salaries, pay progression and counting of previous service

15. Residents in Foundation Year 1 (F1) and Foundation Year 2 (F2) shall be paid a basic salary based on the single pay point (also known as the pay spine) applicable for each level.

16. Pay progression for Residents in Foundation training will be based on the development of competency denoted by the progression from F1 to F2.

17. Following completion of Foundation Programme (i.e. for those who hold a FPCC or equivalent), Residents shall be paid a basic salary at an appropriate point on the registrar scale with standard progression every two calendar years on the doctor's incremental date.

Standard progression

18. Pay progression between all points except those defined in paragraph 19 below will require a resident to have two calendar years of equivalent experience per pay point.

Enhanced progression

19. Pay progression between points 2 and 3 of the registrar pay scale will be known as enhanced pay progression. It will require a resident to have 4 years total equivalent experience following completion of their Foundation Programme, of which 2 years must be in a formal training programme (including dental core training) or equivalent.

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[2] For example, a 50% flexible (part-time) resident on a rota where a full-time resident is required to work an average of 48 hours per week (40 hours basic and 8 hours additional) will have their basic salary calculated on an average of 24 hours' per week.

Equivalent experience

20. Residents in the career grades who return to training will have all years of equivalent experience post-foundation counted for the purposes of standard and enhanced progression.

21. Residents with experience gained in local employment (i.e. LEDs) or from work abroad will be able to access enhanced progression based on the following criteria:
    a. Competencies completed as per equivalent training year and specialty requirement (this may be evidenced by an appropriate certificate of readiness)
    b. Evidence of regular meetings with an Educational Supervisor or equivalent
    c. Provide evidence to demonstrate their contributions to a wider role, for example (albeit not exhaustive), meaningful participation in or contribution to relevant:
        i. Management or leadership
        ii. Service development and modernisation
        iii. Teaching and training (of others)
        iv. Committee work
        v. Representative work
        vi. Innovation
        vii. Audit
    d. Evidence of Continual Professional Development (including courses, training sessions and presentations)
    e. Evidence presented as would be expected from ARCP or appraisal process.

22. Where a resident is able to evidence the criteria described in paragraph 21 above, each year of service as an LED or doctor abroad will be regarded as equivalent to a Training Programme year for the purposes of calculations towards standard and enhanced pay progression in line with paragraph 19 above. If the resident is unable to provide equivalent evidence, then each calendar year in service will be counted as half a year in a formal training programme for these purposes.

23. Residents who have undertaken an out of programme experience (OOP) or an academic qualification relevant to their training programme will have each year of these counted as equivalent to a Training Programme year.

Dental Core and Speciality Trainees & Pay Progression

24. Dental Core Training (DCT) typically lasts two years (DCT1 and DCT2).

25. On completion of DCT2, dentists who move directly into a Dental Specialty Training programme enter at DST1 are higher level trainees.

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26. If a trainee completes DCT2 and immediately progresses into DST1, they will be assimilated to the enhanced pay progression framework (R-PF), at pay point 3.

27. If the trainee remains in a core role (e.g., DCT3, staff grade, or other non-specialty training post), they will not move into the enhanced pay framework. Instead, they will continue on the standard pay progression scale.

Additional hours included in Job Plan

28. Additional hours of work (i.e. above the 40 hours defining WTE basic pay) set out in a resident's job plan shall be remunerated at the basic pay rate, 1/40th of weekly whole-time equivalent for each additional hour worked. This paragraph does not apply to Flexible (part-time) residents. Flexible (part-time) residents are paid in accordance with paragraph 14.

Hours that attract a pay enhancement

29. An enhancement of 50 per cent of the hourly basic pay rate shall be paid on any hours worked between 19.00 and 07.00 on Monday to Friday, and any hours worked on Saturday, Sunday or a bank holiday.

30. The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota cycle (as set out in the Job Plan), as described in paragraph 147 of Schedule 04 of these TCS and converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure, and the resident will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked, as per paragraph 63-65 on annual salaries.

Counting of hours

31. Average total hours, and average hours that attract an enhancement, will be assessed in quarter hours, rounded up and paid to the nearest quarter hour.

On-call availability allowance and payment for work undertaken

32. A resident on an on-call rota who is required by the employer/host to be available to return to work or to give advice by telephone, but who is not normally expected to be working on site for the whole period, will be paid an on-call availability allowance of 50% of the basic hourly rate for the hours they are available.

33. Residents will be paid for any actual hours worked while on-call—either on site or remotely—at the appropriate rate for the hours worked.

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34. For pay purposes, the on-call availability allowance will count towards the pay for actual hours worked for each hour or part thereof applicable. i.e. payment

for actual work performed will form a “top up” of the hourly availability rate, or any part thereof, up to the relevant rate.

35. Where a resident is required to work for 75% or more of the on-call period, they shall be paid for the total on call period at the full appropriate hourly rate and not the 50% availability rate.

36. The number of hours in the rota for which an on-call availability allowance is paid will be assessed across the length of the rota cycle (as set out in the Job Plan), as described in paragraph 147 of Schedule 04 of these TCS and converted into equal weekly amounts by dividing the total number of on-call availability hours to be paid by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure, and the resident will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked, as per paragraph 63-65 on annual salaries.

37. Residents will be paid for their average hours of work undertaken while on call, either on site or remotely, at the appropriate rate for the hours worked. The hours paid will be calculated prospectively across the rota cycle and the estimated average hours at each rate of pay will be set out in the job plan. For the purposes of pay, these total estimates shall be converted into equal weekly amounts by dividing the total number of prospective hours at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure, and the doctor shall be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked (as per paragraphs 63-65 on annual salaries).

38. If during an on-call duty period the resident works a greater number of hours than the prospective estimate of predictable and unpredictable hours set out in their individual job plan, the resident will be compensated at the appropriate rate and payment for these hours will be made retrospectively via the rostering system, in accordance with the overtime payment process.

Additional hours outside of the Job Plan (Overtime)

39. The majority of work expected of the doctor must be clearly defined in the individualised job plan, which determines their regular pay. However, in some circumstances, additional work may be undertaken that is not detailed in the job plan. This may include, but is not limited to:
    a. Staying beyond a scheduled shift end time due to service demands.
    b. Performing a greater number of hours than the prospective estimate of predictable and unpredictable hours (either remotely or on-site) during a non-resident on-call duty period.
    c. Undertaking work outside of scheduled hours to participate in a training opportunity required for progression within the training programme.

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d. a GP registrar who may be required to undertake OOH shifts. Further information and guidance can be found via the Committee of General Practice Education Directors (COGPED) website.

In these circumstances, the resident must report the additional hours worked outside of the job plan via the rostering system. They will receive payment at the appropriate hourly rate for the time and day the work was performed. For residents undertaking additional work to meet their GP training requirements during a GP practice placement, these additional hours must be recorded using the appropriate documentation, which must be signed by a supervising GP or approved trainer.

40. All additional work undertaken outside the job plan must wherever possible be recorded within the same rota cycle in which it occurred and claimed in the roster period it is worked in accordance with the NHS Wales Roster Management Policy. The Employer/Host Organisation will take a pragmatic approach with late submissions where there is good reason for the delay.

41. Authorisation for additional pay will be in accordance with the organisations' pay and financial controls processes. Additional work will be paid in the next payroll cycle after it is submitted, subject to ordinary payroll deadlines in operation in the relevant organisation.

42. It is expected that all submissions for additional pay are accurate and genuine; Whilst the host organisation will have internal governance measures in place and an individual with responsibility for authorising the roster, no separate clinical supervisor sign-off will be required. Therefore, claims will not ordinarily be scrutinised or queried prior to payment. Where the payroll team has concerns regarding whether a claim is genuine, this should be forwarded to the Guardian of Safe and Flexible Working for review, and if required, further investigation.

43. The Guardian of Safe and Flexible Working will undertake additional monitoring of overtime worked to understand patterns that may represent persistent resource issues, issues with training arrangements and work scheduling (additional hours and/or overtime) in order to ensure resident job plans are accurate, reflective of service demands and maintain safe design limits.

44. Where the resident believes that the additional hours of work have caused them to breach their safe working limits as defined in Schedule 03, they should also submit a job plan exception report as detailed in Schedule 05.

45. Deliberately fraudulent claims will be considered a conduct issue and dealt with in accordance with procedures contained in Upholding Professional Standards in Wales.

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GP Registrars – Out of Hours (OOH) Requirements

46. In addition to the normal agreed working week, a GP registrar working in a practice may be required, as part of their training requirements to gain experience of working in acute, emergency care, out of hours. All OOH activity must be recorded using the appropriate documentation/system in place for the relevant service/organisation, which must be signed by a supervising GP or approved trainer. Further information and guidance can be found via the Committee of General Practice Education Directors (COGPED) website.

Pay premia

General practice

47. A pay premium shall be paid to residents employed on general practice training programmes. This is not a recruitment premium and is not targeted at a hard to fill speciality.

48. The premium will be paid at a rate of 30% of pay point R-PF1. This will be paid pro-rata based on the average hours worked (Schedule 02 paragraph 14 refers) for residents who work flexibly (part time).

49. Such a premium is only payable to a resident on such a programme whilst the resident is working in a general practice placement. It is not payable when the resident is working in a hospital or any other setting.

50. Such a premium will not be payable to residents on a different training programme (for example, on a Foundation training programme) when they are working in a general practice placement.

Oral and maxillo-facial surgery (OMFS)

51. A pay premium will be payable to residents undertaking higher training in OMFS to recognise the requirement for such residents to complete undergraduate degrees in both medicine and dentistry. The premium will be payable at the point in time when the resident commences employment in a post on a higher training programme in OMFS.

52. The premium will be paid at a rate of 8.6% of pay point R-PF1.This will be paid pro-rata based on the average hours worked (Schedule 02 paragraph 14 refers) for residents who work flexibly (part time).

53. Payment of such a premium to that resident shall continue while they remain employed under these TCS, until such time as the resident exits the particular training programme to which that premium applies.

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Resident Recruitment and Retention Premia (RRP)

54. In order to ensure effective application of equal pay for equal value principles, employer/hosts will be required to submit applications for any temporary recruitment and retention premia. These applications for payment, review and/or withdrawal or extension of the premium will be overseen by the Medical and Dental Business Group (MDBG).

Leave and pay for new parents

55. The provisions governing maternity pay are set out in Schedule 12.

56. Additionally, to the above provisions, if a resident returns from an approved period of time out of programme and:

    a. the continuity of service provisions means the resident is eligible for maternity leave and pay, but
    b. the reference period for calculating maternity pay means that the value of the occupational maternity pay would otherwise be nil, then the maternity pay reference period is defined as being the resident's last period of paid employment in the previous training placement immediately prior to commencing the period of time spent out of programme.

Pension arrangements

57. Residents will be eligible for membership of the NHS Pension Scheme, the provisions of which are set out in the NHS Pension Scheme Regulations 2015 (as amended).

58. The following will be pensionable in the NHS Pension Scheme:
    a. All hours worked up to 40 hours per week on average and paid at the basic pay rate.

59. The following will not be pensionable in the NHS Pension Scheme:
    a. Payments for additional rostered hours above 40 per week.
    b. Enhancements paid under the provisions of paragraph 29-30
    c. On Call Availability allowance
    d. Pay premia
    e. Travelling, subsistence and other expenses paid as a consequence of the resident's work for the employing organisation or the wider NHS.

Changes to the job plan affecting pay.

60. Where pay is increased as a result of changes to the job plan, pay will be altered from the date that the job plan review is requested and paid retrospectively. It is expected that party initiating the review will provide a proposal of the new job plan and wherever possible supply supporting information in accordance with NHS Wales Resident Doctor and Dentist Job Planning Policy.

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61. Where changes to the job plan are required by the employer and/or Guardian and total pay would be decreased as a result, the resident's total pay will be protected and so remain unchanged until the end of the particular placement covered by that job plan. This protection will not extend to any subsequent placement, including a placement where the resident returns at a later date to the same post.

62. Where changes to the job plan are requested by the resident or a group of residents who are all in agreement to the proposed changes and agreed by the employer, and total pay would be decreased as a result, the resident's total pay will be reduced in line with the change in the job plan, from the date that the change is implemented.

Payment of annual salaries

63. The annual salaries of full-time employees will be apportioned as follows:

    a. For each calendar month: one-twelfth of the annual salary
    b. For each odd day: the monthly sum divided by the number of days in the month.

64. The annual salaries of flexible (part-time) residents should be apportioned as above except in the months in which employment commences or terminates when they will be paid the proportion of a full month's pay, based on the calendar days employed.

65. Where full-time residents terminate their employment immediately before a weekend and/or a public holiday and take up a new salaried post with another NHS employer/host immediately after that weekend and/or that public holiday, payment for the intervening day or days, i.e. the Saturday (in the case of a 55-dayworking week) and/or the Sunday and/or the public holiday, shall be made by the first employer/host.

Locum pay

66. As part of this contract's framework agreement, BMA Cymru Wales, NHS Wales Employers and Welsh Government have agreed to develop either a set of payment rates, or a suitable and consistent methodology for determining these rates.

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Schedule 03
Working Hours

Principles

67. Contractual limits on working hours and protected rest periods, as set out in this schedule, are necessary to ensure both patient safety and the safety of the resident.

68. The employer and the resident must comply with the regulatory limits set out in the Working Time Regulations 1998 (the Regulations), as amended, or any successor legislation. The employer/host and the resident should pay particular attention to the safeguards on hours and rest, including those related to night workers, as set out in the Regulations.

69. The employer/host has a contractual and statutory responsibility for ensuring the resident is not contracted, or otherwise required, to work outside the limits covered in paragraph 68 above.

70. Individual residents have a professional responsibility for ensuring that their total hours of work, including any work undertaken for any other employer/host, comply with the contractual and regulatory limits set out in paragraph 68 and 69 above.

71. To provide assurance to both the employer/host and the resident on safe working hours as described in paragraph 68 and 69 above, a Guardian of Safe and Flexible Working (hereafter referred to as the Guardian) will be appointed. Each Health Board or Trust will have an appointed Guardian. Health boards/Trusts with smaller numbers of residents may appoint a single Guardian to work collaboratively across multiple health boards/trusts. The Single Lead Employer will appoint a 'Lead Guardian' to provide strategic oversight on its behalf and ensure compliance with the safeguards within host organisations. This role is described in Schedule 05.

72. The employer/host organisation should refer to jointly agreed national policy guidance on good rostering practice, including the appropriate use of technology, and the correct way to roster shifts with hours worked during the night period, in designing the job plan. This joint policy guidance will be developed in social partnership as part of this contract reform.

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Limits on hours

73. No resident should be rostered for more than an average of 48 hours of actual work per week, as calculated over a 26-week reference period, or the rota length if this is shorter.

74. No more than 72 hours' actual work should be rostered for or undertaken by any resident, working on any working pattern, in any period of 168 consecutive hours.

75. No shift (other than an on-call duty period) shall be rostered to exceed 13 hours in duration.

76. No more than four long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) must be rostered or worked on consecutive days. Where four long shifts are rostered on consecutive days, there must be a minimum of 48 hours rest period rostered immediately following the conclusion of the fourth shift.

77. No more than four shifts where at least three hours of work falls into the period between 23.00 and 06.00 must be rostered or worked consecutively.

78. Where shifts (excluding non-resident on-call duty) as defined in paragraph 77 above are rostered singularly, or consecutively, then there must be a minimum 46-hour rest period rostered immediately following the conclusion of the shift(s).

79. Where any part of a shift takes place between 23:00 and 06:00 and is at least 8 hours in duration, the majority of the shift must take place outside of core hours in line with the NHS Wales Rostering Policy for Resident Doctors and Dentists.

80. A maximum of seven shifts of any length can be rostered or worked on seven consecutive days subject to the restrictions outlined in paragraphs 73-79 above. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days. Where seven shifts of any length are rostered or worked on seven consecutive days, there must be a minimum 48-hours' rest rostered immediately following the conclusion of the seventh shift.

81. The maximum number of consecutive shifts described in paragraphs 76 and 80 above can be increased by one to a maximum of five and eight respectively where the employer/host, the Guardian, the residents on the rota and the RDF (with an LNC resident doctor representative present) agree through local processes that it is safe and acceptable to both parties to do so. Any agreement will be reviewed annually as per the original process and any resident on such a rota will have the right to request a job plan review/ appeal their job plan at any time, as set out in Schedule 04. The minimum 48-hours rest described in paragraphs 76 and 80 above will apply following the conclusion of the increased maximum shifts where they are agreed.

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Foundation year 1 residents, this agreement will be made with the Guardian on their behalf.

82. All reasonable steps should be taken to avoid rostering residents to work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 in 3 weekends, with an absolute limit of 1 in 2.

83. By exception, authorisation for a rota using a pattern greater than 1 in 3, and up to the absolute limit of 1 in 2, can be granted if there is a clearly identified clinical reason agreed by the relevant clinical director for that rota and deemed safe and appropriate by the Guardian. Such rotas should be co-produced, and must be approved by the affected residents, agreed via the RDF (with an LNC resident doctor representative present) and reviewed annually.

84. For flexible (Part Time) residents' weekend frequency, a pro-rata approach based upon the resident's average hours' work per week across the rota cycle must be taken. This is set out in Table 1 below.

Table 1 – Flexible (Part-Time) Resident Weekend frequency pro rata calculator

Average hours' work per week across the rota cycle	*Typical Weekend Frequency*	*Absolute limit*
36 - <40	*1 in 4*	*1 in 3*
32 - <36	*1 in 5*	*1 in 3*
28 - <32	*1 in 5*	*1 in 3*
24 - <28	*1 in 6*	*1 in 4*
20 - <24	*1 in 7*	*1 in 4*

85. Where agreed with the resident and the Guardian, the frequency of weekend working for flexible (part time) residents can be increased above the typical weekend frequency limit set out in Table 1 paragraph 84. Save for circumstances in paragraph 86, the weekend frequency should not exceed the absolute limit which corresponds to the resident's average hours' work per week across the rota cycle as per Table 1 above. The resident must not be unreasonably pressured to accept this arrangement.

86. For flexible (part time) residents, by exception, authorisation for a rota using a pattern greater than absolute limits set out in Table 1 in paragraph 84 can be granted. This can be granted if it is deemed safe and appropriate by the Guardian provided:

a. there is a clearly identified clinical reason agreed by the relevant clinical director for that rota or;

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b. it is requested by the resident.

87. Before using a rota pattern that is greater than the absolute limit which corresponds to the resident's average hours' work per week across the rota cycle as per Table 1 in paragraph 84, such rotas should be co-produced, and must be approved by the affected residents, agreed via the RDF (with an LNC resident doctor representative present) and reviewed annually.

88. No full time or flexible (part time) resident shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2.

89. Residents that wish to work at a frequency greater than 1 weekend in 3, by undertaking additional work, for extra-contractual locum work, are able to agree to do so but must not work an average weekend frequency of greater than 1 weekend in 2.

90. Other than as set out in paragraphs 76, 78, and 80 above where longer minimum rest periods may apply, under the Regulations there must be at least 11 hours' continuous rest between rostered shifts, other than on-call duty periods.

91. Any breaches of 11 hours' rest in a 24-hour period (excluding on-call duty periods) will be subject to time off in lieu, which must be within 24 hours. In all circumstances where, due to service needs as required by the employer/host, the rest period is reduced to fewer than eight hours, the default assumption is that the resident will be unsafe to undertake work due to fatigue. The resident will be entitled to inform the employer/host that they will not be attending work as rostered, other than ensuring a safe handover of patients. No detriment in pay will be experienced by the resident.

Breaks

92. A resident must receive[3]:
    a. at least one 30-minute paid break for a shift rostered to last more than five hours,
    b. a second 30-minute paid break for a shift rostered to last more than nine hours, and
    c. A third 30-minute paid break for a night shift as described in paragraph 12 rostered to last 12 hours or more.

93. The breaks described in paragraph 88 above can be taken flexibly during the shift and should be evenly spaced where possible. These would normally be taken separately but may if necessary be combined into one longer break. Where the breaks are combined into one break this must be taken towards the middle of the shift wherever possible. No break should be taken within an hour

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[3] Paid breaks will apply to Residents whether they are working in primary or secondary care placement

of the shift commencing or held over to be taken at the end of the shift. Breaks are counted as working time for pay purposes.

94. Breaches of the break requirement are addressed in Schedule 05.

On-Call Duty Periods

95. For the purposes of this Schedule, on call is set out in the Definitions Section of these TCS).

96. A resident carrying an on-call bleep whilst already present at their place of work as part of the resident's rostered duties does not meet the definition of on-call.

97. The host organisation/employer must ensure there are clear and effective arrangements, including appropriate equipment if necessary, so that the resident can be contacted immediately at any time during a period when the resident is on call. Facilities must be provided in line with Schedule 11 of the TCS.

98. Where a resident is required to attend a clinical emergency when on-call, suitable arrangements must be made by the host/employer, so the resident is able to attend their principal place of work, or other agreed location, ensuring an appropriate response time to meet clinical and patient needs specific to their role.

99. Appropriate arrangements regarding this point are to be agreed between the employer/host and the resident and detailed in the Job Plan to allow for annual review.

100. The maximum length of an individual on-call duty period is 24 hours; however, the maximum length of an on-call duty can be extended by between 15 minutes and one hour to allow overlap and ensure there is adequate time for clinical handover.

101. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, may be agreed locally where both the employer/host and the resident agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest. This will be subject to scrutiny and approval by the Guardian and the LNC.

102. Unless agreed locally as described in paragraph 98 above, there must be no more than three on-call periods in any period of seven consecutive days.

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103. The day following an on-call period (or following the last on-call period, where more than one 24-hour period is rostered consecutively) must not be rostered to last longer than 10 hours.

104. Whilst on-call, a resident should expect to get eight hours rest per 24-hour period, of which at least five should be continuous rest between 22:00 and 07:00. Where this is not expected to be possible, then the provisions of paragraph 106 below apply.

105. Where it is expected that the rest requirements set out in paragraph 104 may not be met, rostered work on the day following the on-call period must not exceed 5 hours.

106. Where during an on-call period, a resident's expected overnight rest is significantly disrupted, defined as causing a breach in the expected rest requirements, the resident must inform their employer/host immediately, or as soon as reasonably practicable, and arrangements must be made for the resident to take appropriate rest. Time off in lieu must be taken within 24 hours. If for any reason this is not achieved, then the additional hours will be paid as set out in Schedule 02 paragraphs 39-45.

107. If, as a result of actual hours worked during the on-call period, a resident's rest has been significantly disrupted, as defined in paragraph 103 above, the default assumption is that the resident may be unsafe to undertake work because of tiredness, and if this is the case, the resident must inform the employer/host that they will not be attending work as rostered, other than to ensure safe handover of patients. No detriment to pay will result from the resident making such a declaration. Arrangements for dealing with this issue must be agreed locally.

108. Rotas must overlap sufficiently to allow time for handover. This is critical for safe transfer of patient information to deliver continuity of care and good quality patient management. Most services will require a minimum handover of 15 to 30 minutes; some services may need to allow for 60 minutes or (in rare cases) longer. Coming in specifically to attend handover or undertake telephone handover is classed as working time and is part of the duty period.

109. The job plan of a resident rostered to be on-call will contain an average amount of time, calculated prospectively, for anticipated work (in both core and unsocial hours respectively) during the on-call period. Such work includes any actual clinical or non-clinical work undertaken either on or off site, including telephone calls, actively awaiting urgent results or updates, and travel time arising from any such calls. Any such work is defined as working time for the purposes of these TCS. Any time during the on-call period when the resident is not undertaking such work, is defined as non-working time for the purposes of these TCS.

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110. A resident's job plan must include an indication of the amount of the expected predictable and unpredictable work whilst on call, during core and unsocial hours.

111. Predictable work refers to routine activities which will occur at specific times during an on-call duty period. This may include but is not limited to ward rounds, anticipated duties and clinical handovers. Such activities, along with the expected hours of work required, should be specified within a Job Plan.

112. Unpredictable work refers to unscheduled activities that occur at unspecified times during an on-call duty period, including but not limited to telephone calls, actively awaiting urgent results or updates and travel time arising from any such calls. For these activities, the employer/host must provide a prospective estimate of the average amount of unpredictable on-call work that will occur during an on-call duty period using the calculation method described below.

113. To inform the calculation of the prospective estimate of the average amount of work, in hours, performed during an on-call duty period, employer/hosts should use all relevant available data. This includes a combination of but is not limited to actual data such as: activity data, calls through switchboard, bleeps, admissions, feedback from colleagues in the department, feedback from staff previously and currently rostered for on-call duties on the relevant rota, previous exception reporting data and overtime reporting for the relevant rota, and recent diary activities or monitoring data.

114. Prospective hours should be communicated to residents in advance of starting work so they are aware when they may be risking a breach of limits on hours and rest requirements. Employer/hosts should provide clarity to the resident on when the on-call duty periods may typically require predictable work in the working pattern, how the estimates were arrived at and what data sources informed the estimate.

115. Prospective hours should be calculated by totalling the number of regular hours of on-call work performed across an actual (and typical) week of on-call duty periods across the rota reference period of a rota cycle, placement length or 26 weeks whichever is shorter. From this, an average amount of work for each weekday (Monday to Friday) and weekend (Saturday and Sunday) can be calculated The total hours should then be divided by the number of on-call duty periods from which the total number of hours were drawn, to provide an average amount of on-call work - during core and unsocial hours - a resident can expect to undertake during their rostered on-call duty periods(s).

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116. All rostered on-call duty periods must have a prospective estimate of unpredictable work a resident can expect to perform, even if it is a very low

intensity pattern, with 15 minutes being the minimum prospective estimate for an individual on-call duty period.

117. The result of the prospective hours calculation will be set out in the generic job plan of the residents due to work on the rota to ensure they are aware of when they may be experiencing an unexpected variation in the number of hours worked during an on-call duty period to enable them to be clear when overtime can be claimed.

118. Employers/host organisations must also remind residents to submit an overtime claim as set out in Schedule 02 when work performed during on-call activity has varied from the prospective estimate for predictable and unpredictable work for the on-call duty period as set out in their job plan.

119. Where a resident(s) on an on-call rota is regularly exceeding or significantly below the prospective estimate for on-call duty period then a job plan review may be required. In the case of a resident(s) regularly exceeding the prospective estimate then consideration should be given to alternative arrangements such as:
   a. having an additional resident on the on-call rota, reducing the workload covered by the on-call resident, or
   b. converting the on-call working pattern to a full-shift working pattern, or
   c. increasing the prospective estimate, provided this maintains compliance safe working requirements.

120. The prospective estimate of predictable and unpredictable hours to be worked during on-call duties must be included in the calculation of a resident's average weekly hours, as set out in paragraph 37 of Schedule 02, and factored into the leave adjustment calculation for employer/hosts using prospective cover.

121. Where the job plan of a resident rostered for on-call duty contains 3 hours or fewer of work on any given day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the provisions of paragraphs 98 and 99 will not apply and a maximum of 7 duty periods can be rostered or worked consecutively. Subject to local agreement and oversight as above, this may be extended to 12 consecutive duty periods.

122. Where a resident is required to work a night shift or a shift on a weekend as part of a rota for a department or service, the employer/host will not, in addition, roster a second resident working that same rota to be available on-call for the same night or weekend. This is unless there is a clearly identified clinical reason agreed by the clinical director and the work pattern is agreed by both the Guardian as being safe and the Director of Medical Education (DME) as being educationally appropriate. A resident who is asked to work such a

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rota who feels that this is inappropriate will have the right to request a job plan review, as set out in Schedule 04.

GP Registrars Working Hours

123. All full-time GP Registrars are employed on a 40-hour per week contract in line with the agreed model contract. This is normally structured as ten (10) four-hour sessions per week in line with COGPED guidance. Alternative arrangements may be agreed where necessary, provided the total weekly working hours remain at 40 hours.

124. In line with current COGPED guidance a full time GP registrar would expect their time to be divided as follows (including contractually mandated breaks). These values may be subject to change in the event the Guidance is amended. In these circumstances, any amendment would be agreed through MDBG.
    a. 28 hours of clinical activity (equivalent to 7 sessions)
    b. 8 hours of structured educational activity (equivalent to 2 sessions)
    c. 4 hours of self-directed educational activity (equivalent to 1 session)

125. For Flexible (Part Time) GP trainees, both working hours and OOH requirements will be calculated on a pro rata basis, in line with their agreed percentage of time training and in line with these TCS.

Opting out of the Working Time Regulations (WTR)

125. A resident may voluntarily choose to opt out of the WTR average weekly limit of 48 hours, subject to prior agreement in writing with the employer/host. A decision to exercise this option is individual, voluntary and no pressure must be placed on the resident to take this option.

126. Under these TCS, where a resident has opted out of the WTR average weekly working hours, overall hours are restricted to a maximum average of 56 hours per week, across all or any organisations with whom the resident is contracted to work or otherwise chooses to work. This must be calculated over the reference period defined in the WTR. Additionally, the maximum of 72 hours worked in any period of 168 consecutive hours applies, as described in paragraph 78 above.

127. Under these TCS, the employer/host and a resident opting out of the WTR weekly hours limit is still bound by all of the other limits set out in the WTR and in these TCS and as such the employer/host and resident must retain suitable records of additional hours worked.

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128. A resident's agreement to opt out may apply either to a specified period or indefinitely. To end any such agreement, a resident must give written notice to the employer/host. The notice period shall be seven days, or a period up to a maximum of three months specified in the agreement, whichever is the longer.

129. Records of such agreements must be kept and be made available to relevant recognised unions and appropriate regulators on request.

Locum Work

130. Where a resident intends to undertake hours of paid work as a locum, additional to the hours set out in the job plan the resident is strongly encouraged to initially offer such additional hours of work to the service of the NHS, so long as work is available appropriate to their grade and competencies.

131. A resident can carry out the additional activity over and above the standard commitment set out in the job plan up to a maximum average of 48 hours per week (or up to 56 hours per week if the resident has opted out of the WTR). The resident is required to ensure that any additional hours of work do not breach any of the safety and rest requirements set out in paragraphs 73-90.

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Schedule 04
Job Plans

Job Plan Principles

132. These terms and conditions of service provide a framework for the safety of residents in the training and service delivery domains of the working experience.

133. Job planning arrangements for Residents shall be governed by the NHS Wales Job Planning Policy – Resident Doctors and Dentists, which includes provisions for the Job Planning Appeals Process.

134. The employer or host organisation shall design job plans (timetables for Dental training) that are safe for patients and safe for residents and shall ensure that Job Plans are adhered to in the delivery of services.

135. Job planning for residents allows employer/hosts to plan and deliver clinical services while delivering appropriate training. They will indicate safe staffing levels for the medical team the placement is in and define education time (EDT) entitlements.

136. Educational planning[4] and clinical work scheduling are interlinked, reflecting the interdependence of training and service commitments of residents. Where the resident is on an integrated academic pathway, the academic components of the placement also need to be reflected in the job plan, in accordance with Follett principles[5]. The resident, academic employer/host, and clinical employer/host will agree a job plan (equivalent is a timetable for residents in Dental training) for the placement prior to its commencement to accurately reflect the resident's various commitments.

137. The employer / host organisation will be responsible for ensuring that a generic resident job plan is prepared for the post, which takes into account:
   a. the expected service commitments, and
   b. the parts of the relevant training curriculum that can be achieved in the post. This latter element must be consistent with the post's Application for Approval of a Training Post, which will be agreed with the postgraduate dean.
   c. measures to protect patient safety and staff wellbeing.

138. The generic resident job plan will form the basis for a personalised resident job plan.

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[4] HEEW Educational Development Time for Doctors in Training: Key Principles
[5] A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties,

139. A job plan will typically apply for the length of the placement and should be discussed at a minimum at the start and finish of the placement. It will identify the number and distribution of hours for which the resident is contracted. The resident job plan will also form the basis of discussions between the resident and their educational supervisor on their progress against training objectives.

140. A job plan may be subject to review from time to time.

141. Job plans should be designed to meet the service delivery needs of the organisation, the education and training needs of the resident and the safety of both patients and residents. The clinical commitments of job plans should be based upon well designed rotas that are, where possible co-produced with residents. The employer/host organisation should refer to jointly agreed NHS Wales Rostering Policy for Resident Doctors and that will be developed in social partnership, including the appropriate use of technology, in designing the job plan.

142. These terms and conditions of service stipulate minimum periods prior to the commencement of placement which the residents must receive each piece of resident job plan documentation. This is set out below and will be in line with the NHS Wales Code of Practice: Provision of Information for Postgraduate Medical/Dental Training.

Generic Job Plan

143. The generic job plan must be provided to a resident at least 8 weeks prior to them starting a placement to ensure that the resident is informed of the work and range of duties that are expected to be undertaken during the placement.

144. The generic resident job plan will list and identify the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the resident, time for quality improvement and patient safety activities, time for portfolio development, time for rota development, periods of formal study (other than study leave), and the number and distribution of hours for which the resident is contracted. It will detail entitlements to Educational Development Time (EDT), minimum staffing levels within the team, and will be subject to regular reviews by the relevant training programme director (TPD).

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145. Details of all statutory and mandatory training that is a requirement to work for an employer/host, or in a department, must be sent to residents alongside their generic work schedule. These training requirements must then be arranged within a residents' rostered hours of work.

146. Generic job plans must account for the health board/local trust induction required to be undertaken prior to, or at, the start of the placement and delivered in line with the NHS Wales Fatigue and Facilities Charter. This must be reflected as hours of work and paid accordingly. Where a resident is commencing work in an unfamiliar setting, their induction must be included in the generic job plan prior to the commencement of clinical duties, which will not be undertaken until the induction has been completed. Any delay will not result in a loss of pay for the resident.

147. A standard full-time generic job plan shall be for a minimum of 40 hours and a maximum of 48 hours per week, averaged over a reference period defined as being the length of the rota cycle, the length of the placement or 26 weeks, whichever is shorter.

148. A flexible (part time) generic job plan shall not exceed 40 hours per week, averaged over this same reference period as described in paragraph 147.

149. When calculating the average total hours, the number of days' leave (including; annual leave, public holidays, and relevant study leave where prospective cover is in operation) that would be taken by a resident, on average, across the length of the rota cycle will be deducted from the rota, and the remaining hours will be divided by the remaining weeks (including part-weeks) in the cycle. For example, in an eight-week cycle with six days' leave deducted, the total remaining hours would be divided by 6.8 weeks.

150. The same method must be used when calculating the average number of hours which attract an enhancement and when calculating the average hours which attract the on-call availability allowance. See Annex 01 for the agreed formula for calculating average hours.

151. A mechanism should be in place for residents to plan and submit leave requests prior to starting in a post. The agreed form for submitting advance leave requests should be issued with the offer of employment and job plan for residents to complete and return to the rota manager prior to the duty roster being issued.

152. The generic job plan will include a description of the hours to be worked, any shift working or on-call arrangements for any and all employer/hosts, including any service commitment to unscheduled urgent or emergency care, and will set out in general terms when and where the resident's duties and responsibilities will be delivered.

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153. Where a job plan contains on-call arrangements, then all non-resident on-call duties must be rostered as separately within a rota, and on-call shifts cannot contain within them a resident shift.

154. When requested by a resident, all reasonable attempts should be made to facilitate set working day patterns, in line with their statutory right to request flexible working provided that service needs can be met. Requests should be made in accordance with the NHS Wales Flexible Working Policy.

155. Unless agreed with the resident, no shift or on call duty period should be rostered on a non-working day in a fixed working pattern.

156. The duties and responsibilities set out in the generic job plan will include, as appropriate:
   a. clinical care and service duties
   b. specific training
   c. work in or for other organisations (if required by the employer / host organisation).

157. Where the resident is required to participate in a service commitment to unscheduled, urgent or emergency care, the job plan shall set out the expected requirements to contribute to a duty roster and/or on-call rota for the safe provision of service. The job plan may include duties throughout the 24-hour day and the seven-day week, including work on statutory and public holidays. This will include a prospective estimation of anticipated actual work (as defined in Schedule 03) during the on-call period, which will be defined as working time for the purposes of these TCS.

158. The job plan for a resident on a general practice training programme working in a general practice setting shall reflect the 2024 COGPED guidance or any successor document on the session split during the average 40-hour week that comprise a minimum full-time contract. Any additional hours of work above 40 must be included in the resident's job plan with agreement and linked through to the curriculum, as per those for residents in hospital settings.

159. The job plan must be designed to facilitate access to the full leave allowance, as outlined in Schedule 08 as well as appropriate training.

Duty roster

160. The duty roster must be provided to a resident at least 6 weeks prior to them starting a placement, to ensure that the resident is informed of the work and range of duties that are expected to be undertaken during the placement.

Flexible (part time) resident job plans

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161. A resident who trains flexibly (part time) must have a bespoke job plan built for them to ensure they are working the correct pro rata proportion of hours and shift types, for their part time percentage and working arrangements, and are being paid correctly. It may also include other professional duties

that are agreed with the educational supervisor, which may include, for example, rota coordination duties, accredited Trade Union duties or participation in the resident doctor forum.

162. The facilitation of bespoke job plans is the responsibility of both the employer (or host organisation as locally agreed) and the resident. This process must begin as soon as possible after notification of placement. It is the employer/host's responsibility to issue the mutually agreed bespoke job plan to the resident. This should be done as soon as reasonably practicable and in any event prior to the resident who trains flexibly starting in post, to allow sufficient opportunity to plan leave and other commitments.

163. When a resident who trains flexibly is provided with their generic job plan, it should include their individual pro-rata entitlement to study leave and annual leave (inclusive of pro-rated public holidays) to ensure they are able to plan in their leave at the earliest available opportunity.

Personalised job plan

164. The generic job plan shall form the basis for a personalised job plan which will be agreed between the educational supervisor and the resident, in accordance with the COPMED Gold Guide and/or other relevant documents, as amended from time to time. The personalised job plan must be agreed before or within four weeks after the commencement of the placement during scheduled hours of work.

165. Where the personalised job plan has not been agreed within four weeks after the commencement of the placement, the resident may submit an exception report. This will be sent to the Director of Medical Education and Educational Supervisor (for residents working in non-hospital settings, including – but not limited to – GP and Public Health registrars, this will be sent to the Head of School instead of the Director of Medical Education, as well as the Educational Supervisor).

166. The resident and the educational supervisor are jointly responsible for personalising the job plan according to the resident's learning needs and the opportunities within the post. It may also include other professional duties that are agreed with the educational supervisor, which may include, for example, rota coordination duties, accredited Trade Union duties or participation in the RDF. Should a resident have a significant caring responsibility, they may raise it as part of the discussion of the personalised job plan initial discussion and/or review. Where possible within the constraints of service delivery, adequate account should be taken of reasonable requests when agreeing the personalised job plan.

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167. The educational review with the educational supervisor will include a discussion of the job plan to ensure that their workplace experience delivers the anticipated learning opportunities.

168. Each resident provided with a written occupational health recommendation relating to the design of their rota or duty roster must have this discussed, mutually agreed and incorporated into its design as soon as possible, and within six weeks of the recommendation being provided. In subsequent rotations, relevant recommendations may need to be carried forward and incorporated into the duty roster from the start of the placement. These recommendations may be subject to review by the occupational health provider for the resident's subsequent placements.

169. If the six-week timescale in paragraph 157 above cannot be met, or if a mutual agreement about a rota change cannot be reached between the employer/host and the resident, the resident must be provided with a documented explanation as to why the recommended change cannot be made or why the timescale cannot be met. A meeting should be arranged to discuss this and explore potential alternative solutions.

170. Residents must have the ability to escalate to the HR department and/or named individual(s) within their host organisation to raise concerns when the occupational health recommendations have not been factored into the design of the duty roster within six weeks of the recommendations being confirmed.

171. The employer/host may need to make changes to a job plan during the placement if there are significant changes in the facilities, resources or services. Every effort should be made to anticipate such changes in the Job Plan and reach agreement on such changes.

GP Registrars – Out of Hours (OOH) Requirements

172. In addition to the normal agreed working week, a GP registrar may be required to undertake OOH shifts. All OOH activity must be recorded using the appropriate documentation, which must be signed by a supervising GP or approved trainer. Further information and guidance can be found via the Committee of General Practice Education Directors (COGPED) website.

Job plan objectives

173. The generic job plan shall describe the training opportunities and the service commitments required to achieve the objectives of the placement.

174. The personalised job plan shall add to the generic schedule the resident's personal objectives in:
   a. training (consistent with the education/training contract between HEIW and the resident), and
   b. service delivery, both to align the resident's service commitments to the employer/host's objectives and to recognise not only that competencies can be achieved through service delivery but that some can only be achieved in this way.

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c. any other duties the resident may hold, including rota coordination and design, and representative functions (e.g. RDF).
d. academic commitments if on an integrated academic training pathway. This should be in accordance with Follet principles. Where employment arrangements place the resident under the new terms and conditions, the resident, academic employer/host and clinical employer/host will agree a job plan for the placement prior to its commencement to accurately reflect the resident's various commitments.

175. The training objectives will set out a mutual understanding of the training needs of the resident over the period of the job plan, and of how, in working to achieve these objectives, the resident will contribute to the objectives of the employer/host.

176. A resident's individual objectives will depend in part on the specialty and the level of competencies achieved and may on occasion differ from the objectives set out in the generic job plan.

Setting and maintaining the job plan

177. The job plan brings together activities to achieve service and learning objectives.

178. As a minimum, there should be an educational review and job plan discussion at the start and finish of the placement for which the job plan applies.

179. The personalised job plan will be discussed and agreed at the first formal meeting between the educational supervisor for the placement and the resident.

180. The resident and educational supervisor will regularly consider progress against agreed learning objectives determined by the curriculum, and the resident's service objectives. This should be reflected in any relevant training portfolio.

181. Job planning discussions should establish whether any changes in support or resources, or in planned service duties, are needed to enable the resident to achieve the objectives within rostered working hours.

182. Discussions shall take place if either the employer/host or the resident consider that the training opportunities, duties, responsibilities, accountability arrangements or objectives have changed significantly, or need to change significantly, or that the agreed objectives may not be achieved for reasons outside the resident's control.

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Resolving disagreements over the job plan

183. The educational supervisor will make every effort to agree with the resident appropriate changes to the job plan, and to implement the changes within a reasonable time, taking into account the remaining duration of the post/placement. If it is not possible to reach agreement or achieve the agreed outcome the resident may invoke the provisions of the job planning appeals process that can be found in the NHS Wales Job Planning Policy – Resident Doctors and Dentists.

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Schedule 05
Guardian of Safe & Flexible Working & Exception Reporting

Safe and Flexible Working

184. The safety of patients is a paramount concern for the NHS in Wales. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around residents' working hours in these terms and conditions are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.

185. There are three functions which oversee the safety of residents in the training and service delivery domains of their working experience.
    a. The employer or host organisation designs job plans that are safe for patients and safe for residents and ensures that job plans are adhered to in the delivery of services.
    b. The director of medical education (DME) oversees the quality of the educational experience.
    c. The Guardian of safe and flexible working (hereafter referred to as the Guardian) provides assurance to the employer, and host organisation if appropriate, on compliance with safe working by the host and the resident.

186. Residents are also responsible for ensuring that both their pattern of work and their total hours of work, including all work undertaken for any employer, whether directly or indirectly (for example through an agency or limited company), comply with the limits set out in Schedule 03, and that they remain safe to carry out clinical duties.

The Role of the Guardian

187. The Guardian is a senior appointment that all health boards/trust will be required to make, although Health Boards/Trusts with a smaller number of residents may appoint a single Guardian to work collaboratively across multiple health board/trusts so long as this does not impact on the effectiveness of the Guardian and has been agreed with the Lead Guardian.

188. The expectations of the Guardian in NHS Wales are centred around ensuring that residents are working safely in accordance with their contractual limits and that working conditions support patient safety and wellbeing. They are also there to promote, signpost and improve support for flexible (part time) residents. The role is intended to champion flexible training pathways and support residents and employers in residents accessing their statutory right to request flexible working arrangements. It will do so by providing guidance, education and being a point of contract on such issues.

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189. The Guardian is expected to act as a custodian and advocate for residents' safe working conditions, ensuring their hours support both wellbeing and patient safety. They serve as a neutral and independent role that monitors, reports, escalates, and helps resolve issues around working time compliance.

190. The Guardian will provide advice and support to residents regarding training and working flexibly. They will be able to signpost residents to information and specialty related support to help in decision making and application for flexible (part time) training opportunities

191. The Guardian is a senior appointment, and the appointee will not hold any other role within the management structure of the employer / host organisation which might compromise their independence. The Guardian shall ensure that issues of compliance with safe working hours are addressed by the resident and/or employer/host organisation, as appropriate.

192. The Guardian shall provide assurance to the host Board that residents' working hours are safe. (This assurance is in addition to the provisions and safeguards as set out in Schedules 03 and 04).

193. The Guardian will provide the lead employer (NWSSP), via the lead Guardian for Wales, with assurance that its employees are working safe rotas and that any exceptions are escalated and resolved within the host organisation.

194. The Guardian will be supported by appropriately qualified managerial/clerical support and provided with sufficient resource and time to undertake the role effectively.

195. Host organisations will be provided with guidance on the appointment and support of the Guardian role. Funding will be provided as part of contract reform for a minimum sessional requirement dependent upon the size of the organisation. This will be reviewed as the role is introduced to ensure that Guardians are properly resourced. Funding also includes the provision of dedicated administrative support to enable the Guardian to function effectively and deliver meaningful improvements in training experience and working conditions. It has been agreed that funding provision will be ringfenced as part of an Implementation and Transition fund.

The role of the Lead Guardian

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196. The Single Lead Employer will appoint a Lead Guardian. The Lead Guardian will be subject to annual performance review undertaken by the SLE (NWSSP) Managing Director or Director of Workforce and Medical Director.

197. The Lead Guardian will:

a. Sit on the appointment panels for Guardians based within host organisations.
b. Be part of the performance review of Guardians within host organisations.
c. Co-define and support the delivery of training to Guardians across Wales.
d. Collate and share best practice.
e. Act as a point of contact, support and guidance to the Guardians within host organisations.
f. Establish a Guardian of Safe and Flexible Working Network, convening and overseeing meetings of the network.
g. Author an annual report covering all GOSFW Guardians work and outcomes across Wales to be presented to NWSSP's Partnership committee and MDBG.
h. Act as an independent escalation point for safety concerns regarding working hours
i. Receive and monitor regular reports from Guardians based in host organisations.
j. If, after collaboration with the RDF and LNC, a Guardian within the host organisation is unable to resolve concerns with the relevant local teams, these issues should be escalated by the Lead Guardian to MDBG.

Appointment of the role of Guardian in Host Organisations

198. The employer and/or host organisation must appoint a named Guardian to assure the safety of residents. Appointment would normally be for a minimum of three years, subject to annual performance review. The performance review should be jointly undertaken by the host organisation and the Lead Guardian.

199. Subject to the agreement of the SLE and lead Guardian, host organisations may appoint a Guardian to cover more than one organisation.

200. The arrangements must be made clear in the employment management agreements between the SLE and host organisations.

201. The named Guardian for each host organisation shall ensure information is available to the host organisation board, and the lead Guardian must see Guardian reports for all of the residents under their employment.

202. The following principles shall be taken into account in appointing to the role:

a. As the host organisations are not the direct employers of the residents, the Lead Guardian will be on the appointment panels within the host organisations.

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b. The appointment panel for the Guardian shall include the medical director or a nominated deputy, the director of people/workforce or a nominated deputy, and two residents, nominated by the joint local

negotiating committee (JLNC) or equivalent. At least one and if possible, both of the residents must be based in the appointing employer (or host organisation, if appropriate).

c. The panel should reach consensus on the appointment.

d. The recruitment process for the appointment of the Guardian should otherwise follow local recruitment processes.

e. The SLE and host organisation, will set the Guardian's time commitment, taking into consideration the number of rotas and the number of residents for whom the Guardian will have responsibility.

f. Funding will be provided as part of contract reform for a minimum sessional requirement dependent upon the size of the organisation. This will be reviewed as the role is introduced to ensure that Guardians are properly resourced.

Responsibilities of Guardian in Host Organisations

203. The Guardian shall:

a. Act as the champion of safe and flexible working hours for residents in approved training programmes.
b. Provide assurance to residents and employers that residents are safely rostered and enabled to work hours that are safe and in compliance with Schedules 03, and 04 of these terms and conditions of service.
c. Receive copies of all exception reports in respect of safe working hours and monitor overtime reporting patterns. This will allow the Guardian to record and monitor compliance with the terms and conditions of service.
d. Require intervention to mitigate any identified risk to resident or patient safety in a timescale commensurate with the severity of the risk.
e. Escalate issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.
f. Require a rota and/or job plan review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed.
g. Have the authority to intervene in any instance where the Guardian considers the safety of patients and/or residents is compromised, or that issues are not being resolved satisfactorily.
h. Issue penalties/fines and distribute monies received as a consequence of financial penalties to improve the training and service experience of residents.
i. Provide guidance and be a visible point of contact for flexible (part time) residents or those considering training flexibly.
j. Advice or signpost flexible (part time) residents to ensure that the delivery of medical education and training meets the standards of regulatory bodies.
k. Work with RDF and LNCs to ensure concerns are addressed by the relevant teams.

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Reporting

204. The Guardian reports to the Lead Guardian and to the Host Health Board, directly or through a committee of the Board, as follows:
    a. The Host Health Board must receive a *Guardian of Safe and Flexible Working Report* no less than twice a year. This report will include information on all rota gaps on all shifts, unsafe staffing incidents, flexible training applications and issues and overtime reporting levels. This report must also be provided to the JLNC or equivalent.
    b. Beyond twice annual reports, there should be regular internal oversight to ensure system responsiveness. Reporting should be embedded in the organisation's quality and safety governance structure, such as the Quality and Safety Committee (or equivalent).
    c. Routine reports from each Guardian to the Lead Guardian will be required, the frequency of these will be determined by the level of exception reporting in each host organisation but will be no less than quarterly.
    d. Where the Guardian has escalated a serious issue in line with paragraph 202 e and g above and the issue remains unresolved, the Guardian must submit an exceptional report to the next meeting of the Board and to the lead Guardian.
    e. There may be circumstances where the Guardian identifies that certain posts have issues that cannot be remedied locally and require a system-wide solution. Where such issues are identified, the Guardian shall inform the Board and make the Lead Guardian aware. The Board will raise the system-wide issue with partner organisations (e.g. SLE, Health Education and Improvement Wales, Welsh Government) to find a solution.

Liaison with residents

205. Each Guardian and host organisation Director of Medical Education shall jointly establish an RDF to advise them.

206. This shall include resident colleagues from the organisation and must include the relevant resident representatives from the LNC (or equivalent) as well as inviting the Chair (or nominated deputy) of the LNC.

207. Residents on the forum may also be elected or otherwise nominated from amongst the residents. Where the Guardian covers specialties that are small or have specific employment requirements, the forum shall include representatives of these groups.

208. The group shall also include relevant educational and People/workforce colleagues as agreed with the group. The RDF or a nominated representative(s) will take part in the scrutiny of the distribution of income drawn from penalties/fines.

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Exception Reporting

209. A new system has been introduced under these TCS for resident doctors to report instances when the individual job plan is not reflected in the actual working conditions, training entitlements, or safe working limits of the resident doctor. This system is called exception reporting and is in place to ensure residents are working within safe limits and experiencing a high-quality training and working environment. Where this does not occur, the Employer/host organisation must take steps to address the issue and ensure a breach does not occur again.

210. This system is not used to report overtime, except when it causes the resident to breach safe working limits. Additional work that is undertaken that is not detailed in the job plan should be reported via the rostering system as set out in Schedule 02.

211. Exception reports should be used to report when factors outside of the resident's control have caused a variance from their personalised job plan. This may include, but is not limited to, the following:

    a. Staffing levels below those defined in the job plan for a given shift.
    b. Being redeployed at short notice to another working area (e.g. a different ward).
    c. Being unable to attend or undertake scheduled training due to service demand.
    d. Performing additional work that causes the resident to breach their safe working hours limits as defined in Schedule 03
    e. Concerns regarding workload in non-resident on-call duty periods
    f. Being required to act in a different role to their normal one (e.g. acting up or acting down, providing cross cover)
    g. Being unable to undertake professional activities that the resident is required to fulfil by their employer/training scheme (e-portfolio, induction, e-learning, quality improvement and quality assurance projects, audits, mandatory training / courses) due to service demand.
    h. Being unable to undertake any activities that are agreed between the resident and their employer, such as quality improvement, attendance at the RDF or LNC/JLNC, rota coordination/maintenance responsibilities, or patient safety tasks directly serving a department or wider employing organisation, due to service demand.

212. Job plan exception reports will be administered using a consistent system across Wales. All residents must have access to this system from the first day their employment begins with NHS Wales under these TCS. Resident doctors will be able to report the type of exception, when and where it occurred, other residents who were also affected, and what steps have already been taken to resolve the issue.

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213. Exception reporting does not prevent local discussion within teams, for example to arrange time off in lieu or other mitigation measures, although should be used in parallel to ensure that an accurate record is kept of when

exceptions have occurred. Employers must use this data to better understand work pressures and design rotas accordingly.

214. The system will work as follows:
   a. Reports regarding access to training opportunities should be sent to the resident's educational supervisor and director of medical education.
   b. Exception reports relating to when the resident's day-to-day work varies significantly and/or regularly from the agreed job plan and acting up or down should be sent to the rota manager/coordinator.
   c. All other reports not described above should be sent to the clinical and/or the educational supervisor of the resident raising the report for actioning and copied to the host/local employer PGME team.
   d. For residents in non-hospital settings, the default should be for all types of exception reports to be sent to the resident's educational supervisor, unless there is a mutual agreement between the resident and the employer or the host organisation, for that placement, for a differing process.
   e. All reports will be accessible to the host Guardian and lead Guardian.
   f. Exception report actioners could include but are not limited to the educational supervisor, clinical leads, rota coordinators, PGME, DME and the Guardian.
   g. Where an exception report has not received a response within 7 working days, the Guardian will have the authority to independently action the report. The Guardian will routinely review the outcome of exception reports to identify whether further improvements to the job plans are required to ensure safe working hours are being maintained. They will also be able to investigate whether other residents were affected and if further action is required.

215. For most variances, the purpose of the system is to act as a repository of evidence regarding issues arising in the workplace. This may be used, for example, in job plan reviews, ARCP evidence and workplace appraisals, and will feature in the reporting requirements of the Guardian.

216. The appropriate course of action will depend on the nature of the exception that occurred. It may include additional education and development time, or changes to the job plan. Where the report has flagged that other residents were affected, the actioner defined in paragraph 212 above may follow up with the other affected residents and, if appropriate, register additional reports to reflect that multiple residents were affected. The actioner may discuss an appropriate action in response to the exception with the affected individual(s) or decide upon the appropriate course of action where this is clear.

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217. For reports of missed training opportunities that were contained in the personalised job plan, the resident will receive educational development time in lieu of their missed training. This will normally involve their release from their normal rostered duties for an equivalent training opportunity (not already

contained in their individual job plan) in the near future, but where this is not possible it may also involve release from their normal rostered duties for individual study or other training activities. In exceptional circumstances, where options above are not available or not appropriate in the circumstances, the resident may receive additional pay in lieu of the lost training time to undertake training or individual study in otherwise un-rostered time.

Job plan exception reports that incur financial penalties

218. The Guardian will review all exception reports copied to them by residents to identify whether a breach has occurred which incurs a financial penalty, as set out in paragraphs below.

219. Where such concerns are shown to be correct in relation to:
   a. A breach of the 48-hour average working week (across the reference period agreed for that placement in the job plan); or
   b. a breach of the maximum 13-hour shift length; or
   c. a breach of maximum of 72 hours worked across any consecutive 168-hour period.
   d. Where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
   e. where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
   f. where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved; or
   g. where daily rest breaks in accordance with paragraph 92 have not been achieved on at least 25% of occasions across a four-week reference period (excluding periods of leave), for the time in which the break was not taken, the resident will be paid for the additional hours at the penalty of two times the relevant hourly rate.

220. In addition to the penalties set out in paragraph 218, the Guardian will also levy a fine on the department employing the resident for those additional hours worked at a penalty rate of two times the relevant hourly rate. Where such a breach that incurs a financial penalty can be demonstrated to affect a group of residents, the Guardian will consider the number of residents affected and will determine a proportionate level of penalty.

221. In addition, where significant and regular levels of additional work or exception reports are being reported in a department, the Guardian shall have the discretion to issue a fine at stipulated penalty rates if, following investigation and intervention, there is no improvement in the department

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222. Where a concern is raised through submission of an exception report that a job plan or duty roster has not been provided within the contractual time limit,

or that access has not been provided to the roster system or exception reporting system within the contractual time limit, the Guardian of safe and flexible working will levy a fine of £500 per resident, per week until the issue has been resolved. This fine will be held in the central fund described in paras 222 - 227 (Subject to the Transition Arrangements set out in Schedule 13).

Disbursement of fines

223. The money raised through fines must be used to benefit the education, training and working environment of trainees. A methodology for determining allocation of funds will be in place (see Transition Arrangements in Schedule 13).

224. The Guardian should devise the allocation of funds using the agreed NHS Wales methodology, in collaboration with the employer/host organisation RDF, or equivalent. These funds should not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEIW as fundamental requirements for residents in training and which should be provided by the employer/host organisation as standard.

225. Further, they must not be used to ensure that the host employer meets the minimum standards set out in the Fatigue and Facilities charter and/or these Terms and Conditions. Examples of where these funds could be spent include but are not limited to courses, events, wellbeing initiatives, additional facilities beyond the minimum standards set out in the Fatigue and Facilities charter.

226. Where the work setting is not suitable for the approach outlined in paragraph 221 (e.g. community settings, general practice), the Guardian will work with the relevant residents to collect and disperse money raised through fines at a regional or national level.

227. The details of the Guardian fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit and should be shared with the LNC. The Guardian's annual report will include clear detail on how the money has been spent. The Lead Guardian will collate information on how fines have been spent as part of their annual report which is sent and presented to NWSSP'S Partnership Committee and MDBG.

Immediate safety concerns

228. Where an exception report indicates concern that there is an immediate and substantive risk to the safety or patients or of the resident making the report, this should be raised immediately (verbally) by the resident with the clinician responsible for the service in which the risk is thought to be present (typically, this would be the head of service or the consultant/on-call). The resident must confirm such reports electronically to the Guardian (via an exception report) within 24 hours.

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229. The employer/host has a duty to respond as follows:
   a. Where the clinician receiving the report considers that there are serious concerns and agrees that there is an immediate risk to patient and/or resident safety, the consultant/on-call shall, where appropriate, grant the resident immediate time off from their agreed job plan and/or (depending on the nature of the reported variation) ensure the immediate provision of support to the resident.
   b. The clinician shall notify the Guardian (copying in the Education Supervisor) within 24 hours, who will undertake an immediate job plan review, and will ensure appropriate (and where necessary, ongoing) remedial action is taken.
   c. Where the clinician receiving the report considers that there are serious but not immediate concerns, the clinician shall ask the resident to submit an exception report to the Guardian, describing the concern raised and requesting a job plan review.
   d. Where the clinician receiving the report considers that the single concern raised is significant but not serious and/or understands that there are persistent or regular similar concerns being raised, the clinician shall ask the resident to raise an exception report to the Guardian within 48 hours. On receipt of the report, the resident and Guardian will determine whether a job plan review should be undertaken.

Residents in General Practice

230. Whilst on placement within General Practice, the Guardian will be the Lead Guardian, based within SLE. Whilst on placement within Secondary Care, the Guardian will be the host organisation Guardian.

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Schedule 06
Private Professional & Fee Paying Work

Principles

231. The resident is responsible for ensuring that the employer/host is advised of any regular commitments the resident has in relation to the provision of any private professional work.

232. The resident is responsible for ensuring any private professional work undertaken by the resident does not result in any detriment to NHS patients or services.

233. The resident should be aware of the relationship between the hours of work undertaken under this schedule and the principles underlying the restrictions on total hours that the resident can work under these terms and conditions of service as set out in Schedule 03.

234. Fee-paying work should normally be carried out in the resident 's own time. However, it will be permissible for the resident to undertake fee-paying work and retain the fee where undertaking the work entails minimal disruption to the NHS (1 hour per month).

235. Where the work requires more time than this, the employer may request that the resident remit the fee to the employer unless they choose to undertake an equivalent duration of compensatory work outside of their normal rostered hours or they authorise their employer to reclaim the salary for the time during which the fee-paying work was undertaken.

236. When undertaking private professional or fee-paying work, residents must make clear their training status on each occasion.

237. Residents are solely responsible for the payment and management of the tax and insurance liabilities and any related costs in respect of any private professional or fee- paying work that the resident undertakes, and for ensuring that they have adequate and appropriate insurance and indemnity for such work, as per GMC guidance. This applies whether or not the work is undertaken on the employer/host's premises, or elsewhere. The resident agrees to indemnify the employer/host for any costs or demands that the employer/host incurs in relation to such liabilities referred to above.

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Disclosure of information about private commitments

238. The resident must keep the educational supervisor informed of any regular commitments in respect of private professional clinical work. This information

must be disclosed as part of the initial job plan discussion and include details of the work involved and when it occurs. The resident must also provide information in advance about any significant changes to this information.

Scheduling of work

239. NHS or other contractual commitments must take precedence over the provision of private professional work, except where a resident is asked at short notice to undertake NHS work beyond their agreed job plan and this would prevent them from meeting pre-existing and previously disclosed private professional commitments which cannot reasonably be rescheduled

Use of NHS facilities

240. The resident must obtain the employing/host organisation's prior agreement to use NHS facilities, staff and/or resources for the provision of private professional or fee-paying work.

241. The employing/host organisation has discretion to allow the use of its facilities, staff and/or resources. They will make it clear which facilities, if any, a resident is permitted to use for private purposes, and to what extent, and whether any charge will be levied for the use of these facilities, staff and/or resources.

242. If a resident with permission, undertakes private professional clinical work in any of the employing/host organisation's facilities, the resident must observe the principles and relevant provisions in the Code of conduct for private practice.

243. Residents must also make themselves aware of and comply with their employing and/or host organisation's policies and procedures for private practice.

Patient enquiries about private treatment

244. Where, in the course of the resident's duties, a resident is approached by a patient and asked about the provision of private professional clinical work, the resident must refer the patient, without advice or comment, to the consultant responsible for the patient's care.

Fee-paying services

245. Fee-paying work should normally be carried out in time for which the resident is not being paid by the employer/host (i.e. in the resident's own time). However, fee-paying work may also be undertaken in the circumstances set out below. This list is not exhaustive but fee-paying work resident residents can claim are:

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a. Section 12 MH Assessment (Psych Trainees who have completed core training and hold a section 12 certification)
b. Section 7 of the pay circular (Current rates can be found here)
   i. 165/Sch 11 Fees for lectures to nurses etc
a. Other grades
   ii. 166/Sch 11 Lecture fee for Postgraduate Medical Education

246. If a fee is paid directly to the resident for such work done during the time for which the resident is paid by the employer/host, the resident must remit the whole fee to the employing organisation, unless the work involves minimal disruption to NHS work.

247. The definition of minimal disruption is around 1 hour per month.

248. Where the fee-paying work does not constitute minimal disruption then the resident may retain the fee for such work carried out during time the resident is being paid by the employer/host, provided that the resident either:

a. undertakes compensatory work outside of their normal rostered hours, either by staying late to complete their normal duties where rest and safety limits permit, or through time back in lieu if the job plan permits, or
b. authorises the employer/host to reclaim the salary for the time during which the fee-paying service was delivered (i.e. at plain time rate if delivered during plain time hours)

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Schedule 07
Other Conditions of Employment

Declaration of Interests

249. A resident must declare:

    a. any outside financial interest or any financial relationship with an external organisation they may have which may conflict or could be perceived to conflict with the policies, business activity and decisions of the employing organisation; and/or

    b. any financial or pecuniary advantage they may gain whether directly or indirectly as a result of a privileged position within the employing organisation.

250. It is the responsibility of the resident to ensure they comply with their corporate responsibilities as set out in NWSSP's standing financial instructions.

Research

251. All research must be managed in accordance with the requirements of the UK Policy Framework for Health and Social Care Research. Residents must comply with all reporting requirements, systems and duties of action put in place by the employing organisation to deliver research governance. Residents must also comply with the GMC guidance Good practice in research as from time to time amended.

Confidentiality

252. A resident has an overriding professional obligation to maintain patient confidentiality as described by guidance from the regulatory bodies, and employer policies from time to time in force, subject to relevant legal exceptions.

253. A resident must not disclose, without permission, any information of a confidential nature concerning other employees or contracted workers, except where there is an overriding public interest or legal obligation to do so.

254. A resident must not disclose, without permission, any information of a confidential nature concerning the business of the employer or of contractors of the employer, save where there is an overriding public or patient safety interest or legal obligation to do so.

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Raising concerns

255. Should a resident have cause for genuine concern about an issue (including one that would normally be subject to the requirements regarding information of a confidential nature set out in paragraph 250 above) the resident has a professional obligation to raise that concern. A resident should raise concerns, in accordance with NHS Wales Speaking Out Safely Framework and relevant procedures and shall not be subject to any detriment for raising such concerns, including those regarding a third party (for example HEIW).

256. If a resident believes that a disclosure of any concern regarding malpractice, patient safety, the safety of residents, other employees or contracted workers, financial impropriety or any other serious risk (including one that would normally be subject to paragraph 250) would be in the public interest, they have a right and a duty to speak out and be afforded statutory protection as required under the Public Interest Disclosure Act 1998 (PIDA) as amended from time to time. A resident making such a qualifying disclosure, whether under PIDA or directly to SLE and/or host employer, shall also have the right not to be subject to any detriment by SLE and/or host employer for raising such concerns, via the provisions of the Employment Management Agreement. As far as practicable, local procedures for disclosure of information in the public interest should be followed.

Publications

257. A resident shall be free, without prior consent of the employing organisation, to publish material and to deliver lectures or speak at an event, whether on matters arising out of NHS service or not. This freedom is subject to the requirements regarding information of a confidential nature set out in paragraph 250 above, and the requirements regarding research set out in paragraph 249 above. Such communications, whether or not these activities take place in the resident's own time, must be in good faith and without malice, and are subject to the employing organisation's protocols and practices (including those on social media usage and the press). The resident must also follow guidance from the relevant regulatory bodies.

258. The resident should be aware of the employing organisation's local policy regarding intellectual property. Where payment is received, the resident should comply with the requirements of Schedule 06 - Private Professional and Fee-Paying Work.

Intellectual Property

259. The resident must comply with the employing organisations policies and procedures for intellectual property. These will reflect the Intellectual property (IP) guidance for National Health Service (NHS) Wales organisations

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Transfer of information

260. Where the resident is required to rotate between employing organisations and/or host organisations, there will be a requirement on the employer/host organisations to transfer such personal and confidential information regarding the resident's employment and training as is deemed necessary by the organisations for the completion of pre-employment checks and for the continuation of the resident's training. It is a condition of employment that the transfer of such information occurs.

261. The employer / host organisation is required under the terms of the Employer Management Agreement between the employer / host organisation and SLE to send and receive information about residents to and from SLE in order to facilitate the management of training programmes. The employer will make every reasonable effort to comply with the time frames set out in the Employer Management Agreement wherever and whenever it is possible to do so. Residents and employers have a mutual obligation to facilitate such data transfers so as to enable appropriate notification of deployment by employers to future appointees, as set out in the Employer Management Agreement. It is a condition of employment that the transfer of such information occurs. The employer/host organisations shall comply with the provisions of the UK General Data Protection Regulation and Data Protection Act 2018 and all relevant Codes of Practice at all times and shall ensure that they have in place appropriate systems to protect the security of any information being transferred.

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Schedule 08
Leave

Principles

262. It is in the interest of residents' health and wellbeing and the continued safety of patients in their care, that they take their full annual leave entitlement.

263. Leave required by the Working Time Regulations 1996 (as amended) must be taken in each leave year, subject to paragraphs 285- 290 of this Schedule.

264. The employer/host and the resident must make every effort to work together to ensure that the resident is able to take the full annual leave entitlement.

265. Study or professional leave must be used for the purpose for which it is granted.

266. Safeguards on hours and rest as set out in Schedule 03 continue to apply during any period of leave.

267. In the case of a resident contracted by the Single Lead Employer (SLE), decisions to approve leave requests rest with the host organisation, unless expressly stated otherwise.

268. As set out in Schedule 03, the rota and job plan must be designed to facilitate access to the full leave allowance as well as appropriate training.

Annual leave

269. The annual leave year runs from the start date of the resident's appointment.

270. The annual leave entitlement for a full-time resident is as follows, based on a standard working week of five days:
    a. On first appointment to the NHS: 28 days
    b. After five years completed NHS service 33 days

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271. These entitlement values include the additional day of annual leave granted by the Minister for Health and Social Services in December 2021 and previous statutory days.

272. Residents may take one day of annual leave against a shift of any length provided the shift takes place wholly on one day and no part of the shift

273. Residents with experience gained in local employment (i.e. LEDs) or from work abroad will have each year of service as an LED or doctor abroad regarded as equivalent to a years' service within the NHS for the purposes of calculations for annual leave entitlement. If the resident is unable to provide equivalent evidence, then each calendar year in service will be counted as half a year of service in the NHS for these purposes.

274. If, on termination of employment, a resident has not taken their full entitlement to accrued annual leave as calculated to the termination date, they will receive payment for the accrued but untaken annual leave.

275. Annual leave on termination of employment will be calculated as follows:

Annual leave entitlement multiplied by the proportion of the leave year that has expired before the termination date – expressed as a fraction minus leave already taken in the leave year.

276. If, upon termination of employment, a resident has taken paid annual leave in excess of their entitlement as calculated to the termination date, a deduction will be made from the final salary in respect of any overpayment of annual leave.

277. As leave is deducted from the rota before average hours are calculated for pay purposes, as set out in Schedule 03, leave may not be taken from shifts attracting an enhanced rate of pay or an allowance, as set out in Schedule 02 of these TCS.

278. Where a resident wishes to take leave when rostered for such a shift or duty, the resident must arrange to swap the shift or duty with another resident on the same rota. It is the resident's responsibility to arrange swaps. The employer/host will take all reasonable steps to facilitate the arrangement of the swap. However, the employer/host is not obliged to approve the leave request if the resident does not make the necessary arrangements to cover the shift.

279. Where the resident's contract or placement is for less than 12 months, the leave entitlement is pro rata to the length of the contract or placement.

280. A flexible (part-time) resident will be allocated leave on a pro rata basis. This will be calculated in the same way set out for pay in Schedule 02, by being calculated pro rata on the average hours' work per week across the rota cycle

281. It may be appropriate for leave to be calculated for some residents in hours.

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282. A resident shall normally provide a minimum six weeks' notice of annual leave to be approved in accordance with local policies and procedures.

283. The employer/host shall, where possible, respond positively to all leave requests, and shall normally agree reasonable requests.

284. Employers/hosts must allow annual leave to be taken when it has been requested for a lifechanging event, provided that the resident has given notice to the employer/host in accordance with paragraph 280-281 of this Schedule. This provision does not apply to leave for circumstances covered by Section 15 of the NHS Terms and Conditions of Service Handbook or local policies such as special leave or bereavement.

285. If, due to circumstances beyond the resident's control, a reasonable request is made for leave outside the minimum six weeks' notice period, then the employer/host will fairly consider this request while paying due regard to service requirements.

286. The resident and the employer/host will work together to ensure that leave is appropriately planned and taken across the year. This is to ensure both access to training and the maintenance of service delivery, and to protect the safety of both residents and patients.

287. In exceptional circumstances, where agreement on planning leave is not possible despite the best reasonable efforts of the resident and the employer/host, some leave may need to be allocated to ensure that all residents are able to take their full leave entitlement while maintaining safe coverage of services. However, leave should not be fixed into a working pattern for this or any other reason without agreement from the resident.

288. In addition to the provisions of paragraph 285, a rota should not be so restrictive in its design to give the appearance of fixed leave being incorporated into the rota, where there is little or no flexibility over when leave can be taken. Where possible, rosters should be designed to contain periods of at least two or three consecutive weeks without shifts attracting enhancements or allowances, to provide residents with the opportunity to take longer periods of leave.

289. Where a resident has been prevented from taking the full allowance of annual leave before the end of the leave year. The outstanding leave will normally be carried forward to the next leave year upon mutual agreement between the resident and employer/host organisation.

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290. Where a resident has been allocated leave on dates not of their own choosing and they are subsequently prevented by sickness from taking their full allocation of leave before the end of the leave year, the leave will

normally be carried forward to the next leave year upon mutual agreement between the resident and employer/host organisation.

291. In other circumstances, subject to the needs of the service, up to five days of leave per annum (pro rata for contracts or placements of less than 12 months' duration or for residents who work flexibly (part-time), may be carried forward to the next post or placement with the same employer/host.

292. With the agreement of the employer/host and in line with local policy, payment in lieu can be made for up to five days' annual leave (pro rata as appropriate) which could not be taken before a move to a new employer/host organisation.

Payment for annual leave

293. Pay is calculated on the basis of what the resident would have received had they been at work, based on the resident's job plan and regular work undertaken in the appropriate reference period. Payment of annual salaries is referred to in Schedule 02 of these TCS.

294. Where the employer/host offers a local scheme for the purchase of additional annual leave, a resident will be permitted to seek participation in such a scheme, subject to any training requirements. The impact of any additional leave must be considered by the Director of Medical Education, Guardian and HEIW and agreed on behalf of the postgraduate dean. Any such agreed additional annual leave can only apply to the placement with that specific employer/host.

Public holidays

295. Public holiday entitlement, as recognised by the NHS and set out in the definitions at the front of these TCS, is additional to annual leave entitlement.

296. A flexible (part-time) resident is entitled to paid public holidays at a rate no less than pro rata to the number of public holidays for a full-time resident, rounded up to the nearest half day.

297. A flexible (part-time) resident will be allocated public holidays on a pro rata basis. As outlined in Schedule 02, basic salary for a flexible (part-time) resident is calculated pro rata on the average hours' work per week across the rota cycle. Therefore, in the same way, the pro rata calculation of public holidays will be based on the average hour's work per week as a percentage of the standard 40-hour working week.

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298. Public holiday entitlement for a flexible (part-time) resident shall be added to annual leave entitlement, and any public holidays shall be taken from the combined allowance for annual leave and public holidays.

299. A resident who in the course of their duty is required to be present in the hospital (or other place of work) at any time (from 00.01 to 23.59) on a public holiday, or who is rostered to be on-call on a public holiday, will be entitled to a standard working day off in lieu. Standard working day is set out in the definitions at the front of these TCS

300. Where a resident's working pattern includes scheduled rest days (sometimes known as zero hours' days) and such a day falls on a public holiday, then the resident will be given a day off in lieu of the public holiday.

301. Where a public holiday, including Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January), falls on a Saturday or a Sunday, the public holiday will be designated instead as falling on the first working weekday thereafter. In such circumstances, no day in lieu then arises for the work undertaken on Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January).

Study and professional leave

302. Each resident has an entitlement to study leave for each year of their training programme.
   a. Resident Doctors in Foundation Year 1 are entitled to 15 days of study leave per annum.
   b. All other Residents are entitled to 30 days of study leave per annum.

303. Study leave includes but is not restricted to participation in:
   a. study (linked to a course or programme)
   b. research
   c. teaching
   d. preparing for and taking examinations
   e. attending conferences for educational benefit
   f. rostered training events.

304. Attendance at statutory and mandatory training (including any local departmental training) is not counted as study leave and should instead be counted as working hours.

305. All requests for study leave will be properly considered by the employer/host. Any grant of study leave will be subject to the need to maintain NHS services (and, where the resident is on an integrated academic pathway, academic responsibilities) and must be authorised by the employer/host.

306. A resident is obliged to use study or professional leave for the purpose for which it has been granted. Safeguards on hours and rest as set out in Schedule 03 will continue to apply.

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307. Study leave will normally be granted flexibly and tailored to individual needs, in accordance with the requirements of the curriculum. This allowance includes the provision of up to 5 days study leave for any individual exam sittings, regardless of the number of sittings in the year.

308. Requests for study leave in excess of these limits should be considered fairly where circumstances indicate such requests to be reasonable and may be granted by the employer/host provided that the needs of service delivery can be safely met.

309. Study leave for Foundation Year 1 residents will take the form of a regular scheduled teaching/training session (or similar arrangement) as agreed locally.

310. Study leave for residents at Foundation Year 2 and above will include periods of regular scheduled teaching/training sessions, and may also, with approval from the educational supervisor and service manager, include:
   a. undertaking an approved external course or event
   b. periods of sitting (or preparing for) examinations for a higher qualification where it is a requirement of the curriculum, noting the entitlement relates to each sitting as referenced in paragraph 306.

311. Requests for such leave shall be viewed positively in most circumstances, but with a view to ensuring that the needs of service delivery can be safely met.

312. Where shifts attracting an enhanced rate of pay or an allowance are required to be swapped to take study leave, or if residents are required to provide internal cover for colleagues on the rota when they take study leave, then prospective cover is in operation. In such situations, residents' study leave allowance for the rota must be factored into the calculation of the average weekly hours of work and pay for that rota. the average weekly hours of work that attract an enhancement, the average hours of work that attract the on-call availability allowance and therefore pay. See Annex 01 for the agreed formula for calculating average hours.

313. Where employing organisations/hosts have alternative arrangements for covering study leave, where internal cover or swaps of shifts are not required, prospective cover does not apply.

314. A resident on a contract of employment of less than 12 months' duration is entitled to study leave on a pro rata basis.

315. A flexible (part-time) resident is entitled to study leave at a rate no less than pro rata to the number of study leave days for a full-time resident, rounded up to the nearest half day. As outlined in Schedule 02, flexible (part-time) residents are paid pro rata based on the proportion of work agreed in the job plan, not their nominal training percentage. Therefore, in the same way as

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pay the pro rata calculation of study leave will be based on the number of hours worked as a percentage of the standard 40-hour working week.

316. Where a flexible (part-time) resident is required to undertake a specific training course required by the curriculum, which exceeds the pro rata entitlement to study and /or professional leave, the employer/host will make arrangements for additional study leave to be taken, provided that this can be done while ensuring safe delivery of services.

317. Study leave should be prospectively sought for all teaching, courses and educational opportunities that fall on non-working days, and where study leave approval is granted it must be compensated with TOIL, or payment if the resident prefers.

318. Where a resident takes parental leave their entitlement to study leave continues, and this may be taken during 'keeping in touch' days or will otherwise accrue to be taken at a later date.

319. Professional leave is leave in relation to professional work, as described in the definitions section of these TCS. Job interviews for NHS, public health, academic, NHS commissioned community health and hospice appointments should be considered professional leave, with time off accommodated appropriately and a resident should not be required to take annual or study leave to attend such interviews. Residents should provide rota coordinators with as much notice as possible to effectively plan the roster.

Sickness absence

320. A resident who is incapable of doing their normal work because of illness shall immediately notify their employer/host in accordance with the employer/host's procedures. A self-certificate will cover days one to seven of the period of sickness (including any non-working days). The resident must obtain a medical certificate for subsequent days.

321. There is no requirement for a resident to compensate the employer/host, in time or pay, for any scheduled duties they were unable to perform due to sickness

322. A resident who becomes ill whilst on annual leave, shall immediately notify their employer/host in accordance with the employer/host's procedures on the first day of sickness. Further annual leave will be suspended from the date of notification subject to provision of a medical certificate.

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323. Residents are required to notify their employer/host as soon as possible of any illness, disease or condition that prevents them from undertaking their duties.

324. Where the employer/host considers at any time that a resident is unable to perform some or all of their duties as a consequence of illness, the employer/host can require the resident to attend an examination by the organisation's occupational health services, in accordance with local procedures.

325. A resident absent from duty owing to illness (including injury or other disability) shall, subject to the provisions of paragraphs 322-332 below, be entitled to receive an allowance in accordance with the following table

Table 2 - Scale of allowances

During the first year of service	One month's full pay and two months' half pay
During the second year of service	Two months' full pay and two months' half pay
During the third year of service	Four months' full pay and four months' half pay
During the fourth and fifth years of service	Five months' full pay and five months' half pay
After completing five years of service	Six months' full pay and six months' half pay

326. The allowances set out in table 2 above are in line with those for all staff in the NHS, as set out in the NHS Terms and Conditions of Service Handbook, and will be amended where any such amendment is agreed by the NHS Staff Council and must also be agreed by Medical and Dental Business group.

327. For residents on these TCS the definition of full pay will include regularly paid enhancements, allowances and premia. Sick pay is calculated on the basis of what the individual would have received had they been at work. This would be based on the previous three months at work. Employers/host organisations can use virtual rotas showing what hours the employee would have worked in a reference period had he or she been at work.

328. Employers/hosts will have discretion to extend the period of sick pay on full or half pay beyond the scale set out in Table 2 above in exceptional circumstances and in line with local employer/host policies:
   a. where there is the expectation of return to work in the short term and an extension would materially support a return and/or assist recovery, particular consideration should be given to those staff without full sick pay entitlements.
   b. in any other circumstance that the employer/host deems reasonable.

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329. During the phased return period, employers/hosts should make the appropriate adjustments to allow the resident to return to work. This may include working reduced hours, undertaking training or administrative activities without loss of pay. Any such arrangements need to be consistent with statutory sick pay rules and in line with the NHS Wales Managing Attendance At Work Policy (or successor policy which is agreed via MDBG).

330. Residents who are unable to take their statutory annual leave (i.e. the leave to which they are entitled under the Working Time Regulations) in any leave year due to sickness absence will be permitted to carry over that leave to a subsequent leave year where employment is continuous.

331. Any carried-over leave must be taken within 18 months of the end of the leave year in which it accrues. Where the resident changes employer/host before taking this entitlement, the outstanding balance will be compensated through pay. The content of this paragraph does not apply to any leave granted under these TCS which exceeds the resident's statutory entitlement under the Regulations, which will lapse if it is not taken in the leave year in which it accrues.

332. The period during which sick pay should be paid and the rate of sick pay for any period of absence is calculated by deducting from the resident's entitlement on the first day of sickness the aggregate periods of paid sickness absence during the 12 months immediately preceding that day. In aggregating periods of absence due to illness no account shall be taken of:
   a. unpaid sick absence
   b. injuries, diseases, or other health conditions sustained or contracted in the discharge of the resident's duties of employment, as defined in Section 22 of the NHS Terms and Conditions of Service Handbook
   c. injury resulting from a crime of violence, not sustained on duty but connected with or arising from the resident's employment, where the injury has been the subject of payment by the Criminal Injuries Compensation Authority (England, Wales and Scotland) and/or the Compensation Agency (Northern Ireland)
   d. as above, but an injury which has not attracted payment of an award as it has not met the loss of earnings criteria or was not one for which compensation above the minimum would arise.

333. The employer/host may, at its discretion, take no account of the whole or any part of the period of absence due to injury (not on duty) resulting from a crime of violence, not arising from or connected with the resident's employment or profession.

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334. For the purpose of calculating the appropriate allowance of paid sickness absence under paragraph 329, previous qualifying service shall be determined in accordance with the resident's statutory rights and all periods of service, (without any break of 12 months or more, subject to paragraph 331 below), with a National Health Service employer/host shall be

aggregated. Previous service with a non-NHS employer where placement is required should be included when calculating the allowance.

335. Where a resident has broken their regular service for one of the following reasons:
   a. in order to go overseas in a rotational appointment forming part of a residents recognised training programme; or
   b. for an approved period of time out of programme for clinical training (OOPT), clinical experience (OOPE) or research (OOPR);
   c. then the resident's previous NHS or approved service, as set out in paragraph 330 above, shall be taken fully into account in assessing entitlement to sickness absence allowance, provided that the employer/host considers that there has been no unreasonable delay between the training or OOP ending and the commencement of the subsequent NHS post.

336. For the purpose of sickness absence allowances, a resident's previous contracted NHS locum service shall be recognised, subject to a minimum of three months' continuous NHS locum service.

Limitation of allowance when insurance or other benefits are payable

337. The sickness absence allowance paid to a resident when added to any statutory sick pay, injuries or compensation benefits, including any allowances for adult or child dependants, must not exceed the pay the resident would have received had they been at work.

Recovering of damages from third party

338. A resident who is absent as a result of an accident is not entitled to sick pay if damages are received from a third party. Employer/hosts will advance to the resident a sum not exceeding the amount of sick pay payable under this scheme, providing the resident repays the full amount of sickness allowance to the employer/host, when damages are received. Once received the absence shall not be taken into account for the purposes of the scale set out in table 2 in this Schedule.

Accident due to sport or negligence

339. An allowance shall not normally be paid in a case of accident due to active participation in sport as a profession, or where contributory negligence is proved.

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Injury sustained on duty

340. An absence due to injury sustained by a resident in the actual discharge of their duty, for which the resident was not liable, shall not be recorded for the purposes of aggregation against future sickness absence.

341. The injury allowance provisions will apply as set out in Section 22 of the NHS Terms and Conditions of Service Handbook 21 and should be read alongside the accompanying guidance issued by NHS Employers.

Termination of employment

342. The sickness absence provisions of these TCS shall cease to apply to a resident on the termination of employment by reasons of permanent ill health or infirmity of mind or body, of resignation, of age, or any other reason, provided that, where a resident is in receipt of sickness absence allowance at the time of expiry of a contract, that allowance shall be paid during the resident's illness, subject as a maximum to the resident's entitlement to allowances under the provisions of table 2 in this Schedule.

Forfeiture of rights

343. If it is reported to the employer/host that a resident has failed to observe the conditions of Schedule 10 or has been guilty of conduct prejudicial to the resident's recovery, and the employer/host is satisfied that there is substance in the report, the payment of the allowance shall be suspended until the employer/host has made a decision regarding the continued payment of the allowance. Before making a decision, the employer/host must give the resident an opportunity of responding to the report. If the employer/host decides that the resident has failed without reasonable excuse to observe the conditions of this Schedule or has been guilty of conduct prejudicial to the resident's recovery, then the resident shall forfeit the right to any further payment of allowance in respect of that sickness or period of absence.

Special leave with or without pay

344. Special leave may be granted in exceptional circumstances, on a short-term basis at the discretion of the employer/host. All requests for special leave will be considered by the employer/host in line with statutory requirements and local policy.

Parental leave

345. General provisions can be found in Schedule 14 – Sections of the NHS Terms and Conditions of Service Handbook applicable to residents.

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Schedule 09
Termination of employment

General

346. Unless stated otherwise, a resident employed under these terms and conditions of service is employed on a fixed-term basis and the contract will terminate at the end of the fixed term without the need for further notice from either party. Upon termination of the contract in these circumstances the resident is immediately entitled to receive the benefit of a period of grace set out in these TCS.

347. The contract of employment can be brought to an end prior to the expiry of the fixed-term arrangements. In such circumstances, either the resident or the employer must give notice in writing, except where the provisions of paragraph 356 apply.

Statutory notice periods

348. The employer shall give, as the minimum period of notice to terminate the employment of a resident who has been continuously employed for at least four weeks (unless the period specified in paragraph 348 below is longer):

    a. one week's notice if the period of continuous employment is less than two years; or

    b. one week's notice for each year of continuous employment if the period of continuous employment is at least two but less than 12 years; or

    c. 12 weeks' notice if the period of continuous employment is 12 years or more.

349. The minimum period of notice to be given to the employer by a resident who has been continuously employed for at least four weeks, shall be one week (unless the period specified in paragraph 348 below is longer). The period of continuous employment shall be computed in accordance with the Employment Rights Act 1996, as amended from time to time.

Contractual notice periods

350. The agreed minimum period of notice by both sides for residents employed under these terms and conditions of service, unless the statutory minimum periods of notice as set out above, are longer, shall be as follows:

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Table 3 - Contractual Notice Periods

F1 F2 StR (Core training) (CT)	One month

StR (Fixed term Specialty Training Appointment) Dental Core Trainee (DCT)	
StR (Run-through) StR (Higher Specialty Training) GP Specialty Registrar SpR	Three months

Application of notice

351. Shorter or longer notice periods can apply where agreed between both parties in writing and signed by both.

Residents rotating from one NHS employer to join another

352. Where a resident terminates employment immediately before a weekend and/or a public holiday and takes up a new salaried post with another NHS employer immediately after that weekend and/or that public holiday, payment for the intervening day or days, i.e. the Saturday (in the case of a five-day working week) and/or the Sunday and/or the public holiday, shall be made by the first employer.

Termination of employment

353. Whilst it is accepted that the majority of residents employed within the NHS do their best to achieve high standards of behaviour and practice, on occasion a resident may fail to meet the standards required, and in some circumstances, this may lead to termination of employment.

354. The process for dealing with matters of conduct, competence, capability or performance is detailed in Upholding Professional Standards in Wales (UPSW).

Grounds for termination of employment

355. A resident's employment may be terminated for the following reasons:

a. Conduct.
b. Capability (including as defined by HEIW in UPSW).
c. Redundancy.
d. In order to comply with a statute or other statutory regulation.
e. Failure to hold or maintain a requisite qualification, registration, place on a General Medical Council approved training programme and/or license to practise.
f. Where there is some other substantial reason to do so in a particular case.

356. Should the application of any of the above procedures result in the decision to terminate a resident's contract of employment, the resident will be entitled to invoke a locally recognised appeals process, as set out in the relevant

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policies of the employing organisation. UPSW must be followed for matters described in paragraph 353 above.

357. In cases where employment is terminated, a resident may be required to work the notice period, or if the employer considers it more appropriate, the resident may be paid in lieu of notice or paid through the notice period but not be required to attend work. Such arrangements are at the sole discretion of the employer.

358. Employment can be terminated without notice in cases of gross misconduct, gross negligence, where a resident's professional registration and/or license to practice has been removed or has lapsed (without good reason) or a resident's removal from a GMC- approved training programme. The postgraduate dean will be informed immediately by the employer when this circumstance arises. In this circumstance the resident will be entitled to invoke the locally recognised appeals process, as set out in the relevant policies of the employing organisation. This process must be in line with ACAS guidance. UPSW must be followed for matters described in paragraph 353 above.

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Schedule 10
Expenses

General

359. Expenses relating to travel, subsistence and other business expenses shall be paid to meet actual disbursements of residents in the performance of their duties and shall not be regarded as a source of pay or reckoned as such for the purposes of pension.

360. Claims for expenses shall normally be submitted within one month and as soon as possible after the end of the period to which the claim relates, subject to local procedures.

361. The following terms are used throughout the provisions set out in this Schedule:

    a. ‘Work base’ means the place of work from which the resident conducts their main duties. Where a resident has a joint contract with more than one employer, the term ‘work base’ means the place from which the resident conducts their main duties within that joint contract, irrespective of employer.

    b. ‘Official journey’ means a journey in the performance of a resident’s duties.

362. Costs incurred by residents shall be reimbursed when, with the agreement of their employer, they use their own vehicles or pedal cycles to make official journeys.

363. When residents use their vehicles for official journeys, they must possess a valid driving licence, Ministry of Transport (MOT) test certificate, vehicle tax and motor insurance that covers business travel. It is the resident's responsibility to cover the costs of such licences, certificates and insurance. Residents must be fit to drive, drive safely and obey the relevant laws e.g. speed limits. The resident must inform the employer if there is a change in their fitness to drive status.

364. When authorising the use of a vehicle, the employer must ensure that the driver has a valid driving licence and MOT certificate, vehicle tax and has motor insurance that covers business travel.

365. The employer and resident will agree the most suitable means of transport for the routine journeys that the resident has to make in the performance of their duties. If a particular journey is unusual, in terms of distance or

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purpose, the mode of travel and expenses payable will be agreed between the employer and resident before it starts.

366. Where the use of a vehicle is essential to the job, the employer may wish to assist by providing a lease or pool vehicle. In exceptional circumstances the employer may provide an advance of basic pay. Principles underpinning lease vehicle policies are provided by NWSSP.

367. The reimbursement of excess travel costs when residents are required to change their principal place of work as a result of organisational change is set out in the Organisational Change Policy[6].

Rates of reimbursement

368. For residents who use their own vehicles or pedal cycles to make official journeys, their travel costs shall be reimbursed at the appropriate rates.

369. The rates of reimbursement are set out in Section 17 (Wales) NHS Terms and Conditions - Reimbursement of Travel Costs.

370. Residents who use their vehicles to make journeys in the performance of their duties e.g. to provide care in the patient's home, will be reimbursed their motoring costs at the appropriate rates shown in Table 4. These rates of reimbursement apply to journeys undertaken on and after 1 April 2026.

Table 4: Rates of reimbursement from 1 April 2026

Column 1	Column 2	Column 3	Column 4
Type of vehicle/allowance	Annual mileage up to 10,000 miles (standard rate)	Annual mileage over 10,000 miles (standard rate)	All eligible miles travelled
Car (all types of fuel)	55 pence per mile	25 pence per mile	
Motorcycle			24 pence per mile
Bicycle			20 pence per mile
Passenger allowance			5 pence per mile
Reserve rate (see below)			28 pence per mile

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[6] N.B. where the criteria is met, this provision does not prevent the doctor from applying under the NHS Wales Relocation Reimbursement Policy which is a separate policy that outlines the financial support available to resident doctors and dentists should they have to relocate or travel to a geographically more distant training location.

Carrying heavy or bulky equipment (see below)			3 pence per mile

371. The rates of reimbursement in Table 4, columns 2 and 3 and the rate of reimbursement for motorcycles in column 4 will apply from 1 April 2026 and are those set out by HMRC as approved mileage allowance payments (AMAP rates). These rates of reimbursement will be adjusted in accordance with the published AMAP rate. The rates will apply to all journeys undertaken on and after 1 August 2026.

372. The reserve rate in column 4 will move in line with any changes agreed by an NHS Staff Council review, Welsh Partnership Forum and Medical and Dental Business Group, currently 50% of the rounded rate for car reimbursement.

Review

373. In accordance with the NHS Wales agreement reached in January 2015, any changes to the AMAP rate will be automatically applied to the standard rate of reimbursement and the rate for motorcycle users.

Eligible mileage

374. Employees will be reimbursed for miles travelled in the performance of their duties which are in excess of the home to agreed work base return journey. Normally, the miles eligible for reimbursement are those travelled from the agreed work base and back. However, when the journey being reimbursed starts at a location other than the agreed work base, for example home (where home is not the agreed work base), the mileage eligible for reimbursement will be as set out in the example in Table 5.

Passenger rate

375. With the exception of lease, pool or hire vehicle users, where other employees or members of an NHS organisation are conveyed in the same vehicle on NHS business and their fares would otherwise be payable by the employer, the passenger allowance in Table 4 will be payable to the vehicle driver.

Reserve rate of reimbursement

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376. A reserve rate of reimbursement, as in Table 4 column 4, will apply to Residents using their own vehicles for business purposes in the following situations:

a. If a resident is working in a GP practice setting and is required to use their own vehicle on the expectation that home visits may be required

to be undertaken. The reserve rate will be paid for the mileage of their return journey from home to work base, and any associated allowances as described in paragraph 385 below.

i. The days on which a resident may be expected to perform home visits should be specified within their generic job plan, or an alternative document providing advance notification that home visits may be required. Further specificity, as required, around when a resident is expected to perform home visits should be added to the personalised job plan when the resident agrees it with their educational supervisor.

ii. When submitting claims for home to work base mileage, in line with local processes for claiming expenses, a resident must either:
   - attach their job plan to the claim form, or any alternative written advance notice they have been provided by their practice, which specifies the days on which they are expected perform a home visit. or
   - obtain validation from a GP practice staff member that that they had been advised they would need their own vehicle available due to the potential requirement to perform a home visit that day, when claiming home to work base mileage for a day not specified in their job plan, or any alternative written advance notice the resident has been received from their practice.

iii. where no detail has been provided within the resident's generic and personalised job plans, or any alternative written advance notice, then the resident must submit a claim for all the days on which they took their vehicle into work due to the possibility of being required to perform a home visit. This claim must be validated by the practice manager or a member of staff who is authorised to validate claims from the GP Practice.

iv. The resident is eligible to claim mileage at the standard rate for any journeys from their principal place of work to the location of any home visit(s).

b. if a Resident unreasonably declines the employers' offer of a lease vehicle.

i. In determining reasonableness, the employer/host and Resident should seek to reach a joint agreement as to whether a lease vehicle is appropriate and the timeframe by which the new arrangements will apply. All the relevant circumstances of the Resident and employer/host will be considered including a

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Resident's personal need for a particular type of car and the employer/hosts' need to provide a cost-effective option for business travel.

ii. If the resident's circumstances subsequently change the original decision will be reviewed. The agreed principles underlying local lease vehicle policies are contained in the NHS Terms and Conditions of Service Handbook at Annex 13;

c. when Residents are required to return to work additional hours (overtime) in line with Schedule 03 on any day and incur additional travel to work expenses on that day. This provision will apply if the Resident chooses to be paid for the extra hours or takes time off in lieu;

e. when a claim for excess mileage is made in situations where there is a compulsory change of base, either permanent or temporary, resulting in extra daily travelling expenses. The period of payment will be for local partnerships to determine, subject to a maximum period of 4 years from the date of transfer. (For those Residents using public transport see paragraph 384);

f. if a Resident uses his or her own vehicle when suitable public transport is available and appropriate in the circumstances, subject to a maximum of the public transport cost which would have been incurred (see paragraph 365) and the rules on eligible miles in paragraph 374 and Table 5.

g. in line with the situation noted above, where an individual chooses to use either a Pedal Cycle or a Motorcycle when eligible for the Reserve rate, then the rate of reimbursement will be the Pedal Cycle or Motorcycle rate as set out in Table 4 Column 4.

Table 5: Eligible mileage: illustrative example
In this example the distance from the Resident's home to the agreed base is 15 miles

	Distance	**Eligible miles**
Journey (outward)		
Home to base	15 miles	None
Home to first call	Less than 15 miles	Eligible mileage starts after 15 miles have been travelled
Home to first call	More than 15 miles	Eligible mileage starts from home, less 15 miles
Journey (return)		
Last call to base	All	Eligible mileage ends at base
Base to home	15 miles	None

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Last call to home	Less than 15 miles	Eligible mileage ends 15 miles from home
Last call to home	More than 15 miles	Eligible mileage ends 15 miles from home

Attendance on training courses

377. Additional travel costs incurred when attending courses, conferences or events at the employer's instigation will be reimbursed at the standard rates in Table 4 when the employer agrees that travel costs should be reimbursed.

378. Subject to the prior agreement of the employer, travel costs incurred when staff attend training courses or conferences and events, in circumstances when the attendance is not required by the employer, will be reimbursed at the reserve rate in Table 4, in line with the rules on eligible mileage in paragraph 376 and Table 5.

"Out of pocket" expenses in respect of business travel

379. This paragraph applies to Residents for whom regular travel in a motor vehicle is an essential part of their duties. During a period when the employee's vehicle is temporarily "off the road" for repairs, "out of pocket" expenses in respect of business travel by other appropriate forms of transport, should be borne by the employer. Reimbursement of these expenses will be subject to the rule on eligible mileage in paragraph 374 and Table 5.

Other allowances

380. Residents who necessarily incur charges in the performance of their duties, in relation to parking, garage costs, tolls and ferries shall be refunded these expenses on production of receipts, whenever these are available. Charges for overnight garaging or parking, however, shall not be reimbursed unless the employee is entitled to night subsistence. This does not include reimbursement of parking charges incurred as a result of attendance at the employee's normal place of work.

Transporting equipment

381. Residents who use their vehicles in the performance of their duties may be required to take equipment with them. Employers have a duty of care under the Health and Safety at Work Act 1974 and related legislation, to ensure that this does not cause a risk to the health and safety of the employee. Residents should not be allowed to carry equipment, which is heavy or bulky, unless a risk assessment has been carried out beforehand. When, after the necessary assessment has demonstrated it is safe to carry equipment, an allowance (see Table 4) shall be paid for all eligible miles

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(see paragraph 376 and Table 5) for which the equipment is carried, provided that either:

a. the equipment exceeds a weight which could reasonably be carried by hand; or
b. the equipment cannot be carried in the boot of the vehicle and is so bulky as to reduce the seating capacity of the vehicle.

Pedal cyclists

382. Residents who use pedal cycles to make journeys in the performance of their duties will be reimbursed for eligible miles travelled at the rate in Table 4 (see paragraph 376 and Table 5 for eligible miles).

Public transport

383. If an employee uses public transport for business purposes, the cost of bus fares and standard rail fares should be reimbursed.

384. Where there is a compulsory change of base, either permanent or temporary, resulting in extra public transport costs for the Resident, these extra costs will be reimbursed, subject to a maximum period of four years from the date of transfer or are entitled to receive two years' excess mileage paid as a lump sum. (For those Residents using their own vehicles for business purposes and incurring additional costs see paragraph 379).

Study leave expenses

385. Residents may be entitled to reimbursement of reasonable study leave expenses, in accordance with the NHS Wales Study Leave Policy, which must meet the minimum standards for provision set out in the Employment Management Agreement (or any successor document) between NWSSP and HEIW/Host organisations.

386. This shall apply equally to residents taking study leave during or accrued while on parental leave as per Schedule 08 paragraph 341.

Relocation expenses

387. Residents and dentists in a training programme should refer to the NHS Wales Relocation Reimbursement Policy which outlines the financial support available to them should they have to relocate or travel to a geographically more distant training location.

388. The reimbursement of excess travel costs when residents are required to change their base as a result of organisational change is set out in the Organisational Change Policy.

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389. Additionally, assistance with relocation expenses, including removal or excess mileage, shall be provided to residents who:

i. need to move their home or incur extra daily travel expenses as a result of being required by their employer to transfer work base.

390. Except where another body (such as HEIW via the NHS Wales Relocation Reimbursement Policy for Residents Doctors and Dentists) has responsibility for providing the assistance, the employer and the resident can agree either:

a. assistance with removal expenses

b. assistance with temporary accommodation and/or excess travel expenses where the resident travels daily the greater distance between their home and second or subsequent principal hospitals.

Removal expenses

391. Except where another body (such as HEIW via the NHS Wales Relocation Reimbursement Policy for Residents Doctors and Dentists) provides the assistance, the scope and level of financial assistance to be provided should be determined by the employer, in agreement with the prospective resident, prior to the post being accepted. In agreeing the assistance to be provided, the employer shall have regard to all the individual resident's circumstances, including the need to re-house dependants and the comparability of new and previous accommodation.

392. The employer shall clearly indicate to the resident the level of assistance that will be provided, the aspects of removal costs that will be reimbursed and, where applicable, the upper limit of payment in all usual circumstances. In providing assistance, authorities should ensure equity, while balancing their own interests with the needs of prospective employees.

393. The employer shall stipulate in the agreement reached with the resident the procedure to be followed and the costs that will be reimbursed in circumstances where an authority has entered into an agreement with solicitors or others to provide house purchase/conveyancing services, private structural surveys, estate agency services and/or a removal service at preferential cost.

Excess travel expenses

394. As outlined in paragraph 384 above, excess mileage may be paid instead of relocation expenses where appropriate and this should be agreed by the employer and the resident prior to any change being made.

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395. Excess mileage is deemed to be the difference, for each single journey, between the distance from the resident's home to base location and the

distance from their home to any second or subsequent work base. Excess mileage may be payable at the first appointment to a work base under the circumstances described in paragraph 389.

Subsistence allowances

396. The purpose of travel and subsistence allowances is to reimburse the necessary extra costs of meals, accommodation and travel and any other business expenses that arise as a result of official duties away from home (or principal hospital).

397. Where, locally, staff and employer representatives agree arrangements that are more appropriate to local operational circumstances, or which provide benefits to staff beyond those provided by these provisions, or are agreed as operationally preferable, those local arrangements will apply.

Night allowances

398. When residents stay overnight in commercial accommodation with the agreement of the employer, the actual receipted cost up to the level set out in Annex 14 of the NHS Terms and Conditions of Service Handbook shall be paid.

399. Where the maximum limit is exceeded for genuine business reasons (e.g. the choice of hotel was not within the employee's control or cheaper hotels were fully booked), additional assistance may be granted at the discretion of the employer.

400. Regardless of accommodation type, residents staying overnight with the agreement of their employer shall be reimbursed for the cost of meals, excluding alcoholic drinks, up to the level set out in Annex 14 of the NHS Terms and Conditions of Service Handbook, subject to the production of receipts. If meals are provided free of charge, the cost of meals cannot be reimbursed. Additional assistance may be granted at the discretion of the employer.

401. Where residents stay for short overnight periods with friends or relatives a flat rate at the level set out in Annex 14 of the NHS Terms and Conditions of Service Handbook is payable. This includes an allowance for meals. No receipts are required.

402. Where accommodation and meals are provided without charge to residents e.g. on a residential training course, an incidental expenses allowance at the level set out in Annex 14 of the NHS Terms and Conditions of Service Handbook shall be payable. All payments of this allowance are subject to the deduction of appropriate tax and national insurance contributions via the payroll system.

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403. Travel costs between the hotel and any temporary place of work shall be separately reimbursed on an actual cost basis.

404. The cost of a sleeping berth (rail or boat) and meals, excluding alcoholic drinks, shall be reimbursed subject to the production of receipts.

Other business subsistence

405. Any expenditure necessarily incurred by residents on postage or telephone calls in the service of their employer shall be reimbursed subject to evidence of expenditure.

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Schedule 11
Facilities

Principles

406. The principles enshrined in this contract have been developed to ensure both patient safety and the safety of the resident.

407. The employer and host organisation must at a minimum provide workplace and rest facilities for residents in line with those set out in the NHS Wales Fatigue and Facilities Charter[7] and the NHS Wales Standards for Hospital Residential Accommodation and Associated Support as amended from time to time. This therefore becomes a contractual requirement.

408. This schedule outlines the type of facilities that must be made available for residents who are required to work during the overnight period.

Access to food and drink

409. Where residents are required to work during the overnight period, they must be able to access both hot and cold food and drink.

410. Outside of the period when restaurant facilities are open, there must be a range of foods available for purchase from vending machines or via other means, as applicable locally. Employers must make reasonable efforts to cater for various dietary requirements.

411. Where catering facilities are limited, organisations must identify alternative local establishments that can provide food during the night or provide facilities for the storage and preparation of food and drink brought in by the resident.

Access to rest facilities

412. Residents who are rostered to work a night shift must have access to a space in which to take a meal and other rest breaks. This should ideally be provided in an area away from patients, where possible.

413. Where a resident advises the employer that the resident feels unable to travel home following shifts such as night, long, late or NROC due to tiredness, the employer must where possible provide an appropriate rest facility where the resident can sleep/rest, without charge. The hours when the resident is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer must cover the cost of alternative arrangements for the resident's safe travel home e.g. a taxi. Where necessary, the employer must also cover reasonable expenses as determined through locally agreed policies for the

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[7] bma-wales-fatigue-and-facilities-charter-september-2024.pdf

resident's return journey to work, either to begin the next shift or, where the resident has left their personal vehicle at work, to collect the vehicle.

414. Where a resident is rostered to work on a non-resident on-call working pattern and must maintain a safe response time for the management of time critical conditions and emergencies or where the resident deems it appropriate e.g. for their own welfare, the employer shall provide the resident with accommodation during the on-call duty period without charge. Where the provision of accommodation is not possible, the employer must make sure that arrangements are in place to provide and cover the cost of alternative accommodation and any travel costs that arise.

415. Where a resident is required to work overnight on a resident on-call working pattern, the resident shall be provided with overnight accommodation to sleep/rest for the resident on-call duty period without charge

416. The employer must provide sufficient and reasonably accessible parking which has well-lit, safe and timely routes to and from the hospital/site for staff expected to travel after dark. Safety assessments should be undertaken to ensure that car parking provision meets the needs of staff working shifts, on-call and at night.

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Schedule 12
Sections of the NHS handbook

Sections of the NHS terms and conditions of service handbook applicable to Resident Doctors and Dentists 2026

417. The following sections of the NHS Terms and Conditions of Service Handbook apply to residents employed under these TCS:
    - Section 15 Leave and pay for new parents
    - Section 16 Redundancy pay (Scotland, Wales and Northern Ireland)
    - Section 17 Reimbursement of Travel Costs (Wales)
    - Section 18 Subsistence allowance
    - Section 22 Injury allowance
    - Section 23 Child bereavement leave
    - Section 25 Time off and facilities for trade union representatives. This should be read in conjunction with All-Wales Recognition Agreement.
    - Section 26 Joint consultation machinery
    - Section 30 General equality and diversity statement
    - Section 32 Dignity at work
    - Section 33 Balancing work and personal life
    - Section 34 Employment break scheme
    - Annex 26 Managing sickness absences – developing local policies and procedures.

418. In relation to the above sections:
    a. In particular, when developing relevant policies and considering flexible working requests, employers must take into account the domestic and family circumstances of residents, including but not limited to caring responsibilities and the working patterns of partners and dependents.

    b. Employers will take into account any guidance and/or All-Wales policies issued by NHS Employers agreed through national collective bargaining arrangements e.g. Medical and Dental Business Group (MDBG).

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Schedule 13
Transitional arrangements

Transition timetable

419. Due to the extent of change required in the short period of time between acceptance and approval of the revised Terms and Conditions of Service (TCS), it will not be feasible to onboard all resident doctors and dentists on a single day and therefore the following transitional arrangements will apply.

420. As set out in the Framework agreement for reform to the terms and conditions of service for resident doctors and dentists in Wales, in August 2026, residents commencing the foundation programme and residents in specialty training programmes whose rotas do not attract bandings in the 2002 contract will be placed under the new terms and conditions. From August 2026, new starters in other training programmes will also begin such employment under the new terms and conditions.

421. From this point onwards, the 2002 contract will be closed to new entrants. However, its pay levels will continue to be uplifted each year as part of the annual pay review process until such time as it is no longer in use

422. By August 2027, all residents training in the foundation programme and all new starters in specialty and core training will have been appointed on the new TCS. At this point, all remaining residents already employed in core training prior to August 2026 will also be transferred to the new TCS.

423. Residents already employed in speciality training prior to August 2026 will have the option of transfer to the new contract from this point. Where all residents on a rota agree to transfer to the new TCS, they will be prioritised over individuals within rotas where not all residents wish to transfer. This will be managed locally.

424. In August 2028, with the exception of those within 12 months of CCT, all remaining specialty registrars will be transferred to the new contract. Further criteria for exceptional consideration will be developed in partnership as part of implementation.

Table 6: Transition to 2026 Resident Doctors and Dentists TCS

August 2026	2002 contract closed to new starters
	New appointments at all levels on these Terms and Conditions
	Existing medical residents at foundation level transfer
	Residents in unbanded rotas (see below) transfer

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September 2026	Dental core residents' year 1
	Paediatrics – foundation and all new appointments at all levels
August 2027	Remaining residents within core training level transfer
	Transition opens to residents in higher training level
September 2027	Remaining Dental residents within core training level
	Remaining Paediatric residents within core training level
August 2028	All remaining residents (excluding dental and paediatric residents) with more than 12 months to CCT or for residents meeting exception criteria transfer
September 2028	All remaining dental or paediatric residents with more than 12 months to CCT or for residents meeting exception criteria transfer

425. Specialties that contain unbanded rotas are as follows (*this list is not exhaustive*). As they will see the most benefit from the increase in basic pay, their transfer is being prioritised above other specialty training programmes.

Table 7: Unbanded Rotas to Transition to 2026 TCS from August 2026

Restorative Dentistry	Special Care Dentistry
Paediatric Dentistry	Pharmaceutical Medicine
Public Health medicine	Rheumatology
Histopathology	Orthodontics
Clinical genetics	Audio Vestibular Medicine
Immunology	Clinical Neurophysiology
Oral Medicine	Rehabilitation
Genito-Urinary Medicine	Sexual and Reproductive Health

There may be certain circumstances in other specialties, where provided all residents are in agreement and this is agreed by the host organisations that their transfer can be prioritised from August 2026.

Locally Employed Doctors

426. Locally employed doctors should be transferred to the new contract alongside their equivalent training groups. However, employers/hosts may prioritise residents in formal training programmes over locally employed doctors on a temporary basis where justified.

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427. All locally employed doctors in scope must be transferred to the new contract by August 2028, and no new locally employed doctor should be employed on terms mirroring the 2002 TCS from 1st August 2026 onwards.

Rota Review, Design, Banding and Monitoring

428. In order to ensure compliance with the safety provisions being introduced as part of the reformed contract, rota redesign is expected to be extensive, and organisations may take some time to arrive at solutions around the changes required to rotas, particularly in more tightly resourced specialties.

429. All rotas must be redesigned to be compliant with the working hours limits prior to implementation of the new contract.

430. Following the redesign of the rota, the banding will be assessed as set out in the 2002 TCS. This banding will be used to determine the level of transitional pay protection required (if any) upon transfer to the new contract. Residents who remain on the 2002 TCS but where the rota is re-banded down will have their pay protected in line with the provisions set out in the 2002 TCS. This re-banding protection will be used for the purposes of transitional pay protection.

431. To ensure organisations have the capacity to undertake this work in time for the implementation of the new Terms and Conditions, systematic rota monitoring will cease. Residents wishing to submit a request for monitoring will still be able to do so in line with their contractual right.

Code of Practice: Provision of Information for Postgraduate Medical Training

432. Development and agreement of a code of practice for NHS Wales is part of the agreement reached. The Code of Practice will be in place prior to commencement of the new TCS.

433. This Code requires Health Education and Improvement Wales (HEIW) to provide programme allocation information to applicants 12 weeks prior to training post commencement, and to supply applicant information to employing organisations (NWSSP) upon acceptance of training programme offers, also 12 weeks in advance of the start date.

434. All parties recognise that these deadlines must be met, albeit, this may not be feasible during the initial implementation period. BMA Cymru Wales has therefore agreed to relax the deadline requirements of the Code of Practice as set out in paragraph 429 below. This relaxation of deadlines applies to the requirement to provide the generic job plan 8 weeks prior to commencement of placement, and the duty roster 6 weeks prior to commencement of placement. As a result, the Guardian will not levy the fines set out in Schedule 05 relating to the late provision of generic job plans and duty rosters.

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435. For posts which commence on or after 1 February 2027, the employer/host organisation must adhere to these deadlines, and the Guardian will have the authority to levy fines for missed deadlines as set out in Schedule 05.

436. Please note that the relaxation of fines set out in paragraphs 428 and 29 does not apply to breaches that attract a financial penalty outlined in Schedule 05.

Methodology for the disbursement of fines levied by the Guardian

437. A methodology for the disbursement of fines levied by the Guardian will be developed in partnership and subject to MDBG approval.

438. In light of the timescales for implementation and subsequent additional adjustment or recruitment that may be required in order to ensure all safe working rules are met, Guardians will be able to agree to a temporary derogation in relation to fines relating to safe working and job plan exception reports on a rota specific basis aligned to the length of the first rotation during the implementation period, subject to the following measures being in place:

a. The department must specify, in writing, the safe working rule(s) they believe is at risk, why and the measures being taken to resolve the risk, including confirmation of engagement with the residents impacted where possible.
b. In exceptional circumstances, where such a risk cannot be resolved or mitigated, the department must meet with the Guardian. The Guardian will then liaise with the RDF (with an LNC representative present) and with the Lead Guardian and Network for views on whether a derogation can be granted in relation to fines for breaching a contractual safe working rule(s).
c. The department will have an obligation throughout to ensure it consults with affected residents.
d. A derogation can only be granted where there is written approval from the Guardian and RDF (with a resident LNC representative present).
e. Once approved, the Guardian must report the agreement to the LNC and affected residents.
f. The Guardian will include in the report to the Lead Guardian, Network and Board.
g. As this is a temporary and exceptional measure, the derogation must be reviewed before the rota cycle ends and must not be rolled into a new rota cycle.

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439. This temporary derogation process has been agreed for the first 6 months of implementation. For posts, placements and rotations which commence on or after 1 February 2027 derogations will not be granted.

440. For clarity, this agreement does not include the penalty rates paid to Residents for breaches of the safe working rules set out in paragraph 219 and does not include fines for breaches of the 48-hour working week limit. Penalty rates paid directly to residents cannot be derogated and must be paid to the resident in the event of a breach of the safe working rules.

441. To provide additional assurance, the following steps will be taken:
   a. Employer/hosts will confirm that all steps are being taken to address any gaps created as a direct result of the safe working rules
   b. This, together with a commitment to honour the contractual requirements of other staff e.g. SAS Doctors in any review or reorganisation of rotas by following and adhering to the contractual job planning process will be communicated by Employing or hosting organisation.
   c. The Lead Guardian will co-ordinate the production of a report setting out related additional rota gaps to inform the Task and Finish Groups for Training Bottlenecks and Locally Employed Doctors respectively.

442. Breaches of the 48-hour working week limit are excluded from this agreement and cannot be derogated.

Residents remaining on the 2002 TCS

443. For residents remaining on the 2002 TCS, Welsh Government pay awards will continue to be applied to the 2002 TCS pay scale alongside those on new TCS.

444. Residents remaining on the 2002 TCS will continue to receive incremental pay progression in line with the terms set out in the 2002 TCS.

Transitional Pay Protection

445. The new contractual arrangements shall include an initial period of pay protection for some existing residents.

446. This Transitional Pay Protection will take the form of cash-floor pay protection. It is intended to protect residents from any immediate drop in pay as a result of changes in the way different working intensities are valued under the new contract.

447. Transitional Pay Protection will be based upon the resident's salary, including banding (or pay protection from re-banding) on the 2002 TCS the day prior to transfer. It will last until their pay under the new contract surpasses it. This will also apply to residents currently paid on the registrar pay scale who may not fulfil the requirements for higher pay progression to pay point 3 and beyond.

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448. Transitional pay protection arrangements will apply to:

a. Residents who were in NHS employment on the day prior to transfer to the 2026 TCS as part of approved postgraduate training programmes under the auspices of:
   i. Health Education and Improvement Wales
   ii. Health Education England
   iii. NHS Education for Scotland
   iv. Northern Ireland Medical and Dental Training Agency
   v. Directorate of Healthcare Delivery and Training

b. Residents who were in a training programme in Wales at any point in the two years prior to them moving onto the new contract.

c. Residents who were employed in the NHS in Wales in a role with TCS that mirror the 2002 TCS in the two years prior to them moving onto the new contract.

d. Residents who held a training post in Wales but have taken time out of training to complete a relevant academic qualification.

449. The transitional pay protection arrangements set out will apply to those residents who meet the criteria above if they either.

a. Move through another post or series of posts on such training programmes under the terms and conditions of service set out above, on or after 1st August 2026, or
b. move directly from such an appointment to an appointment to a post on such a training programme, on or after 1st August 2026.

450. The transitioning of residents onto the 2026 TCS must be conducted in accordance with the below requirements:

451. The existing process, as set out within this schedule, should be used for determining a resident's eligibility for pay protection.

452. Where a resident is assessed as being eligible for Transitional Pay Protection, the value of resident's salary, including banding (or pay protection from re-banding), on the 2002 TCS or 2016 TCS the day prior to transfer will be used for the purposes of this calculation.

453. Where time has elapsed, since a resident's last such employment, their most recent rota in a training programme in Wales or in a role with terms that mirror the 2002 TCS in Wales, will be used for the purposes of calculation of their pay protection, albeit utilising the pay scale values contained in the most recent pay circular for the 2002 TCS.

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454. A resident's protected level of pay will be calculated and shall be used as a baseline or 'consistent cash floor' for each year until the resident exits training.

455. The resident's actual total 'new contract' pay at appointment to the first post and subsequently at appointment to each new post under these TCS shall be calculated as per the provisions of Schedule 2 of these TCS.

456. The protected level of pay shall then be compared against the resident's actual total new contract pay.

457. Where actual total new contract pay is lower than the protected level of pay, the resident shall receive actual total new contract pay plus an additional amount in pay protection sufficient to return the resident's total pay to the protected level of pay.

458. Whether new contract pay or the protected level of pay has the higher value may change over the course of a residents training programme. It is possible that the protected pay may be higher than new contract pay in some training placements, but not in others.

459. Residents absent from training at the point of transition who are on maternity leave, paternity leave, adoption leave, shared parental leave or sick leave, or for approved out of programme (OOP) purposes, shall have their protected level of pay calculated as the sum of:

a. the incremental pay point that the resident might otherwise have reached had they not been absent utilising the pay scale values contained in the most recent pay circular for the 2002 TCS; plus
b. the value of the banding supplement (or pay protection from re-banding), under the 2002 TCS for the rota on which the resident would have been working on at the point of transition.
c. Where moving to these TCS results in higher pay for the resident this must be construed in the same way as a pay award or moving to a higher pay point for the purposes of the recalculation of maternity pay in accordance with Section 15.23 of the TCS handbook.

Changes in hours during transition

460. For residents who are working flexible (part time) at the point of transition, the transitional pay protection shall be calculated as per the 2002 TCS. Those whose hours are subsequently increased or decreased (or who move from full time to less than full time) shall have their cash floor value increased or decreased on a corresponding pro-rata basis.

461. Where pay increases as a result of changes to the job plan, the resident shall be paid the new increased level of actual total pay. Where this remains lower than the cash floor (having been recalculated as per paragraph 411), the resident shall continue to receive actual total pay plus a reduced amount of

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additional pay protection sufficient to return the resident's total pay to the level of the cash floor.

462. Where changes to the job plan of a resident granted pay protection under these provisions are required by the employer/host, and total pay would be decreased as a result, the resident shall continue to receive their previous level of protected pay.

463. Where a resident requests and an employer/host agrees changes to the job plan that result in hours being decreased, the value of the cash floor will be decreased in proportion to the decrease in hours in line with paragraph 452 above.

Pay protection under previous arrangements

464. Where, at the point of taking up an offer of appointment under these TCS, a resident has previously re-entered training from a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training) and is in receipt of pay protection on the basic salary (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) previously earned in that grade, this protected salary shall be taken into account in the calculation of the cash floor.

465. Once this has been taken into account in the calculation of the cash floor, any previously agreed pay protection arrangements will be discontinued.

Review of transitional pay protection arrangements

466. Pay protection arrangements will be subject to review following completion of implementation to assess the utilisation of the pay protection and consider the reinvestment of funding freed up by the diminishing need for pay protection as residents progress up the new pay structure.

Estimation of unpredictable work during an on-call duty

467. As set out in Schedule 03, a resident's job plan must include an indication of the expected predictable and unpredictable work whilst on call, during core and unsocial hours.

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468. It is acknowledged that, owing to insufficient robust data, the employer/host organisation may initially be unable to provide an accurate estimate of the unpredictable work a resident may perform during on-call duties. Consequently, during the initial transition (August 2026), job plans may

indicate a minimal estimate unpredictable work during such periods, even though there remains a likelihood of unpredictable work arising. As per Schedule 03, residents should overtime report any hours worked above that which is set out in the job plan. There is a recognition that setting an initial minimal unpredictable estimate worked will lead to an increased number of hours being processed through the overtime reporting system but that this will allow a robust mechanism for estimating unpredictable work during on-call duties.

469. To minimise the administrative burden on employers/hosts and the resident employers/hosts should actively seek to develop an accurate estimate of unpredictable work using all relevant available data. This includes a combination of but is not limited to actual data such as: activity data, calls through switchboard, bleeps, admissions, feedback from colleagues in the department, feedback from staff previously and currently rostered for on-call duties on the relevant rota, previous exception reporting and overtime reporting data for the relevant rota, and recent diary activities or monitoring data.

Areas for further development and agreement under the 2025 Framework

470. The contract reform agreed is very wide-ranging and requires support of a range of non-contractual changes to working practices, partnership arrangements and resourcing. It is recognised that it was not feasible to discuss all changes required for full implementation of the new contract in the context of negotiation.

471. Therefore, all parties have committed to a programme of work, some as part of implementation plans, to take forward to priorities established in the new contract and ensure they are put into practice as best as possible. The following areas for further development, for implementation and future work were agreed by all parties:

a. The Code of Practice: Provision of Information for Postgraduate Medical Training will be reviewed in partnership and an equivalent document agreed for Wales to reflect its new contractual status.
b. A single lead employer (SLE) implementation working group will examine the relationship between contract implementation and the SLE arrangements for residents in Wales to ensure clear, mutually agreed division of contractual responsibilities between the lead and host employers.
c. A Digital Systems Working Group will be established to support the practical implementation of the new contract. This group will collaborate closely with workforce teams, the SLE, and payroll departments to ensure digital systems and processes are aligned with the new requirements. This Group will also develop an NHS Wales Rostering Policy for Resident Doctors and Dentists.

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d. Work in partnership will take place to identify ways in which production and provision of rotas/schedules/job plans can be streamlined to avoid delays.
e. Work in partnership will continue to develop mechanisms for locally employed doctors to achieve greater security of employment.
f. Work in partnership will continue to review, identify and address causes for and impact of “bottlenecks “in training.
g. Work in partnership will be undertaken to agree appropriate rates for or a methodology for setting extra contractual work undertaken by residents in NHS Wales organisations. As the contract deal was approved by all parties for implementation, BMA Cymru Wales will cease to promote the BMA 2002 TCS rate card unless a dispute arises in the future or partnership talks to agree rates fail.
h. Work in partnership will be undertaken to develop appropriate policy/guidance to support effective resident job planning.
i. Work in partnership will be undertaken to develop criteria for identification of “mandatory” courses and to establish a process for automatic approval of attendance or participation of these courses as part of an overarching study leave improvement workstream as detailed later in this document.

This programme of activity is not exhaustive, and all parties will agree additional elements through the implementation period.

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Annex 01

Average Hours Pay Calculation

Calculating average total hours, enhanced hours and on-call duty hours in a rota cycle for the purposes of calculating pay

Introduction – the effect of prospective cover

1. The term prospective cover refers to a requirement placed in advance on a resident to cover the absence of colleagues when they are taking leave from the rota. The term is also used when a resident is unable to take leave against shifts which attract a pay enhancement (e.g.night shifts or weekend shifts) or additional pay allowance (on-call availability allowance).

2. As a resident is unable to take annual leave against a shift which attracts an enhanced rate of pay under the new contract, it is important to have consideration for this annual leave and public holidays when calculating the average weekly hours, a resident works per week as part of the reformed resident contract.

3. Similarly, where prospective cover is in place for study leave, this should also be included as the resident is again unable to take study leave against a shift of any type that attracts an enhanced rate of pay.

4. If this calculation is not made in these instances, then it will fail to account for the prospective cover in operation.

5. Therefore, this calculation is vital when calculating an accurate figure for the number of additional hours, enhanced hours and on-call duty hours per week a resident undertakes.

Average weekly hours calculation

6. The allowance for leave calculation for residents requires the input of the following variables:

   A = Leave entitlement in days* (annual leave + public holidays days + study leave) (Pro-rata for flexible (part-time) residents)

   B = Rota cycle in weeks

   C = Length of standard day for the rota (The length of a standard day for a rota is determined by assessing the mean shift on the rota which does not attract any pay enhancement or pay allowance)

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D = Total hours in rota cycle (inclusive of prospective hours in an on-call duty period)

E = Days worked in a normal working week. For full time residents this will normally be 5, however, for flexible (part-time) residents leave weeks are based on the number of days in your normal working week.

Using the above inputs, we calculate the following:

F = Leave per rota cycle in days (A/(365/7))*B

G = Leave per rota cycle in weeks (F/E)

H = Leave per rota cycle in hours (F*C)

I = Remaining hours in rota cycle after leave is deducted (D-H)

J = Remaining weeks in rota cycle after leave is deducted (B-G)

K = Average weekly hours (I/J). This figure should be rounded up to the nearest quarter of an hour.

***Leave entitlements:**

- 28 days annual leave (33 with 5 years NHS employment)
- 30 days study leave (15 days if an F1)
- 8 public holidays

Average hours per week calculation

7. For those working full time, any hours above the standard 40-hour working week will be paid will be paid 1/40th of your weekly salary.

8. The basic salary for a flexible (part-time) resident is calculated pro rata on the average hours' work per week across the rota cycle[8].Calculating average hours per week that attract an enhanced rate of pay.

9. Using the above calculation method, we can then determine the number of hours worked which attract an out of hours enhancement on average per week by dividing the total number of enhanced hours by remaining weeks in rota cycle (j)

L = Total hours in rota cycle that attract an enhanced rate of pay i.e. outside of core hours.

M = Average weekly number of hours that attract an enhanced rate of pay (L/J)

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[8] For example, a 50% flexible (part-time) resident on a rota where a full-time resident is required to work an average of 48 hours' per week (40 hours basic and 8 hours additional) will have their basic salary calculated on an average of 24 hours' per week.

Calculating on-call availability supplement

10. Using the above calculation method, we can then determine the number of hours on average per week which attract an on-call availability supplement i.e. NROC duty periods. This is done by subtracting the total number of prospective hours for anticipated work during on-call duty period from the total number of hours on-call and then dividing this by the remaining weeks in rota cycle (J)

    N = Total hours in rota cycle that attract an on-call availability supplement i.e. rostered on-call duty periods.

    O = Prospective hours for anticipated work (in both core and unsocial hours respectively) during on-call duty periods.

    P = Average weekly number of hours that attract an on-call availability supplement (N-O/J).

    You will be paid an availability rate of 50 per cent of their basic hourly rate for the hours you are available (P).

Payment for hours worked during an on-call duty period

11. Any actual hours worked above the prospective estimate while on-call – either on site or remotely – will be paid at the appropriate rate for the hours worked. Payment for these hours will be made retrospectively via the rostering system, in accordance with the on-call payment process.

12. Where you are required to work for 75% or more of the on-call duty period, you shall be paid for the total on-call duty period at the full appropriate hourly rate and not the 50% availability rate.

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Annex 02

NHS Wales Fatigue and Facilities Charter

Contractual Status

As set out in Schedule 11, the provisions contained within the NHS Wales Fatigue and Facilities Charter are now included within these Terms and Conditions of Service and are therefore contractual for Residents on the 2026 Contract.

The full Charter and associated documents can be accessed here.

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Subject:	PTHB Policy & Written Control Documents Summary Report as of 7 September 2026
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Business Governance Officer/PA to Director of Corporate Governance
Purpose:	The purpose of this paper is to provide the Committee with an overview of the position relating to Powys Teaching Health Board Policies and Written Control Documents – as at 7 September 2026.
Recommendations:	The Committee is asked to: • **CONSIDER** the position (as of 7 September 2026) of Policies and Written Control Documents and take **ASSURANCE** that the organisation has an appropriate system for tracking and reviewing these documents. • **CONSIDER** and discuss the current position of Policies and Written Control Documents with a particular focus on those Policies given Medium Priority ratings.
Executive Summary:	The Corporate Governance Team are responsible for ensuring Powys Teaching Health Board's Policies and Written Control Documents are readily available and accessible to all staff via the Policies and Written Control Documents SharePoint site. The team are also responsible for the management, monitoring and reporting of these documents. A live database of Policies and Written Control Documents is maintained and information is reported to Executive Committee and Board on an annual basis. The report provides a summary of the overall position, in respect of live Policies broken down by Directorate that are • In-date • Expired • Due to expire within 3 months A summary of the overall position, in respect of Written Control Documents broken down by Directorate that are • In-date • Expired • Due to expire within 3 months • A summary of each directorates' policies, which have expired and their risk level • Next steps to be taken.

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Policy and Process Update

- Since the introduction of the Virtual Policy Consultation group in January 2026, twenty-five policies have been circulated for consultation. This has strengthened policy governance by increasing organisational engagement, improved oversight of policy development and has supported a more robust consultation process.

- The establishment of the Policy Review Groups has also significantly strengthened policy governance arrangements. By formally reviewing and ratifying policies which fall out of the remit of PTHB Executive Committee and Board approval, these groups have reduced the number of policies requiring escalation, improving the efficiency of the approval process.

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SUMMARY POSITION – Live Policy Documents

Summary of all Live Policy documents by Directorate – 7 September 2026:

The table below provides a summary of the overall position of Live policy documents as of 7 September 2026, broken down by directorate.

- There are a total of 153 live policy documents on the Policies and Written Control Documents SharePoint site. This figure does **not** include All Wales/External Policies or appendices.
- 100 Policies (65.4%) are reported as In-Date
- 38 Policies (24.8%) are reported as Expired
- 15 Policies (9.8%) are due to expire within 3 months.

Count of Expired or 3 months to expiry	Column Labels			
Row Labels	Due To Ex	Expired	In Date	Grand Total
Policy				
Director of Corporate Governance / Board Secretary	1	1	5	7
Director of Strategic Improvement and Transformation		1	1	2
Executive Director of Allied Health Professions, Health Sciences and Digital	1	2	4	7
Executive Director of Finance, Capital and Support Services		2	13	15
Executive Director of Nursing, Quality, Women and Family Health	4	8	18	30
Executive Director of Nursing, Quality, Women and Family Health and Executive Director of Allied Health Professions, Health Sciences and Digital		1	1	2
Executive Director of Planning, Performance and Commissioning			1	1
Executive Director of Primary Care, Community and Mental Health		7	16	23
Executive Director of Public Health			2	2
Executive Director People, Culture and Transformation	9	12	27	48
Executive Medical Director		4	12	16
Policy Total	**15**	**38**	**100**	**153**
Grand Total	**15**	**38**	**100**	**153**

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SUMMARY POSITION – Live Written Control Documents

Summary of all Live Written Control Documents – 7 September 2026:

The table below provides a summary of the overall position of Written Control Documents as of 7 September 2026.

- There are a total of 398 live Written Control Documents on the Policies and Written Control Documents SharePoint site. This figure does **not** include forms, appendices and All Wales/External Written Control Documents. Some Written Control Documents are not held centrally and are held locally by directorates and are not included within the figures below.
- 257 (64.6%) Written Control Documents are reported as In-Date
- 116 (29.1%) Written Control Documents are reported as Expired
- 25 (6.3%) Written Control Documents are due to expire within 3 months.

Count of Expired or 3 months to expiry	Column Labels			
Row Labels	Due To Expire	Expired	In Date	Grand Total
WCD				
Framework		3	1	4
Guideline	4	31	60	95
Procedure	2	41	36	79
Protocol	5	15	42	62
Service Specification		1		1
Standard Operating Procedure	14	24	118	156
Strategy		1		1
Grand Total	25	116	257	398

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SUMMARY POSITION – Live Written Control Documents by Directorate

The table below provides a summary of the overall position of Written Control Documents held centrally as of 7 September 2026, broken down by directorate.

Count of Expired or 3 months to expiry	Column Labels			
Row Labels	Due To Expire	Expired	In Date	Grand Total
WCD				
Director of Corporate Governance / Board Secretary		6	14	20
Director of Strategic Improvement and Transformation			2	2
Executive Director of Allied Health Professions, Health Sciences and Digital	4	27	25	56
Executive Director of Finance, Capital and Support Services		21	7	28
Executive Director of Nursing, Quality, Women and Family Health	7	39	82	128
Executive Director of Planning, Performance and Commissioning		1		1
Executive Director of Primary Care, Community and Mental Health	9	15	63	87
Executive Director of Public Health			9	9
Executive Director People, Culture and Transformation	1	2	2	5
Executive Director of Medical Director	4	5	53	62
WCD Total	**25**	**116**	**257**	**398**
Grand Total	**25**	**116**	**257**	**398**

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Expired Policies by Level of Risk

The table below provides a summary of the level of risk which has been assigned by Directorates to policies which have expired.

- There are a total of 38 live Policies on the Policies and Written Control Documents SharePoint site which have expired
- 8 (21.1%) Policies are reported as Medium Risk
- 30 (78.9%) Policies are reported as Low Risk

Row Labels	High	Medium	Low	Grand Total
Policy				
Director of Corporate Governance / Board Secretary			1	1
Director of Strategic Improvement and Transformation			1	1
Executive Director of Allied Health Professions, Health Sciences and Digital			2	2
Executive Director of Finance, Capital and Support Services		2		2
Executive Director of Nursing, Quality, Women and Family Health		3	5	8
Executive Director of Nursing, Quality, Women and Family Health and Executive Director of Allied Health Professions, Health Sciences and Digital			1	1
Executive Director of Primary Care, Community and Mental Health		2	5	7
Executive Director People, Culture and Transformation		1	11	12
Executive Medical Director			4	4
Policy Total	**0**	8	30	**38**
Grand Total	**0**	**8**	**30**	**38**

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Expired Policies by Level of Risk

Directorates were asked to review their policies which had expired, confirming the level of risk associated with this policy being out of date; and the expected review date for this policy. Below is a summary of the policies proposed medium risk, broken down into directorate.

Executive Director of Nursing, Quality, Women & Family Health					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update received from Directorate	Expected Date of Review
GNP 001	20 April 2023	Verification of Expected Death by a Health Care Professional	Medium	Still requires updates. Plan to be agreed by Q4	Q4
GNP 064	11 April 2021	Policy for safe effective nutrition hydration and catering provision for patients In hospital	Medium	Document drafted and awaiting final review before it can be shared with Virtual Policy Consultation Group	Q4
GNP 065	13 December 2020	Enhanced Care Policy	Medium	This document was reviewed and signed off by Executive Director of Nursing in 2023 but never updated on the intranet? Process issue - however, this will need to be reviewed following national changes in scoring and escalation processes. Date delayed to align with national update.	Q3

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Expired Policies by Level of Risk

Executive Director of Primary Care, Community and Mental Health					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
MHP 078	1 November 2022	Rapid Tranquilisation Policy	Medium	To be reviewed by Dr Shooter. September 2026 identified as the target date for CPAG approval.	September 2026
MHP 063	1 August 2021	Powys Community Mental Health Teams Joint Operational Policy	Medium	The policy is currently in draft with the authors and will be ready to go to CPAG in November.	Q3

Executive Director of Finance, Capital and Support Services					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
FCP 029	01/03/2018	Counter Fraud, Bribery and Corruption Policy and Response Plan	Medium	Currently under review. Due to be shared with Heads of Service imminently for Technical Approval. Following which will go via VPCG and formal ratification via Exec Committee	End of Q3
CGP 008	6 July 2025	Bribery Policy	Medium	Currently under review. SBAR due to be submitted to Director of Corporate Governance and Deputy Director of Finance imminently, recommending CGP 008 is combined into the above FCP 029 to have one policy.	End of Q3

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Expired Policies by Level of Risk

Executive Director of People, Culture and Transformation					
Current Doc Ref Code	Date Policy Expired	Policy Title	Proposed Level of Risk	Update from Directorate	Expected Date of Review
OHP 003	13/07/2025	Occupational Immunisation Policy	Medium	Policy amended and comments sought. Policy to be shared with Virtual Policy Consultation Group, prior to policy going via approval process.	Q3

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Key Findings since last report presented to the ARAC Committee

Since the last report presented to ARAC Committee (figures as at 23 April 2026)

Policies

- The number of live policies have increased from 148 to 153, an increase of 5 policies (3.3%).
- The number of expired policies have reduced from 46 to 39, a decrease of 7 policies (15.2%).
- The number of policies due to expire within three months have increased from 1 to 15, an increase of 14 policies.

The number of policies due to expire within the next three months indicates a high number of policies which will require review, during the forthcoming reporting period.

Written Control Documents

- The number of live written control documents have increased from 362 to 398, an increase of 36 documents (9.9%).
- The number of expired written control documents have reduced from 119 to 116, a reduction of 3 documents (2.5%).
- The number of written control documents due to expire within three months have increased from 14 to 25, an increase of 11 documents.

The most significant increase was seen in Standard Operating Procedures, which have increased by 28 documents, alongside an improvement in compliance through a reduction in expired SOPs. Whilst the number of documents due to expire within the next three months have increased from 14 to 25, the overall position demonstrates a modest improvement in document review compliance and an increase in the volume of documented governance controls across the Health Board.

Expired Policies by level of risk

There are currently no reported 'high risk' expired policies. 'CDP 008 Missing Persons Policy' was deemed a high risk, but since the last report, this policy has been reviewed and formally ratified via Executive Committee held on 16 September 2026.

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Next Steps:

- Executive Directors to review all expired policies deemed medium risk, within their directorate.
- A summary report of Policies and Written Control Documents will be provided to ARAC Committee biannually, with the next report going to Audit, Risk & Assurance Committee in May 2027.

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Agenda item: 5.7

AUDIT RISK AND ASSURANCE COMMITTEE	**22 OCTOBER 2026**
Subject:	SINGLE TENDER WAIVERS
Approved and presented by:	Hywel Pullen, Interim Executive Director of Finance
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	None

PURPOSE:

To inform the Audit Risk and Assurance Committee that there have been two Single Tender Waiver requests made between 1 June 2026 and 31 August 2026

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there has been two Single Tender Waiver requests made between 1 June 2026 and 31 August 2026
- Take **ASSURANCE** an appropriate reporting mechanism is in place.

Approve/Take Assurance	Discuss	Note
Y	N	Y

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

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EXECUTIVE SUMMARY:

In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements

HEADING:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its July 2026 meeting which covered the period from 1 April 2026 and 31 May 2026.

A summary of the use of Single Tender Action from 1 June 2026 to 31 August 2026 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW-STA-63029	TENDER	QBTECH	ADHD DIAGNOSIS TOOL	THERE IS ONLY ONE SUPPLIER	13/08/2026	£29,578	12 months	Prospective	A1
POW-DIR-64081	TENDER	INTERNATIONAL CONVENTION CENTRE (ICC WALES)	PROVISION OF VENUE FACILITIES AND ASSOCIATED CONFERENCE SERVICES FOR NATIONAL CANCER CONFERENCE FEBRUARY 2027	THERE IS NECESSITY TO RETAIN A PARTICULAR SUPPLIER FOR REAL BUSINESS CONTINUITY	03/09/2026	£47,468	6 months	Prospective	A2

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.

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.

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Agenda item: 7.1

AUDIT RISK & ASSURANCE COMMITTEE	**22 OCTOBER 2026**
Subject:	**AUDIT PROCESS AND REPORTING HANDBOOK**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A
Appendices:	**Appendix 1-** Audit Process and Reporting Handbook

PURPOSE:

The purpose of this paper is to present the Audit, Risk and Assurance Committee with the updated Audit Process and Reporting Handbook for approval. The handbook was initially published in March 2025 following approval by the Committee who requested a review of the document after 12 months.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **APPROVE** the revised Audit Process and Reporting Handbook and
- **Take ASSURANCE** the organisation has a system in place to equip colleagues with the necessary information should they be involved in an audit within the Health Board, whether internal audit or external audit.

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

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	Internal and External Audit are key components of the Health Board's financial, operational and assurance processes. They operate across the organisation. This Audit Process and Reporting Handbook is therefore relevant to all the Health Board's wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:
Internal and external audit are both key components of the Health Board's financial, operational and assurance processes and both play a crucial role in ensuring transparency, accountability, and good governance within the organisation. The Audit Process and Reporting Handbook was developed to provide colleagues with useful information should they be involved in an audit and to support them through audit process, including defining roles and responsibilities of those involved, senior management and the Board's committees, a glossary of key terms and information regarding the audit tracking process. The handbook's scope does not include other forms of audit such as clinical or quality audits. Following review the key updates made to the handbook include: • Greater alignment with, and reference too CGP 014 the Board Assurance Framework; • Updated terminology and references to reflect current arrangements; and • Transfer into the most recent template for Health Board Written Control Documents
NEXT STEPS:
If approved the Corporate Governance Team will republish and distribute the handbook, ensuring that awareness is raised via the appropriate communication channels. Following this initial review following a 12 month period, the handbook will now be reviewed every 3 years in accordance with CGP 004 Management of Policies and Other Written Control Documents.

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Audit Process and Reporting Handbook

Document Reference No:	
Version No:	2
Publication Date:	TBC
Review Date:	January 2028 (3 months prior to expiry date)
Expiry Date:	March 2028
Author:	Deputy Board Secretary
Document Owner:	Director of Corporate Governance
Accountable Executive:	Director of Corporate Governance
Approved By:	Audit, Risk and Assurance Committee
Approval Date:	TBC
Document Type:	Guidance
Parent Policy:	CGP 012 Board Assurance Framework
Scope:	Organisation wide

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

To ensure that you are always using the latest version of this written control document, please refer to the version on the Corporate Governance SharePoint site

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Associated Policies and Written Control Documents
CGP 014 Board Assurance Framework
CGP 005 Risk Management Framework

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Document established	March 2025
2	Document reviewed and transferred into new template	July 2026

1.0 Introduction

1.1 Scope

This handbook applies to all employees of the Health Board involved in internal or external audit activities. This handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Health Board.

1.2 Introduction

This handbook is intended to equip colleagues with the knowledge you need should you be involved in an audit within the Health Board, whether that is an internal audit or external audit. It also sets out roles and responsibilities including those for senior management and the Board's Committees.

2.0 Why is audit important?

Regular audits are an important part of organisational learning and development. They provide valuable assurance to the Board and our key stakeholders on performance and act as the 'third line' within the Three Lines Model, as implemented within the Health Board as part of the Board Assurance Framework. The importance of the 'third line' is the ability to provide independent and objective assurance on all identified matters. It is important to understand that an audit is not a fault-finding exercise. Internal audits are designed to support you and your teams to identify areas of noncompliance and provide opportunities for improvement. They can be a great celebration of

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success, particularly where a substantial assurance rating is provided. Also, when a reasonable assurance rating is given to an audit there are often areas of excellent work recognised.

The annual programme of work conducted by the Auditor General for Wales[1] provides assurance for the Board and our stakeholders on the regularity of the financial statements and the efficient, effective and economical use of resources by the Health Board. Whilst an overall rating is not provided by Audit Wales, key findings are highlighted within their reports.

The insights that audits generate provide tangible opportunities for improvement. Because they serve as an additional quality control step, you will be able to pinpoint the root causes of any operational or process issues. Knowing this, you will then be able to take your processes to the next level.

By conducting audits on a regular basis, we are demonstrating to our people, our patients and our stakeholders that Powys Teaching Health Board takes issues of quality, patient safety, health and safety, and regulatory compliance seriously.

Internal audit reports contribute to our end of year Head of Internal Audit Opinion (see section 3)

3.0 Internal Audit

3.1 What is Internal Audit?

Internal audit is an independent assessment of a system or process through an objective examination of evidence. The aim is to give management and the Audit, Risk and Assurance Committee confidence (assurance) that:

- appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and
- those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.

We have included a Glossary at **Annex 7.2** to aid in your interpretation of this handbook and of any internal audits you may review.

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[1] Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions.

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3.2 Who are internal audit and what do they do?

As set out above, the Health Boards's internal audit services are not carried out 'in house' but by the NWSSP Audit and Assurance Services. They deliver their work primarily through the following:

Annual Audit Plan

Annually a plan is developed which sets out a range of internal audit reviews that will be conducted in the Health Board that financial year. The plan is aligned to the Health Board's strategic risks and is developed in conjunction with your Executive Director and following consideration of the key documents such as the Board Assurance Framework, Strategic Risk Register and Integrated Plan. In proposing areas to audit, Directorates are encouraged not to focus on areas we feel we have robust processes, but those that we believe can be improved or made more efficient. You can find the list of audits planned for each year here. Where necessary, particularly to address emerging risks in year, the plan may be adjusted. The plan is approved by the Audit, Risk and Assurance Committee.

Individual audits and advisory reviews

Throughout the year Internal Audit undertake assurance and consultancy (or advisory) audit reviews in line with the annual audit plan. Each report aims to provide an assurance opinion (assurance report) or advice (consultancy reports) over a specific system or process. Actions to address highlighted issues are agreed with management before being presented to the Audit, Risk and Assurance Committee.

Head of Internal Audit Opinion

The Head of Internal Audit Opinion (HoIA Opinion) is provided to the Health Board annually. It is based on the outcome of audit and consultancy work undertaken during the year and other information available to Internal Audit. The HoIA Opinion contributes to assurances available to the Board to underpin the Board's assessment of the effectiveness of governance and control. It is an integral piece of the Health Board's governance framework, providing assurance to inform the annual governance statement and identifying improvement opportunities.

3.3 Why is a particular audit happening?

You may be wondering why a particular area or process in your Directorate is being audited. You will see above that an annual audit plan is developed so it is likely that this process or area of work was identified during the annual risk-based planning process or has become an emerging risk during the year. It may also have been

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specifically requested, e.g., by management, the Audit, Risk and Assurance Committee, a third party, etc.

3.4 The stages of an internal audit

There are a number of stages to an internal audit review. Before work starts on your audit be sure to understand the various roles and responsibilities and your part in it (see section 6).

We have set out below the various stages your internal audit will take. You may be involved in all or some of them.

a) Planning

Whilst the area for the audit will have been identified in the annual audit plan, the specifics of what the audit will cover will be agreed with your Executive Director at this first step in the internal audit. A meeting will take place with the internal auditor assigned to the audit, the Director and / or the lead manager responsible for the area or process, and an audit brief will then be agreed.

You should consider appointing a person as the central point of contact (POC) for the audit in your Directorate. That person should be involved at this planning stage and throughout to ensure Internal Audit have everything they need, and those that need to contribute to the process are fully informed.

b) Fieldwork

Fieldwork is the process of examining evidence to form an opinion, with respect to the area being audited, systems are designed to mitigate risks identified in the brief, and the mechanisms in place to mitigate those risks are operating effectively.

A kick off meeting will be held with Internal Audit and your POC in advance of commencing the fieldwork.

Internal Audit may request a number of documents or interviews with subject matter experts within the Health Board. Your POC should coordinate these interviews and provide internal audit with all documents they request. The POC should keep a log of documents provided.

Ensure a timeframe for completion of the fieldwork is agreed. The POC will ensure they are aware of that timeframe and the date the draft report is planned to be released.

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c) The Internal Audit Report (draft to final)

At the end of the fieldwork a draft report will be prepared. The Health Board has 15 working days to check the accuracy of the report and agree, or otherwise, the recommendations in the report and develop actions to address recommendations.

The report itself will set out the agreed purpose and audit objectives agreed at the planning stage. The executive summary provides a snapshot of the purpose of the audit, an overview of main issues, the overall risk rating, and a breakdown of ratings for the objectives and recommendations. It may look something like this:

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has looked at and the interviews it has conducted during the fieldwork.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	1,2,3	Limited
2	There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	-	Substantial
3	Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant NICE and BACPR guidelines.	4	Reasonable
4	Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	5	Reasonable
5	Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	-	Substantial
6	Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	6	Reasonable

Management Actions

2 High Priority

4 Medium Priority

Themes

Performance Monitoring
Governance
Risk Management

Risk Types

Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk
Quality or Safety Issues

Appendix 7.3 provides a detailed description of the various assurance ratings.

Issues identified and actions agreed under each objective are then summarised in the Findings and Agreed Action Plan.

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Findings & Agreed Action Plan

Objective 1: The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	**Limited**

Overview / Summary of Observations

The Community Cardiology Service has no formal documented structure that outlines its position within the overall Health Board organisational structure.

The Service is also not currently supported by effective local governance and management arrangements that facilitate its operational decision making and reporting mechanisms. We note that local governance arrangements were in place during the Services' project management and pilot phases, but these have not been continued or developed to support the Service now that it is fully operational.

The Service has Standard Operating Procedures in place that describe the purpose and current operational processes of its three constituent Service areas and also the roles of the key staff within these service areas. We note that at the time of our audit these had been reviewed and updated but required formal approval.

Service management has identified that the current budgeted staffing levels in respect of the Cardiology Diagnostics & Management Clinic and Cardiac Rehabilitation Service are inadequate to ensure efficient and effective delivery of patient management and treatment. This position is evidenced by the times for referrals and assessments we noted as part of our testing under Objective 3. A Business Case to increase and improve staffing is due to be submitted to the Health Board Investments Benefits Group in early 2025.

The operational Service also lacks formal risk management arrangements as required and stipulated by the Health Board's Risk Management Framework. Again, we note that risk management was in place through the Services' project phase.

Key Findings	Risk & Impact	Agreed Management Action

Whilst the auditors will suggest a proposed management action, this will be based on the evidence provided, it may be necessary to highlight any concerns about the wording, practicality or relevance of the proposed action. This is particularly the case where the action cannot be completed fully by the Health Board and where the closing of the action would require involvement on and dependency of third parties. Third party actions may cause significant delays in closing an action, seeing an impact in any improvements, and may require escalation to the Audit, Risk and Assurance Committee.

Issues are categorised according to their level of priority and the timeframe within which management actions should be completed. The prioritisation table is set out in **Annex 7.4.**

Each issue must be met with an agreed management action. You will have to respond with a management response within the 15 day window mentioned above.

Management actions are an important consideration and usually the last step in finalising the audit report. Often they will be obvious and likely a plan or action you already have in train or were planning. Sometimes actions will require careful planning and resourcing.

It is important to remember that the actions you promise to deliver and the dates within which you indicate they will be completed by will be monitored closely not only by your Directorate, but also by the Executive Committee and the Audit, Risk and Assurance Committee. This is primarily done via the audit tracker which is regularly reported into those forums. It is therefore crucial that management actions are:

- Approved by the Executive Director and actions assigned to suitably senior members of the team to enable them to close off actions and escalate them

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- Framed in a way which broadly meets the requirements of SMART principles:
    - Specific – is there an output or a process that is required to address the issue
    - Measurable – what evidence will you be able to provide to demonstrate the action is closed
    - Achievable – are there resourcing or other challenges that may prohibit the action being completed, or is a third party involvement required which may provide challenging
    - Realistic – will the action address the issue, does it provide value for money and will it have the desired impact
    - Timebound – do not over promise and underdeliver. Take account of pressures during the winter and annual leave, as well as the required governance routes for the action before suggesting a date by which the action will be closed off

Issues that are rated 'high' must be given priority and should where possible receive a shorter turnaround time to close the action.

Any **differences of opinion** regarding the applicability, relevance, practicality or timeliness of issues and actions should be fully discussed between auditors and the Executive Director prior to it being submitted for consideration by the Executive Committee and the Audit, Risk and Assurance and other Board Committees. If an agreed way forward cannot be found, the issue(s) should be referred to the Director of Corporate Governance/Board Secretary.

Internal audit will aim to provide the final report within ten working days of receipt of the management responses.

d) Follow Up

Internal Audit conduct a follow up audit of the Health Board's Audit Tracker annually to verify if agreed actions have been implemented and whether the actions taken have been effective in mitigating risk.

3.5 Reviewing and monitoring of Internal Audits

Once the internal audit report is finalised it is reviewed and discussed by the Executive Committee and the Audit, Risk and Assurance Committee. Reports relevant to Board Committees are also presented to their next meeting.

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Section 6 on Roles and Responsibilities goes into more detail on the focus of these various groups.

Audit actions are transposed to the Audit Tracker. Further detail on Audit Tracker appears at section 5 below.

4. External Audit

4.1 Who is the Health Board's external auditor and what are their statutory duties and powers?

The Auditor General for Wales is the statutory external auditor of most of the Welsh public sector. This means that they audit the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies. At many of these public bodies, including the Health Board, the Auditor General also has a statutory requirement to satisfy themselves that the organisation has proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources.

The Auditor General for Wales is a crown appointment and their statutory duties and powers are contained in the following legislation:

- Government of Wales Act 1998
- Government of Wales Act 2006
- Public Audit (Wales) Act 2004
- Public Audit (Wales) Act 2013
- Well-being of Future Generations (Wales) Act 2015[2]

Further information can be found in:

- Access rights of the AGW
- A guide to Welsh public audit legislation

4.2 What work does the Auditor General undertake at the Health Board?

To discharge their statutory duties, the Auditor General undertakes an annual programme of audit work at the Health Board, which is summarised in the Annual Audit Plan. This plan is developed following assessments of the Health Board's strategic risks, with a process similar to that described for internal audit above. The Annual Audit Plan will set out the work the Auditor General intends to undertake to audit the Health Board's accounts and undertake an independent

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[2] In line with the Wellbeing of Future Generations (Wales) Act the Auditor General must carry out examinations of each named organisation's well-being objectives and the steps being taken to meet them.

examination of the charitable funds, as well as a programme of performance (or value for money audit work that will typically include:

- Structured Assessment work; and
- Thematic work which may examine issues specific to the Health Board or which is part of a wider examination that is also being taken forward at a number of other bodies.

The Annual Audit Plan, which also sets out the fee the Auditor General must charge for the work, is agreed by the Executive Committee and approved by the Audit, Risk and Assurance Committee.

Audited Financial Accounts
The Auditor General for Wales audits the financial statements of the Health Board annually. In addition, Audit Wales staff will undertake an independent examination of the Powys Health Charity annually. The aim of the audit is to verify that the financial statements are prepared in accordance with relevant accounting standards and to provide reasonable assurance that they are free from material misstatements. These certified financial statements are filed with the Welsh Government (Health Board accounts) and Charities Commission (Powys Health Charity) along with the accompanying respective annual reports.

The Welsh Government Manual for Accounts guides the preparation of the Health Board's financial statements and the Finance Capital and Support Services Directorate oversees their preparation and liaises with Audit Wales throughout.

Structured Assessment
The Structured Assessment takes place annually and primarily examines corporate arrangements relating to governance, systems of assurance, planning, and financial management.

A project brief is agreed with the Executive Committee and the Board and follows similar stages to that of an internal audit above.

The Structured Assessment Report assures the Board, our people, the public and key stakeholder that the Health Board has sound corporate governance arrangements and that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

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Local performance audit reviews
In addition to the Structured Assessment, the Auditor General may also review certain arrangements at the Health Board in more depth.

This audit work is determined as part of the local audit planning process and is specific to the risks facing the Health Board.

All Wales thematic reviews
The Auditor General may also undertake work at the Health Board which is part of a wider thematic review examining a specific issue or service area across all NHS bodies in Wales.

National value for money examinations
In addition to the annual programme of audit work at the Health Board, the Auditor General undertakes a number national value for money examinations each year which focus on a range of topical issues, including those relevant to NHS bodies. Depending on the topic under review, national value for money examinations may involve the capture of information from the Health Board, and the published outputs from the work may include recommendations for the Health Board to respond to.

4.3 How does the Auditor General report their findings?

The findings from the audit of the accounts, the Structured Assessment and any additional performance audit reviews are set out in individual reports which are agreed with management and presented to the Audit, Risk and Assurance Committee and/or the Board. Similar to Internal Audit, management actions will be provided to address any audit recommendations contained in the Audit General's reports and these will be monitored via the Audit Tracker.

Data Protection
During the course of the Auditor General's audit work, if any personal data is processed, such as during interviews or within Health Board documents, it is done so in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation.

5.0 The Audit Tracker

A tracker is maintained by the Corporate Governance Team to provide a central overview on progress against management actions on Internal Audits and Audit Wales reports. From time to time regulator reports may also be included.

Directors and the POC or action owner must ensure the actions are completed by the agreed dates. Of course, it is understandable that sometimes that is not possible and changes to agreed completion dates are warranted.

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The Audit Tracker enables an Executive Director to propose changes in completion dates. This should not be required if realistic dates are provided in the original audit but where it is needed justification should be provided. The Executive Director should include in the justification the progress to date as well as any risks to a delay in completion of the action.

Any changes to dates due must be approved by the Executive Committee.

Directorates are supported to undertake regular reviews of the Audit Tracker aligned to work programme of the Audit, Risk and Assurance Committee. The Audit Tracker must be updated by the Executive Director or Action Owner when requested, ensuring:

- Where an action is proposed for closure evidence demonstrating that is provided, signposted or confirmed as available locally;
- Early warning of any actions not yet due but which may be at risk of delay
- Where a date change is required an update is required including the rationale and progress made since the date of the last review, obstacles to further progress and confirmation, or otherwise, that the revised date is achievable.

Where it is no longer possible to complete the action the Director of Corporate Governance/Board Secretary can support the Directorate to propose closure to the Audit, Risk and Assurance Committee and internal/external audit colleagues.

Where the implementation an action is delayed beyond 6 months of the originally agreed date the responsible Executive Lead may be invited to attend the next meeting of the Audit, Risk and Assurance Committee to discuss the various issues involved.

Once all actions have been implemented they will be classified as complete, departments are asked to maintain records or evidence in relation to the completion of management actions as this may be requested at a later date.

6.0 Roles and Responsibilities

6.1 Executive Directors

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- Agree the internal audit brief;
- Agree recommendations / identified issues and develop management responses;

- Ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- Support and empower your team to provide all requested audit evidence in a timely manner;
- Agree a directorate process to track management actions;
- Oversee the implementation of agreed actions;
- Attend the Audit, Risk and Assurance Committee to provide assurance to members relating to an unsatisfactory or limited assurance internal audit report;
- Lead a discussion of their audit report in the Board Committees where the subject of the audit is in the remit of that Committee; and
- Ensure reviews of the audit tracker are undertaken as requested by the Corporate Governance Team.

6.2 Audit Point of Contact (may be action owner or business manager in directorate)

- Communicate any issues to auditors which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc;
- Provide auditors with the contact details for everyone involved in the system/process being audited, even if from a different team or division; and
- Update the audit tracker when requested.

6.3 Audit Interviewees

- Cooperate and be open and honest with the audit team
- Clearly explain the process and/or system being audited providing any evidence such as meeting minutes etc as may give wider context;
- Provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner;
- Communicate challenges in providing information and/or pressures within the point of contact in your directorate; and
- Answer to the best of your ability – Auditors know that people can be nervous, and sometimes will forget the answer to a question. It is acceptable to say: "I forget that right now, but here is where I can find that information," and then to show the auditor the procedure or other information they need. If an employee doesn't know an answer, it is far worse to make up the answer than to just say, "I don't know, but I can find out."

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6.4 Director of Corporate Governance / Board Secretary

- Ensure there is an adequate provision of internal and external audit services;

- Coordinate the development and approval of the annual audit plan
- Coordinate reporting of final audit reports to Executive Committee, Audit, Risk and Assurance and other relevant Committees;
- Maintenance of the audit tracker;
- Coordinate audit tracker reviews;
- Prepare progress and tracker reports to Executive Committee, Audit, Risk and Assurance Committee and Board Committees;
- Facilitate escalations from Internal Audit or on tracker; and
- Lodge quarterly Welsh Government return of audits.

6.5 Audit, Risk and Assurance Committee

- Facilitate direct and unrestricted access for the Head of Internal Audit and Auditor General for Wales to the Board;
- Review and recommend Internal Audit Charter for approval by Board;
- Receives the Internal Audit confirmation of independence annually;
- Receives regular reports from Audit Wales and Head of Internal Audit on its activities;
- Agree annual Internal Audit plan;
- Review internal audit reports, Structured Assessments and other Audit Wales reports, and scrutinise of the adequacy of management actions in response to recommendations / identified issues;
- Receive and scrutinise Audit Tracker update reports;
- Scrutinise the progress of audits overall, escalating to the Board any issues of concern; and
- Receive and review Head of Internal Audit Opinion.

6.6 Board Committees

- Receive audits in their remit;
- Monitor management actions to address recommendations / identified issues; and
- Scrutinise impact of actions in response to audit recommendations / identified issues in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

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6.7 Executive Committee

- Develop proposal for annual Internal Audit plan;
- Review Structured Assessment briefs;
- Receive and review all final Internal Audit reports, Structured Assessment and Audit Wales reports;

- Receive and scrutinise Audit Tracker update reports
- Oversight of the audit framework; and
- Receive and review Head of Internal Audit Opinion.

6.8 Internal Audit

- Provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively;
- Provide annual Head of Internal Audit Opinion to Audit, Risk and Assurance Committee;
- Provide regular reports on progress to Audit, Risk and Assurance Committee;
- Present annual Internal Audit plan;
- Present finalised Internal Audit reports to Audit, Risk and Assurance Committee;
- Review Audit Tracker and raise concerns to Director of Corporate Governance/Board Secretary and/or Audit, Risk and Assurance Committee; and
- Agree timeframes for the various stages of internal audit work with the Director of Corporate Governance/Board Secretary.

6.9 External Audit

- Provide independent assurance on the financial statements and the corporate arrangements for securing economy, efficiency and effectiveness in the Health Board's use of resource.
- Agree the briefs for audit work with the Director of Corporate Governance/Board Secretary and/or relevant Executive Director
- Provide regular reports on progress to Audit, Risk and Assurance Committee;
- Present annual Audit plan to Audit, Risk and Assurance Committee;
- Present finalised Audit reports, including the Annual Audit Report to Audit, Risk and Assurance Committee (or other Committees or the Board by agreement);
- Review tracker and raise concerns to Director of Corporate Governance/Board Secretary and/or Audit, Risk and Assurance Committee; and
- Agree timeframes for the various stages of performance audit work with the Director of Corporate Governance/Board Secretary and for the audit of the financial statements with the Executive Director of Finance, Capital and Support Services.

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7.0 Appendices

7.1 Reference and Bibliography

- CGP 005 Risk Management Framework
- CGP 014 Board Assurance Framework

- Internal Audit Charter
- About-us | Audit Wales

7.1 Glossary of Terms

Glossary of terms	
Term	**Definition**
Assurance	From an internal audit perspective, this means providing an independent assessment of a system of process through an objective examination of evidence. More generally, assurance can be defined as confidence based on objective information.
Audit Brief	Documentation that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics., including the audit team, key contacts and timeframes.
Audit Report	Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.
Governance	The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement of objectives.
Executive Lead	Individual within the organisation identified as the lead for the audit, usually a director. Responsibilities include: • Agreeing the audit brief; • Providing management responses to recommendations; • Overseeing the implementation of agreed actions.
Risk Management	A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.
Audit meetings	Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc. Kick-off meeting: usually held at the beginning of the fieldwork phase, audit use this meeting to get a detailed understanding of the system under review. Debrief meeting: at the end of the audit, a meeting will be held with key individuals to debrief on findings.
Control	Any measures put in place by management, the Board or other partied to manage risk and increase the likelihood that organisational goals and objectives will be achieved.
Assurance opinion	The auditors overall view of whether, for the system being audited: • The controls have been adequately designed to mitigate identified risk' and

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	• The controls are operating effectively (i.e., are being adhered to in practice) Assurance opinions are defined in **Annex 2.**
Findings	Audit findings may support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system. Alternately, findings may relate to non-compliances within the system e.g., policies and procedures have not been followed.

7.3 Internal Audit Assurance Ratings

Assurance Opinion

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

7.4 Internal Audit Finding Prioritisations

Prioritisation of Findings

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

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8.0 Equality Impact Assessment

Has an Equality Impact Assessment (EIA) been completed	YES:	NO: X
Name of the person giving this response	Stella Gwynne	
If NO:	See EIA for the associated CGP 014 Board Assurance Framework	
If YES:	Attach EIA as an appendix to this document	

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.2

AUDIT RISK AND ASSURANCE COMMITTEE	**22 OCTOBER 2026**
Subject:	LOSSES AND SPECIAL PAYMENTS INTERIM REPORT 2026-27
Approved and presented by:	Hywel Pullen, Interim Executive Director of Finance
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	None

PURPOSE:

To receive the Interim Report of Losses and Special Payments for the period 1st April 2026 to 31st August 2026.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

- **RECEIVE** this Interim Report on Losses and Special payments covering the period 1st April 2026 to 31st August 2026.
- Take **ASSURANCE** appropriate reporting mechanisms are in place.

Approve/Take Assurance	Discuss	Note
Y	N	Y

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

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EXECUTIVE SUMMARY:

Losses and special payments are items that the Welsh Government would not have contemplated when they passed legislation or agreed funds for the NHS; such payments would also include any ex gratia payments made by the THB.

By their nature they are items which should be avoidable and should not arise. They are subject therefore to special control procedures and are included within a separate note in the THB's annual accounts.

HEADING:

The following relate to payments made on behalf of cases for which Powys THB have responsibility. Claims relating to the Residual Clinical Negligence (relating to former Health Authorities) cases are scrutinised by the Welsh Risk Pool advisory panel and therefore are not required to be included below.

This paper provides an interim report for the period 1st April 2026 to 31st August 2026.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Redress, Compensation Claims & Inquest Case Co-Ordinator, manages the claims on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support are provided by Legal & Risk Services on the processes and on the management of individual cases. Addressing learning following settlement of individual cases, learning and evidence is shared with Welsh Risk Pool (WRP) with the LFER process for reimbursement.

Systems and processes have been established and databases documenting all claims activity alongside the individual claims files exist. Decision making on payments are approved in a number of ways:

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery. All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety Committee. The last report was provided to the August 2026 Committee.

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- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2026 to 31 August 2026, the THB made payments in respect of 5 cases totalling £9,903.08 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year to date the THB has not received reimbursement in respect of cases that exceeded the £25,000 THB liability.

Details of the payments are included in Appendix Ai.

	No. of payments	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	11	5	£ 9,903.08
Total	**11**	**5**	**£ 9,903.08**

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 16 cases which are which are inclusive of clinical negligence (11),and personal injury (5) claims with NWSSP Legal and Risk Services instructed to act on behalf of the health board.

There has been no reimbursement to date from Welsh Risk Pool during 2026/27 but a couple of claims have concluded and been recently submitted to Welsh Risk Pool for reimbursement.

Redress (Putting Things Right)

These relate to smaller claims that are managed by the THB in line with the Putting things Right Legislation. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2026 to 31st August 2026 are included in Appendix Aii.

	No. of payments/receipts	No. of cases	£
Redress Payments	4	2	£16,130.66
Total	**4**	**2**	**£16,130.66**
Redress Receipts	0	0	£0
Total	**0**	**0**	**£0**

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There are currently 9 open redress cases at variable stages

General Medical Practice Indemnity (GMPI)

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2026 to 31st August 2026 are included in Appendix Aiii.

	No. of payments/receipts	No. of cases	£
GMPI Payments	13	5	£130,417.60
Total	**13**	**5**	**£130,417.60**
GMPI Receipts	0	0	£0
Total	**0**	**0**	**£0**

There are currently 7 open GMPI cases at variable stages of review/progression.

There has been no reimbursement to date from Welsh Risk Pool during 2026/27 but one claim has been withdrawn and associated costs to date have been recently submitted to Welsh Risk Pool for reimbursement.

Other Special Payments

There have been 18 Ex Gratia payments made during 1st April 2025 to 31st August 2026. The payments relate to the recognition payments for Health Care Support workers rebanded from Band 2 to 3. This exercise was reported at the March 2026 Audit Risk and Assurance meeting and Welsh Government have formally provided approval for the losses due to value.

Conclusion

The Audit Committee is asked to note the above interim report for 2026/27 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

The Audit Risk and Assurance Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

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Losses And Special Payments for 2026-27 Financial Year 1st April 2026 to 31st August 2026					Appendix Ai	
Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Pa	Payments	Amount by case	Additional Information
CN	DEFENCE COSTS	SSPLR154920	Apr-26	£750.00	£750.00	Interim Payments Case ongoing
CN	DEFENCE COSTS	SSPLR147420	Apr-26	£1,102.50		
CN	DEFENCE COSTS	SSPLR147420	May-26	£3,080.00		
CN	DEFENCE COSTS	SSPLR147420	Jul-26	£400.00	£4,582.50	Interim Payments Case ongoing
PI	DEFENCE COSTS	SSPLR149755	Jul-26	£732.80		
PI	DEFENCE COSTS	SSPLR149755	Jul-26	£1,092.81		
PI	DEFENCE COSTS	SSPLR149755	May-26	£842.90	£2,668.51	Interim Payments Case ongoing
CN	DEFENCE COSTS	SSPLR154114	Jun-26	£655.88		
CN	DEFENCE COSTS	SSPLR154114	Jul-26	£376.47	£1,032.35	Interim Payments Case ongoing
PI	DEFENCE COSTS	SSPLR22673275	May-26	£513.55		
PI	DEFENCE COSTS	SSPLR22673275	Jul-26	£356.17	£869.72	Interim Payments Case ongoing
		TOTAL		£9,903.08	£9,903.08	
Reimbursements from Welsh Risk Pool						
Receipt Date	Nature of Reimbursement From Welsh Risk Pool	WRP Reference		Amount		
Nil reimbursements to date						
		Total		£0.00		

Appendix Aii

Redress Losses And Special Payments for 2026-27 Financial Year 1st April 2026 to 31st August 2026			Appendix Aii			
Payment Date	Redress Reference	WRP Reference	Nature of Payment	Amount	Amount by case	Additional Information
P02-27	Red 69	PTR/030/1898/DS	DEFENCE COSTS	£3,520.00		
P02-27	Red 69	PTR/030/1898/DS	DAMAGES	£11,000.00		
P03-27	Red 69	PTR/030/1898/DS	CLAIMANT COSTS	£1,600.00	£16,120.00	Interim Payments Case ongoing
P02-27	RED79	RED/7A7/0061/RG	DEFENCE COSTS	£10.66	£10.66	Interim Payments Case ongoing
			Total	£16,130.66	£16,130.66	
Reimbursements from Welsh Risk Pool						
Receipt Date	WRP Reference	Redress Reference		Amount		Amount by case
Nil Reimbursements received in year						
			Total	£0.00		£0.00

Appendix Aiii

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GP Indemnity Losses And Special Payments for 2026-27 Financial Year

Appendix Aiii

1st April 2026 to 31st August 2026

Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount by case	Additional Information
May-26	SSPLR1246192	DEFENCE COSTS	£2,115.00	£2,115.00	Interim Payments Case ongoing
Jun-26	SSPLR149851	CLAIMANT COSTS	£55,000.00	£55,000.00	Interim Payments Case ongoing
Apr-26	SSPLR154808	DEFENCE COSTS	£2,550.00		
Apr-26	SSPLR154808	DAMAGES	£6,000.00		
May-26	SSPLR154808	DEFENCE COSTS	£600.00		
Jun-26	SSPLR154808	CRU COSTS	£915.00		
Jun-26	SSPLR154808	CLAIMANT COSTS	£40,000.00		
Jun-26	SSPLR154808	DEFENCE COSTS	£500.00		
Jul-26	SSPLR154808	CLAIMANT COSTS	£20,000.00		
Aug-26	SSPLR154808	DEFENCE COSTS	£1,557.60	£72,122.60	Interim Payments Case ongoing
Jul-26	SSPLR154978	DEFENCE COSTS	£210.00		
Jul-26	SSPLR154978	DEFENCE COSTS	£270.00	£480.00	Interim Payments Case ongoing
Jun-26	SSPLR155471	DEFENCE COSTS	£700.00	£700.00	Interim Payments Case ongoing
		Total	**£130,417.60**	**£130,417.60**	**£0.00**

Reimbursements from Welsh Risk Pool

Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Nil Reimbursements received in year			
		Total	**£0.00**

Appendix Aiv

Other Losses And Special Payments for 2026-27 Financial Year

Appendix Aiv

1st April 2026 to 31st August 2026

Payment Date	Losses Reference	Nature of Reimbursement	Amount
Apr 26 to Aug 26	PTHB Band 2- 3 2026-27	18 x Recognition payment in respect of the Band 2-3 exercise. Approval provided by Welsh Government for Loss	£51,835.08
		Total	**£51,835.08**

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Learning Disabilities Eligibility Assessment & Care Co-ordination Processes

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Substantial Assurance

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Executive Summary 1

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Review Reference	PTH-2526-26
Fieldwork	May - July 2026
Executive Sign Off	August 2026
Audit Committee	October 2026
Executive Lead	Elaine Lorton, Executive Director of Primary, Community Care and Mental Health.
Audit Team	Ian Virgil, Head of Internal Audit
	Ken Hughes, Audit Manager

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Executive Summary

Purpose

Our review of the Learning Disability service was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board') and focussed on the robustness and documentation of the eligibility assessment and care co-ordination processes.

Overview

The Community Adult Learning Disability Team is a multi-disciplinary team that provides healthcare services to adults over the age of 18 with a learning disability. The multi-disciplinary team includes nurses, health care assistants and specialist consultants in Epilepsy, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychiatry and Psychology. The department of Health makes a clear distinction between Learning Disability and Learning Difficulty. For an individual to be classed as having a Learning Disability they must have significant impairment of intellectual functioning. A learning difficulty such as dyslexia, ADHD or Dyspraxia does not affect general intellect, and these needs are met through mainstream services. To ensure patients are eligible for the Learning Disability service they must meet the eligibility criteria. Assessment is a key element of the teams work to ensure that referrals to the team meet the eligibility criteria. A care co-ordinator must then be allocated for all eligible patients who will Work collaboratively with the patient and Mental Health Service Providers with a view to agreeing outcomes which those Mental Health Services are designed to achieve.

We have concluded **substantial** assurance on this area. The following matters require management attention:

- There was no up to date terms of reference in place for MDT meetings.
- The quality of MDT meeting notes needs to be improved to ensure they clearly include all salient information regarding the initial assessment including the outcome and rationale for acceptance or rejection by the LD service.

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 Dementia Pathway SOP that is due to replace the out-of-date Adult Intellectual Disabilities Operational Framework has been in draft since February 2026 and had not been approved at the time of our audit in July 2026.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The eligibility criteria and assessment and care co-ordination processes are adequately documented.	-	**Substantial**
2	A record is kept of all referrals to the service, the outcome of their assessment and any appeals or challenges to the outcome.	-	**Substantial**
3	The assessment process for each referral is properly documented and the rationale for acceptance or rejection is clearly recorded.	1, 2	**Reasonable**
4	A care co-ordinator is identified for all eligible patients, and an appropriate Care and Treatment Plan (CTP) is put in place and reviewed regularly.	-	**Substantial**
5	The assessment and allocation of services and care co-ordination for eligible patients is appropriate and is undertaken within reasonable timescales.	-	**Substantial**
6	Mechanisms are in place for recording and monitoring the level of service delivery and outcomes and reporting these upwards through the Service Group and Health Board to provide appropriate assurance.		**Substantial**

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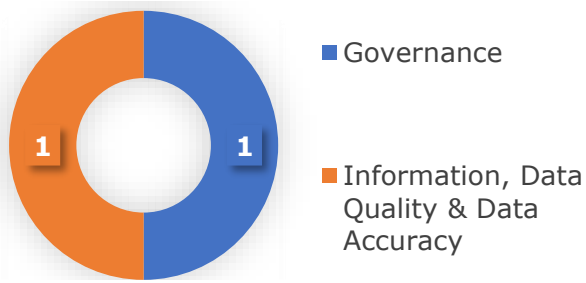
Management Actions

0	2
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: The eligibility criteria and assessment and care co-ordination processes are adequately documented.	**Substantial**

Overview / Summary of Observations

The eligibility criteria is clearly documented and requires all patients to have a diagnosed Learning Disability to be eligible for the service. The eligibility criteria is contained within the Adult Intellectual Disabilities Operational Framework. This was due for review in August 2023. A new Standard Operational Policy covering the eligibility process has now been drawn up. This is dated February 2026, but we note it was still in draft and had not been approved at the time of our audit. The process for checking eligibility has also been documented in an easy to follow 'flow chart'.

The PTHB SharePoint site has a dedicated Learning Disabilities page. This had a section for Learning Disability Documents & Resources which included the Learning Disability Referral Criteria, Referral Form and a list of some 74 Learning Disability Champions covering the Health Board together with their contact details. The PTHB website has a dedicated Learning Disability page and provides information on who may or may not be eligible for LD services, and signposts users to make an enquiry to the LD team via the e-mail link provided if they think someone may be eligible.

In summary, the eligibility criteria and assessment process has been adequately documented. A new Standard Operational Policy has been drawn up to replace the out-of-date Operational Framework, and the eligibility criteria and supporting documentation such as standard referral forms are readily available to all PTHB staff.

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Objective 2: A record is kept of all referrals to the service, the outcome of their assessment and any appeals or challenges to the outcome.	**Substantial**

Overview / Summary of Observations

Referrals can be made by a variety of routes, for example self-referral by the patient or their carer, from mainstream healthcare services, via Social Services or from the patient's GP. There is a standard referral form which is available on the Learning Disabilities SharePoint page. However, we were informed that some referrals are made verbally over the telephone or are brought up during the fortnightly MDT meetings. GP's tend to make referrals by letter rather than using the standard referral form.

When referrals are received basic checks are carried out to ensure all the necessary details have been received including the patients consent to the referral. The referral details are then entered into the WCCIS (system). Any referral documentation such as the standard referral form, GP referral letter or e-mail is uploaded to the Referral section of WCCIS. The case is then scheduled for discussion at the next fortnightly Multi-Disciplinary Team (MDT) meeting. The outcome of each assessment should then be recorded in the MDT minutes.

Eligibility for the service is considered at the fortnightly MDT meetings and there are three possible outcomes, i.e. referral accepted, decision pending as further information required or rejected. The main eligibility criteria is the diagnosis of an existing 'Learning Disability'. If there is an existing Learning Disability diagnosis the patient is accepted as eligible for the service. If it is possible they may have an undiagnosed Learning Disability the referral is put on hold and further information is gathered which could take between 4 weeks (for eligibility screening) up to 14 weeks if a psychological assessment is required. The patient may also be assessed as not eligible for the LD service. In this case they may be signposted to other relevant services.

A sample of 10 referrals was selected for testing to ensure that the details were promptly recorded in WCCIS prior to the referral being considered at the next available MDT meeting. In each case, the referral had been made promptly recorded on the system and had been scheduled for the next available MDT for initial assessment. Of the ten referrals tested, three had been rejected, all of which had been signposted to other NHS services and none of the decisions had been challenged.

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Objective 3: The assessment process for each referral is properly documented and the rationale for acceptance or rejection is clearly recorded.	**Reasonable**

Overview / Summary of Observations

As noted previously, to qualify for the LD service referrals must have a suspected Learning Disability or a Learning Disability diagnosis before the age of 18 in accordance with the documented eligibility criteria.

All referrals are initially recorded on the WCCIS system and are scheduled to be discussed at the next fortnightly Multi-Disciplinary Team (MDT) meeting. Meeting notes are kept for all MDT meetings. The meeting notes from 15 MDT meetings were reviewed and it was noted that meetings were attended by a wide variety of different staff and the number of attendees in attendance varied significantly. We were informed that MDT meetings were initially covered by a terms of reference, but this could not be located during the audit.

The MDT assessment meeting notes were reviewed for a sample of referrals to ensure the assessments had been undertaken promptly, in a fair and robust manner, the rationale for the outcome of the assessment was clear, and the outcome had been accurately recorded in the minutes matching the outcome recorded in the WCCIS system. Whilst all referrals were considered promptly at the next scheduled MDT meeting, the meeting notes did not always record the outcome of the discussion or the rationale for accepting or rejecting each referral.

	Key Findings	Risk & Impact	Agreed Management Action
1	**MDT Terms of Reference** A review of the meeting notes from 15 MDT meetings showed that 22 different staff had attended the meetings. The average number of meetings attended by each attendee was 8/15. The lowest attendance was six and the highest number of attendees was 16, and the average number of attendees was 12. The meetings had been chaired by five different attendees, although we note that all were suitably experienced staff. We were informed that a terms of reference had previously been drawn up for the group, but this could not be located at the time of our audit. An up-to-date terms of reference is important to ensure the group's remit is clear and valid, and decisions are made by an appropriate number of suitably qualified and experienced members of the group.	The group's remit is unclear. Decisions may be made without staff with the necessary knowledge and experience being present.	**Agreed Action:** A new terms of reference will be drawn up for the group that sets out the remit of the group, membership, roles and responsibilities and quorum for making decisions. **Expected Evidence of Implementation:** An updated and approved terms of reference is in place.
		Medium Priority	**Officer:** Head of Nursing Learning Disabilities **Target Implementation Date:** 30th September 2026
	Theme: Governance	Control Design	

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2	**MDT Meeting Notes / Minutes** The MDT meeting notes from the initial review for ten referrals were reviewed. Although the WCCIS system shows that five referrals were accepted, three were rejected, one assessment was ongoing and one referral was under 18, this was not always accurately reflected in the MDT meeting minutes. For 5/10 referrals, there was insufficient detail in the MDT minutes and the rationale for acceptance / rejection was not adequately recorded.	The MDT minutes do not accurately reflect decisions made during meetings and action taken.	**Agreed Action:** The quality of the MDT minutes and requirements for future meetings will be reviewed to ensure that they provide a comprehensive record of the MDT meeting for all future referrals considered. **Expected Evidence of Implementation:** Improved quality of MDT Meeting Notes / Minutes that accurately reflect the decisions taken during MDT meetings, the outcome of discussions and the rationale for acceptance or rejection.
		Medium Priority	**Officer:** Head of Nursing Learning Disabilities
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30th September 2026

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Objective 4: A care co-ordinator is identified for all eligible patients, and an appropriate Care and Treatment Plan (CTP) is put in place and reviewed regularly	**Substantial**

Overview / Summary of Observations

Care Co-ordination is a statutory role under the Mental Health (Wales) Measure 2010 and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011. It applies to individuals receiving secondary mental health services and requires a designated Care Co-ordinator to oversee and manage their care. The Care Co-ordinator is responsible for:

- Working collaboratively with the service user, their family/carers (where appropriate), and relevant service providers to agree care outcomes;
- Developing and maintaining a Care and Treatment Plan (CTP);
- Ensuring the CTP is regularly reviewed and updated;
- Promoting effective co-ordination of services involved in the person's care; and
- Maintaining contact with the individual and, where appropriate, their family or carers.

The legislation places a duty on the relevant Mental Health Service Provider (Local Health Board or Local Authority) to appoint a Care Co-ordinator as soon as reasonably practicable and normally within 14 days of a person being accepted into secondary mental health services. In summary, the Care Co-ordinator acts as the lead professional responsible for ensuring that mental health care is planned, coordinated, reviewed, and delivered effectively to meet the individual's needs.

Testing was undertaken on a sample of five referrals to ascertain whether a care co-ordinator had been allocated and a care and treatment plan drawn up. Whilst all had been allocated a care co-ordinator, a care and treatment plan had only been drawn up for one of the five clients reviewed. However, a CTP is not always required, and we were informed that this is determined using a CPT screening tool as part of the assessment process.

Objective 5: The assessment and allocation of services and care co-ordination for eligible patients is appropriate and is undertaken within reasonable timescales.	**Substantial**

Overview / Summary of Observations

Once a referral has been accepted by the LD service the client is offered an assessment and diagnostic appointment to determine the services they will need. The assessment process for people with learning disabilities should incorporate reasonable adjustments to maximise participation and outcomes, in line with the Equality Act 2010. Prior to assessment, informed consent must be obtained. If there are concerns about the person's capacity, a capacity assessment should be completed, ensuring the individual is fully informed about the assessment process in accordance with the Mental Capacity Act 2005.

For our sample selected for review, assessments had been carried out within reasonable timescales and appropriate services had been allocated by the LD team.

Objective 6: Mechanisms are in place for recording and monitoring the level of service delivery and outcomes and reporting these upwards through the Service Group and Health Board to provide appropriate assurance.	**Substantial**

Overview / Summary of Observations

The Learning Disability Service has various reporting requirements internally and to the Welsh Government.

A quarterly Safeguarding Strategic Service Group Exception Report is prepared for the Director of Nursing and Board members. This report demonstrates the Learning Disability Service Groups compliance with National Safeguarding Quality priorities.

A range of Learning Disability metrics are also collated monthly. These include targets where appropriate and are submitted to the NHS Executives. Review of the June 2026 Return identified that only about half of the metrics for June had been completed, although all figures had been included for previous months. We were informed that the team could not complete the figures due to missing information from Primary Care, but the issue preventing the information being received has now been resolved.

A quarterly Reporting Template is also completed that reports Learning Disability Health Check progress. This reports on the number of individuals within the PTHB are that are on GP Learning Disability registers, and the number offered a health check and the take up of health checks. It also provides metrics on the accuracy of LD registers, the number of HB staff that have received specific LD training and the use of funding and interventions. The report also highlights the services key achievements for each quarter. We were informed that the Welsh Government has now stopped funding this work. However, progress on the health checks and Health Equality Framework are reported via the Learning Disability matrix.

A Quality Assurance (Quals) report is also produced monthly that provides data in areas such as compliments, referrals, assessment outcomes, staff sickness and vacancies. This is a new internal report which is submitted to LD services monthly.

The Welsh Government required all Health Boards to provide details of all patients with a learning disability as at the 8th April 2026 who are occupying a hospital bed together with details of their length of stay, whether discharge/ transfer planning is underway and if there are any barriers to progress. This is requested annually. Powys had two inpatients at the 2026 census date.

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Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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.

Prioritisation of Findings

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

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Public Sector Internal Audit Standards

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

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

Item Title	May 12/05/2026	June 23/06/2026 (Annual Accounts)	July 07/07/2026	Oct 22/10/26	Jan 12/01/2027	Mar 09/03/2027
Minutes of previous meeting	✓		✓	✓	✓	✓
Declaration of Interests	✓		✓	✓	✓	✓
Action Log	✓		✓	✓	✓	✓
Committee Risk Register (Risk SRR011 - Failure of Digital & Electrical Infrastructure) **In-Committee Item**	✓		✓	✓	✓	✓
Annual Work Programme	✓		✓			
Work Programme (updated through year)			✓	☒	✓	✓
Annual Assessment of Committee Effectiveness						
Committee Governance Action Plan			✓	☒		✓
Committee Annual Report	✓					
Audit Findings Tracker			✓			✓
WHC/MD Tracker			✓			✓
Organisational Register of interests, Gifts and Hospitality			✓			✓
Board Assurance Framework	✓					
Review of Terms of Reference						✓
Review of Standing Orders and Standing Financial Instructions						✓
Confirmation of Clinical Audit Programme			✓			
Approach to the Annual Accounts						✓
PTHB Draft Accountability Report and Financial Accounts (Invite D&P	✓					
PTHB Final Accountability Report and Financial Accounts and Letter of Representation		✓				
Head of Internal Audit Opinion Draft	✓					
Head of Internal Audit Opinion Final			✓			
Internal Audit Annual Plan						✓
Internal Audit Progress Report	✓ **25/26**	✓ **26/27**	✓	✓	✓	✓
Internal Audit Reports (as required)	✓	✓	✓	✓	✓	✓
Internal Audit Trend Report					✓	
Enquiries of Management and Those Charged with Governance		✓				
External Audit Annual Plan	✓					✓
External Audit Progress Report	✓		✓	✓	✓	
External Audit Reports (as required)	✓	✓	✓	✓	✓	✓
Structured Assessment						✓
Counter Fraud Annual Plan	✓					✓
Counter Fraud Update	✓		✓	✓	✓	
Counter Fraud Reports (as required)	✓		✓	✓	✓	✓
Single Tender Waivers Annual Report	✓					
Single Tender Waivers (including extensions to contracts)	✓		✓	✓	✓	✓
Losses and Special Payments Annual Report	✓					
Losses and Special Payments	✓			✓		✓
Post payment Verification Yr End May, Mid Yr Jan	✓				✓	
Review of Risk Management Framework	✓					
Assurance of Risk Management arrangements inc. revised Risk						✓
Audit Handbook				✓		
Hosted Body annual report (HCRW)	✓					✓
Information Governance and Records Management Annual Report			✓			
IG Toolkit (National Audit replaces Caldicott Principles)	✓					
Information Governance and Records Management Performance and Assurance Monitoring Report					✓	
Strategic risk deep dive: Digital Infrastructure -**In-Committee Item**			✓		✓	
Digital First Annual Plan					✓	
Digital First 6monthly monitoring report (including cyber security) **In-Committee Item**	✓			✓		
SFI executive financial delegation limits				☒		
WCCIS Update (Connected Care Programme) **In-Committee Item**			✓		✓	✓
WCCIS (Connected Care Programme) Replacement Update **In-Committee Item**				✓	✓	
Policy Management Assurance Report	✓			✓		
Financial Grip and Control	✓				✓	

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Powys Teaching Health Board Glossary (Last updated August 26)

Acronym	
AD ECP	Associate Director of Estates, Capital & Property
ACEO	Acting Chief Executive Officer
ADoF	Acting Director of Finance
ADCEO / EMD	Acting Deputy Chief Executive / Executive Medical Director
CEO	Chief Executive Officer
DCEO / ED FC&SS	Deputy Chief Executive Officer / Executive Director of Finance, Capital & Support Services
DCG	Director of Corporate Governance
D I&T	Director of Improvement & Transformation
E MD	Executive Medical Director
ED PH	Executive Director of Public Health
ED PC&T	Executive Director of People, Culture & Transformation
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED AHPHS&D	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
ED PCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
A&E	Accident and Emergency
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AQS	Annual Quality Statement/Report
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
AF	Audit Findings
APB	Area Planning Board
AGS	Annual Governance Statement
BAF	Board Assurance Framework

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BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAHPO	Chief Allied Health Professionals Officer
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
COC	Continuity of Care
CDO	Chief Dental Officer
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPCF	Community Pharmacy Contractual Framework
CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taf Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
DAP	Dental Access Portal
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/Pathway of Care Delays
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
DOI	Declaration of Interest
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group

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EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GLP-1	Glucagon Like Peptide
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
G&H	Gifts and Hospitality
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIA	Health Impact Assessment
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
IBG	Investment Benefit Group
ICB	Integrated Care Board
ICF	Integrated Care Funding
ICU	Intensive Care Unit
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium-Term Plan
IPFR	Individual Patient Funding Request
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report

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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
KSF	Knowledge and Skills Framework
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LPMHSS	Local Primary Mental Health Support Services
LRF	Local Resilience Forum
LTA	Long Term Agreement
LTCs	Long-Term Conditions
NDR	National Data Resource Platform
NICE	National Institute for Health and Care Excellence
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MD's	Minimum Data Set
MDTs	Multi-Disciplinary Teams
MAP	Medical Associate Practitioner
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NWSSP	NHS Wales Shared Services Partnership
JCC	NHS Wales Joint Commissioning Committee
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive

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NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
ODEC	Organisational Development, Engagement and Communications
OOC	Out of County
OOH	Out of Hours
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PALS	Patient Advice and Liaison Service
PEQS	Patient Experience, Quality and Safety Committee
PREM	Patient-Reported Experience Measure
PROM	Patient-Reported Outcome Measure
PCMW	Primary Care Model for Wales
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
QOF	Quality and Outcomes Framework
RaTS	Remuneration and Terms of Service Committee
DDRB	Review Body on Doctors' and Dentists' Remuneration
RCN	Royal College of Nursing
REES	Race Equality Employment Standard
RIIC	Research, Innovation & Improvement Coordination

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RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
RAMI	Risk Adjusted Mortality Index
RMF	Risk Management Framework
RHCW	Rural Health and Care Wales
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
SPPP	Social Partnership and Public Procurement (Wales) Act 2023
RJC	South East Wales Regional Joint Committee
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

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WCVA	Wales Council for Voluntary Action
WESB	Wales Employment and Skills Board
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
WLGA	Welsh Local Government Association
WNCR	Welsh Nursing Care Record
WNHSC	Welsh NHS Confederation
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust
WCD	Written Controlled Document
YTD	Year to Date

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